

HMO Blue® Texas

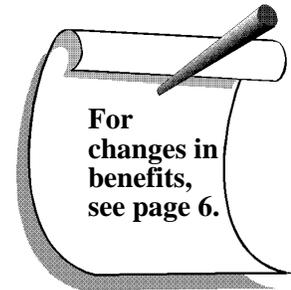
<http://www.bcbstx.com/fep/hbtx>

2007

A Health Maintenance Organization

Serving: The Houston metropolitan area

Enrollment in this Plan is limited. You must live or work in our geographic service area; see page 7 for requirements.



Enrollment code for this Plan:

Houston area
YM1 Self Only
YM2 Self and Family

This Plan has an Excellent accreditation from the NCQA. See the 2007 Guide for more information on accreditation

Authorized for distribution by the:



**United States
Office of Personnel Management**
Center for
Retirement and Insurance Services
<http://www.opm.gov/insure>



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 HMO Blue Texas About
Our Prescription Drug Coverage and Medicare**

OPM has determined that the HMO Blue Texas 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 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.

Please be advised

If you lose or drop your FEHB 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, 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 for personalized help,
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

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Introduction

This brochure describes the benefits of HMO Blue Texas under our contract (CS 1951) with the United States Office of Personnel Management, as authorized by the Federal Employees Health Benefits law. The address for HMO Blue Texas administrative offices is:

HMO Blue Texas
P.O. Box 660044
Dallas, TX 75266

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, 2007, unless those benefits are also shown in this brochure.

OPM negotiates benefits and rates with each plan annually. Benefit changes are effective January 1, 2007, and changes are summarized on page 8. Rates are shown at the end of this brochure.

Plain Language

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

- Except for necessary technical terms, we use common words. For instance, "you" means the enrollee or family member, "we" means HMO Blue Texas.
- 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 or email OPM at fehwebcomments@opm.gov. You may also write to OPM at U.S. Personnel Management, Insurance Services Programs, Program Planning & Evaluation Group, 1900 E Street NW, Washington, DC 20415-3650.

Stop Health Care Fraud!

Fraud increases the cost of health care for everyone and increases your Federal Employees Health Benefits 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:

- Do not give your plan identification (ID) number over the telephone or to people you do not know, except for your health care providers, authorized health benefits 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 877-299-2377 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, DC20415-1100

- 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 (unlesshe/she is disable and incabpable 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.

Preventing medical mistakes

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.
- Contact your doctor or pharmacist if you have any questions.

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.

Visit these Web sites for more information about patient safety.

Ø 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.

Ø www.npsf.org. The National Patient Safety Foundation has information on how to ensure safer health care for you and your family.

Ø 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.

Ø www.leapfroggroup.org. The Leapfrog Group is active in promoting safe practices in hospital care.

Ø www.ahqa.org. The American Health Quality Association represents organizations and health care professionals working to improve patient safety.

Ø 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.

Section 1 Facts about this HMO plan

This Plan is a health maintenance organization (HMO). We require you to see specific physicians, hospitals, and other providers that contract with us. These Plan providers coordinate your health care services. The Plan is solely responsible for the selection of these providers in your area. Contact the Plan for a copy of 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, coinsurance, and deductibles described in this brochure. When you receive emergency services from non-Plan providers, you may have to submit claim forms.

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

How we pay providers

We contract with individual physicians, medical groups, and hospitals to provide the benefits in this brochure. These Plan providers accept a negotiated payment from us, and you will only be responsible for your copayments or coinsurance. Some Primary Care Physicians (PCP) are paid under a method known as capitation. Capitation pre-pays a physician based on a fixed monthly amount per person, no matter how few or many services a patient uses.

Most specialists are paid on a fee-for-service basis (as set for specific services).

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) lists the specific types of information that we must make available to you. Some of the required information is listed below.

- On January 1, 2004, Southwest Texas, Inc. d/b/a HMO Blue Texas merged with Health Care Service Corporation. HMO Blue Texas is offered by Blue Cross and Blue Shield of Texas, a Division of Health Care Service Corporation, a Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association;
- Care management, including medical practice guidelines; and
- Disease Management Program.

If you want more information about us, call 877-299-2377, or write HMO Blue Texas @ P.O. Box 660044, Dallas, TX 75266-0044. You may also visit our Web site at www.bcbstx.com/fep/hbtx.

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:

Houston Territory

The Texas counties of: Austin, Brazoria, Chambers, Colorado, Fort Bend, Galveston, Grimes, Harris, Liberty, Matagorda, Montgomery, San Jacinto, Walker, Waller, Washington and Wharton.

Ordinarily, you must get your care from providers who contract with us. If you receive care outside our service area, we will pay only for emergency care 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.

Section 2 How we change for 2007

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 will increase by 34.7% for Self Only or 30.6% for Self and Family.
- Coverage for standard replacement of durable medical equipment (DME) when determined to be medically necessary by a participating primary care physician and needed because of growth by members who are under 18 years of age.

Section 3. How you get care

Identification cards

We will send you an identification (ID) card when you enroll. You should carry your ID card with you at all times. You must show it whenever you receive services from a Plan provider, or fill a prescription at a Plan pharmacy. Until you receive your ID card, use your copy of the Health Benefits Election Form, SF-2809, your health benefits enrollment confirmation (for annuitants), or your 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 877-299-2377 or write to us at P.O. Box 660044, Dallas, Texas 75266-0044. You may also request replacement cards through our Web site at www.bcbstx.com/fep/hbtx.

Where you get covered care

You get care from “Plan providers” and “Plan facilities.” You will only pay copayments, deductibles, and/or coinsurance.

- **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, www.bcbstx.com/fep/hbtx.

- **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, www.bcbstx.com/fep/hbtx.

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 (PCP). This decision is important since your PCP provides or arranges for most of your health care. To select a PCP, refer to the provider directory or website to find a doctor that meets your personal criteria and preferences (provider type, location, etc.).

- **Primary care**

Your PCP can be a family practitioner, internist, pediatrician. Your PCP will provide most of your health care or give you a referral to see a specialist. Your PCP is part of a Limited Provider Network. This means all of your medical care must come from providers who are in the same Limited Provider Network. You will not be able to select any physician or provider outside of your PCP network, even if that physician is participating in HMO Blue Texas. For more information on Limited Provider Networks, please refer to the Provider Directory.

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

- **Specialty care**

Your PCP will refer you to a specialist for needed care. When you receive a referral from your PCP, you must return to the PCP after the consultation, unless your PCP authorized a certain number of visits without additional referrals. The PCP must provide or authorize all follow-up care. Do not go to the specialist for return visits unless your PCP gives you a referral. However, you may see a Plan OB/GYN or mental health substance abuse provider without a referral.

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

- If you need to see a specialist frequently because of a chronic, complex, or serious medical condition, your PCP will work with the specialist, to develop a treatment plan that allows you to see your specialist for a certain number of visits without additional referrals. Your PCP will use our criteria when creating your treatment plan (the physician may have to get an authorization or approval beforehand)..

- If you are seeing a specialist when you enroll in our Plan, talk to your primary care physician. Your PCP will decide what treatment you need. If he or she decides to refer you to a specialist, ask if you can see your current specialist. If your current specialist does not participate with us, you must receive treatment from a specialist who does. Generally, we will not pay for you to see a specialist who does not participate with our Plan.
- If you are seeing a specialist and your specialist leaves the Plan, call your PCP, who will arrange for you to see another specialist. You may receive services from your current specialist until we can make arrangements for you to see someone else.
- If you have a chronic 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 PCP or specialist will make necessary hospital arrangements and supervise your care. This includes admission to a skilled nursing or other type of facility.

• **If you are hospitalized when your enrollment begins**

If you are in the hospital when your enrollment in our Plan begins, call our customer service department immediately at 877-299-2377. If you are new to the FEHB Program, we will arrange for you to receive care and reimburse you for your covered expenses while you are in the hospital beginning on the effective date of your coverage.

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

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

These provisions apply only to the benefits of the hospitalized person. 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 cases, the hospitalized family member's benefits under the new plan begin on the effective date of enrollment.

Also, if you are in the hospital when your enrollment in our Plan is terminated due to cancellation of coverage (i.e. termination of employment, non-payment of premiums), we will only cover an additional 30 days of medically necessary inpatient stay from the date of termination under Temporary Continuation of Coverage (TCC).

How to get approval for...

• **Your hospital stay**

Plan physicians must provide or arrange your care and you must be hospitalized in a Plan facility.

- **How to precertify an admission** Except for emergency care, your PCP or OB/GYN must authorize all referrals in advance. If your PCP or OB/GYN cannot render the services you require then the PCP or OB/GYN will refer you to the provider (s) you need. Any referral services will be subject to all of the terms, conditions, limitations and exclusions of the HMO Blue Texas plan.
- **Maternity care** Plan physicians must provide or arrange your care and you must be hospitalized in a Plan facility.
- **What happens when you do not follow the precertification rules when using non-network facilities** Your physician must get preauthorization of all network or non-network facilities. Only those facilities which are preauthorized by a Member's PCP will be covered, except in a Medical Emergency. If preauthorization is not received, the entire cost of any such non-Covered Services will be the Member's responsibility. It is the member's responsibility to consult with the PCP in all matters regarding medical care.

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 the following services that include, but are not limited to the following:

- Hospitalization
- Outpatient Facility
- Ancillary Facility
- Referral to a non-participating provider
- Surgical procedures
- Durable Medical Equipment
- Growth Hormone Therapy

Section 4 Your costs for covered services

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 certain services.

Example: When you see your primary care physician you pay a copayment of \$20 per office visit or a \$30 copayment when you see a specialist and when you go in the hospital, you pay \$150 per inpatient admission.

Deductible

We do 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 20% of our allowance for durable medical equipment.

Your catastrophic protection out-of-pocket maximum

After your copayments total \$1,000 per person or \$3,000 per family enrollment in any calendar year, you do not have to pay any more for covered services. However, copayments or coinsurance for the following services do not count toward your catastrophic protection out-of-pocket maximum, and you must continue to pay copayments or coinsurance for these services:

- Prescription Drugs
- Durable Medical Equipment
- Dental
- Vision
- Blood and Blood Products
- Prosthetic Devices
- Allergy Serum and Injections

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.

Section 5 Benefits

This benefits section is divided into subsections. Please read the important things you should keep in mind at the beginning of each subsection. Also read the General Exclusions in Section 6; they apply to the benefits in the following subsections. To obtain claim forms, claims filing advice, or more information about our benefits, contact us at 877-299-2377 or at our Web site at www.bcbstx.com/fep/hbtx.

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.
- A facility copay applies to services that appear in this section but are performed in an ambulatory surgical center or the outpatient department of a hospital.
- We have no calendar year deductible.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

Benefit Description	You pay
Diagnostic and treatment services	
Professional services of physicians <ul style="list-style-type: none"> • In physician's office • Consultations by specialists • Office medical consultations • Second surgical opinion 	\$20 per PCP visit or \$30 per specialist visit
<ul style="list-style-type: none"> • In an urgent care center 	\$35 per office visit
<ul style="list-style-type: none"> • During a hospital stay • In a skilled nursing facility 	Nothing
At home <ul style="list-style-type: none"> • House calls • Visits by nurses and health aides 	\$20 per PCP, nurses and health aides visit or \$30 per specialist visit
Lab, X-ray and other diagnostic tests	
Tests, such as: <ul style="list-style-type: none"> • Blood tests • Urinalysis • Non-routine pap tests • Pathology • X-rays • Non-routine Mammograms • CAT Scans/MRI • Ultrasound • Electrocardiogram and EEG 	Nothing.

Benefit Description	You pay
Preventive care, adult	
<p>Routine physical once a year</p> <p>Routine screenings, such as:</p> <ul style="list-style-type: none"> • Periodic Health Assessments <ul style="list-style-type: none"> - Total Blood Cholesterol - Colorectal Cancer Screening, including <ul style="list-style-type: none"> - Fecal occult blood test - Sigmoidoscopy, screening – every five years starting at age 50 - Double contrast barium enema – every five years starting at age 50 - Colonoscopy screening – every ten years starting at age 50 • Chlamydia infection screening • Routine Prostate Specific Antigen (PS) Test – one annually for men age 50 or older or at least 40 years of age for men at increased risk. • Osteoporosis Screenings – one annually for women age 65 and over. The screening is covered at age 60 for women at increased risk. 	Nothing based on physician's recommended schedule
Routine Pap test	Nothing, for annual exam; otherwise \$20 for each additional PCP visit or \$30 per each additional specialist visit
<p>Routine mammogram – covered for women age 35 and older, as follows:</p> <ul style="list-style-type: none"> • From age 35 through 39, one during this five year period • From age 40 through 64, one every calendar year • At age 65 and older, one every two consecutive calendar years 	Nothing
<p>Routine immunizations endorsed by the Centers for Disease Control and Prevention (CDC):</p> <ul style="list-style-type: none"> • Tetanus-diphtheria (Td) booster – once every 10 years, ages 19 and over (except as provided for under Childhood immunizations) <ul style="list-style-type: none"> - Influenza vaccine, annually - Pneumococcal vaccine, age 65 and older 	Nothing
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Physical exams required for obtaining or continuing employment or insurance, attending schools or camp, or travel.</i> • <i>Treatment for work related injury (if covered by workmen's compensation), educational testing and therapy and nutritional counseling and diet planning.</i> 	<i>All charges.</i>

Benefit Description	You pay
Preventive care, children	
<ul style="list-style-type: none"> • Childhood immunizations recommended by the American Academy of Pediatrics • Immunizations against diphtheria, haemophilus influenza type B, hepatitis B, measles, mumps, pertussis, polio, rubella, tetanus, varicella and rotavirus 	Nothing
<ul style="list-style-type: none"> • Well-child care charges for routine examinations, immunizations and care (up to age 22) • Examinations, such as: <ul style="list-style-type: none"> - Eye exams through age 17 to determine the need for vision correction - Ear exams through age 17 to determine the need for hearing correction - Examinations done on the day of immunizations (up to age 22) 	Nothing
Maternity care	
<p>Complete maternity (obstetrical) care, such as:</p> <ul style="list-style-type: none"> • Prenatal care • Delivery • Postpartum care <p>Note: Here are some things to keep in mind:</p> <ul style="list-style-type: none"> • Plan physicians must provide or arrange your care and you must be hospitalized in a Plan facility. • You may remain in the hospital up to 48 hours after a regular delivery and 96 hours after a cesarean delivery. We will extend your inpatient stay if medically necessary. • We cover routine nursery care of the newborn child during the covered portion of the mother's maternity stay. We will cover other care of an infant who requires non-routine treatment only if we cover the infant under a Self and Family enrollment. Surgical benefits, not maternity benefits apply to circumcision. • We pay hospitalization the same as for illness and injury. See Hospital benefits (Section 5c). If a newborn stays beyond the mother's discharge, satisfaction of a separate Hospital admission copayment may be required. 	\$20 for initial PCP visit only or \$30 for the first specialist visit only and nothing for delivery
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Routine sonograms to determine fetal age, size or sex.</i> • <i>Charges for normal delivery outside of the service area.</i> 	<i>All charges.</i>

Benefit Description	You pay
Family planning	
<p>A range of voluntary family planning services, limited to:</p> <ul style="list-style-type: none"> • Voluntary sterilization (See Surgical procedures Section 5 (b)) • Surgically implanted contraceptives • Injectable contraceptive drugs (such as Depo provera) • Intrauterine devices (IUDs) 	\$20 per PCP visit or \$30 per specialist visit plus \$25 per procedure
<ul style="list-style-type: none"> • Surgically implanted contraceptives (such as Norplant) 	\$20 per PCP visit or \$30 per specialist visit plus 50% of our allowance
<p>Note: A diaphragm and oral contraceptives are covered under the prescription drug benefit</p>	See page 39 for prescription drug benefit.
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Reversal of voluntary surgical sterilization</i> • <i>Genetic counseling</i> 	<i>All charges.</i>
Infertility services	
<p>Diagnostic testing to determine the cause of infertility.</p> <p>Note: We cover oral fertility drugs under the prescription drug benefit.</p>	\$20 per PCP visit or \$30 per specialist visit
<p>Treatment of infertility such as:</p> <ul style="list-style-type: none"> • Artificial insemination: <ul style="list-style-type: none"> - <i>intra vaginal insemination (IVI)</i> - <i>intra cervical insemination (ICI)</i> - <i>intra uterine insemination (IUI)</i> 	\$20 per PCP visit or \$30 per specialist visit plus 50% of the Plan's allowance for each service as determined by us, including physician office visit and laboratory testing.
<ul style="list-style-type: none"> • Oral Fertility drugs 	Note: See page 39 for prescription drug benefit
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Assisted reproductive technology (ART) procedures, such as:</i> <ul style="list-style-type: none"> - <i>in vitro fertilization</i> - <i>embryo transfer, gamete intra-fallopian transfer (GIFT) and zygote intra-fallopian transfer (ZIFT)</i> • <i>Services and supplies related to ART procedures</i> • <i>Donation, preservation, analysis and storage of sperm, eggs or embryos</i> • <i>Cost of donor sperm</i> • <i>Injectible Fertility Drugs</i> • <i>Infertility services after voluntary sterilization</i> 	<i>All charges.</i>

Benefit Description	You pay
Allergy care	
<ul style="list-style-type: none"> • Testing and treatment 	\$25 for each session of testing; \$20 per PCP visit or \$30 per specialist visit
<ul style="list-style-type: none"> • Allergy injections 	\$20 per PCP visit or \$30 per specialist visit
Allergy serum	Nothing
<i>Not covered: Provocative food testing and sublingual allergy desensitization</i>	<i>All charges.</i>
Treatment therapies	
<ul style="list-style-type: none"> • Chemotherapy and radiation therapy <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"> • Respiratory and inhalation therapy • Dialysis – hemodialysis and peritoneal dialysis • Intravenous (IV)/Infusion Therapy – Home IV and antibiotic therapy 	\$30 per visit
<ul style="list-style-type: none"> • Growth hormone therapy (GHT) <p>Note: Growth hormone is covered under the prescription drug benefit.</p> <p>Note: – We will only cover GHT when we preauthorize the treatment. The attending physician must obtain preauthorization. We will ask your physician 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>	See page 39 for prescription drug benefit
Physical and occupational therapies	
<p>Services of each of the following:</p> <ul style="list-style-type: none"> • Qualified physical therapists, • Occupational therapists, • Chiropractic care as physical therapy when performed by a qualified physical therapist <p>Note: Physical and occupational therapy is limited to services that assist the member to achieve and maintain self-care and improved functioning in other activities of daily living.</p>	Outpatient: \$20 per visit Inpatient: Nothing – included in admission

Physical and occupational therapies - continued on next page

Benefit Description	You pay
Physical and occupational therapies (cont.)	
<ul style="list-style-type: none"> Cardiac rehabilitation following a heart transplant, bypass surgery or a myocardial infarction is provided subject to limitations below. <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>Note: Your coverage is limited to services that continue to meet or exceed the treatment goals established for you by your physician. For the physically disabled, treatment goals may include maintenance of functioning or prevention of or slowing of further deterioration.</p>	<p>Outpatient: \$20 per visit</p> <p>Inpatient: Nothing – included in admission</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> Long-term rehabilitative therapy Exercise programs 	<p><i>All charges.</i></p>
Speech therapy	
<ul style="list-style-type: none"> Services of a Speech Therapist <p>Note: Speech therapy includes coverage for rehabilitation or developmental medical care.</p> <p>Note: Your coverage is limited to service that continue to be medically necessary.</p>	<p>\$20 per visit</p>
Hearing services (testing, treatment, and supplies)	
<ul style="list-style-type: none"> One audiogram if medically indicated per year Initial placement of hearing aid when medically necessary <p>Note: Fitting and purchase of hearing aid device(s) is limited to \$800 per ear, one cleaning of the hearing device(s) per year, and replacement every 4 years if medically indicated.</p> <ul style="list-style-type: none"> Hearing testing for children through age 17, which include; (see <i>Preventive care, children</i>) 	<p>Nothing</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> Replacement for loss, damage or functional defect Batteries unless necessary at the time of initial replacement 	<p><i>All charges.</i></p>

Benefit Description	You pay
Vision services (testing, treatment, and supplies)	
Eye exam (vision screening) to determine the need for vision correction for children through age 17 (see Preventive care, children)	Nothing
<ul style="list-style-type: none"> Implantable lenses following intraocular surgery for cataracts. 	Nothing
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <i>Eyeglasses or contact lenses and after age 17, and examinations for them (See page 46 Non-FEHB Benefits)</i> <i>Eye exercises and orthoptics</i> <i>Radial keratotomy and other refractive surgery</i> 	<i>All charges.</i>
Foot care	
<p>Routine foot care when you are under active treatment for a metabolic or peripheral vascular disease, such as diabetes.</p> <p>Note: See Orthopedic and prosthetic devices for information on podiatric shoe inserts</p>	\$20 per PCP visit or \$30 per specialist visit
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <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> <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> <i>Corrective orthopedic shoes, arch supports, braces, splints or other foot care items.</i> 	<i>All charges.</i>
Orthopedic and prosthetic devices	
<ul style="list-style-type: none"> Artificial limbs and eyes; stump hose Externally worn breast prostheses and surgical bras, including necessary replacements following a mastectomy. Prosthetic appliance or surgical bras are limited to \$10,000 per occurrence for replacements unless due to the natural process of maturation. One wig as a result of current chemotherapy or radiation treatment for cancer and limited to \$300. Terminal devices such as a hand or hook Braces for arms, legs, back or neck External cardiac pacemaker 	Nothing

Orthopedic and prosthetic devices - continued on next page

Benefit Description	You pay
Orthopedic and prosthetic devices (cont.)	
<ul style="list-style-type: none"> • Internal prosthetic devices , such as artificial joints, pacemakers, cochlear implants, and surgically implanted breast implant following mastectomy. Note: See 5(b) for coverage of the surgery to insert the device. • Internal prosthetic devices, such as artificial joints, pacemakers, cochlear implants, and surgically implanted breast implant following mastectomy. Note: Internal prosthetic devices are paid as hospital benefits; see Section 5(c) for payment information. Insertion of the device is paid as surgery; see Section 5(b) for coverage of the surgery to insert the device. • Foot orthotics when medically necessary <p>Note: Coverage is limited to the initial device unless otherwise stated.</p>	Nothing
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Orthopedic and corrective shoes (unless built into a leg brace) or other foot care items</i> • <i>Arch supports</i> • <i>Heel pads and heel cups</i> • <i>Lumbosacral supports</i> • <i>Corsets, trusses, elastic stockings, support hose, and other supportive devices</i> • <i>Replacement of external prosthetic devices, except for standard replacements needed because of physical growth by members who are under 18 years of age</i> • <i>Repair or periodic maintenance of any external prosthetic devices</i> • <i>Devices provided solely for cosmetic purposes that have no functional applications</i> • <i>Dentures</i> • <i>Corrective orthopedic appliances for non-dental treatment of temporomandibular joint (TMJ) pain dysfunction syndrome</i> 	<i>All charges.</i>

Benefit Description	You pay
Durable medical equipment (DME)	
<p>We cover rental or purchase of durable medical equipment, at our option, including repair, maintenance or adjustment of durable medical equipment when determined to be medically necessary by your Plan physician. Coverage is limited to the initial placement and standard replacements needed because of growth by members who are under 18 years of age. Under this benefit, we also cover</p> <ul style="list-style-type: none">• Oxygen;• Dialysis equipment;• Hospital beds;• Standard wheelchairs;• Crutches;• Walkers;• Bedside commodes;• Suction machines;• Orthopedic tractions• Annual audiogram (if medically necessary) <p>Note: Call us at 877-299-2377 as soon as your Plan physician prescribes this equipment. Blood Glucose Monitors and Insulin Pumps are covered under your pharmacy benefits.</p>	20% of the allowed amount
<p><i>Not covered:</i></p> <ul style="list-style-type: none">• <i>Motorized Wheelchairs</i>• <i>Deluxe equipment such as motor driven hospital beds</i>• <i>Comfort items</i>• <i>Bed boards</i>• <i>Bathtub lifts</i>• <i>Over bed tables</i>• <i>Air Purifiers</i>• <i>Disposable supplies</i>• <i>Elastic stockings</i>• <i>Sauna baths</i>• <i>Replacement, repair or mainenance of equipment, if determined not to be medically necessary</i>• <i>Exercise equipment</i>• <i>Stethoscopes</i>• <i>Sphygmomanometers</i>• <i>Arch supports</i>• <i>Disposable supplies</i>	<i>All charges.</i>

Benefit Description	You pay
Home health services	
<ul style="list-style-type: none"> • Home health care ordered by a Plan physician and provided by a registered nurse (R.N.), licensed practical nurse (L.P.N.), licensed vocational nurse (L.V.N.), or home health aide. • Services include oxygen therapy, intravenous therapy and medications. 	\$20 per office visit
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Nursing care requested by, or for the convenience of, the patient or the patient's family;</i> • Home care primarily for personal assistance that does not include a medical component and is not diagnostic, therapeutic, or rehabilitative. 	<i>All charges.</i>
Chiropractic	
<p>No benefit</p> <p>Note: Chiropractic care provided by a Chiropractor is not covered. However, chiropractic care for physical therapy is included in Physical and Occupational Therapies on page 21.</p>	All charges.
Alternative treatments	
No benefit	<i>All charges.</i>
Educational classes and programs	
<p>Coverage is limited to classes and programs for the following conditions:</p> <ul style="list-style-type: none"> • Diabetes • Asthma • Congestive heart failure • Mothers-to-be program (pregnancy management) <p>Note: Program must be provided or arranged by our Plan.</p>	Nothing

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.
- We have no calendar year deductible.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- The amounts listed below are for the charges billed by a physician or other health care professional for your surgical care. Look in Section 5(c) for charges associated with the facility (i.e. hospital, surgical center, etc.).

YOUR 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 services require preauthorization and identify which surgeries require preauthorization.

Benefit Description	You pay
Surgical procedures	
<p>A comprehensive range of services, such as:</p> <ul style="list-style-type: none"> • Operative procedures • Treatment of fractures, including casting • Normal pre- and post-operative care by the surgeon • Correction of amblyopia and strabismus • Endoscopy procedures • Biopsy procedures • Removal of tumors and cysts • Correction of congenital anomalies (see <i>Reconstructive surgery</i>) • Surgical treatment of morbid obesity (bariatric surgery) <ul style="list-style-type: none"> - prior approval is required - individual must weigh 100 pounds or 100% over his or her normal weight according to current underwriting standards; - eligible members must be age 18 or over • Insertion of internal prosthetic devices . See 5(a) – <i>Orthopedic and prosthetic devices</i> for device coverage information. <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>Nothing</p>

Benefit Description	You pay
Surgical procedures (cont.)	
<ul style="list-style-type: none"> • Voluntary sterilization (e.g., Tubal ligation, Vasectomy) 	\$20 per PCP visit or \$30 per specialist visit plus \$25 per procedure
<ul style="list-style-type: none"> • Treatment of burns 	\$20 per PCP visit or \$30 per specialist visit
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Reversal of voluntary sterilization</i> • <i>Routine treatment of conditions of the foot; see Foot care</i> 	<i>All Charges.</i>
Reconstructive surgery	
<ul style="list-style-type: none"> • Surgery to correct a functional defect • Surgery to correct a condition caused by injury or illness if: <ul style="list-style-type: none"> - the condition produced a major effect on the member's appearance and - the condition can reasonably be expected to be corrected by such surgery • Surgery to correct a condition that existed at or from birth and is a significant deviation from the common form or norm. Examples of congenital anomalies are: protruding ear deformities; cleft lip; cleft palate; birth marks; and webbed fingers and toes. • Surgery to improve the function of or to attempt to create a normal appearance of abnormal structure caused by congenital defects, developmental deformities, trauma, tumors, infections or disease for a child who is younger than 18 years of age. • All stages of breast reconstruction surgery following a mastectomy, such as: <ul style="list-style-type: none"> - surgery to produce a symmetrical appearance of breasts; - treatment of any physical complications, such as lymph edemas; - breast prostheses and surgical bras and replacements (see <i>Prosthetic devices</i>) <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>Note: If you need lymph node dissection for the treatment of breast cancer, you may remain in the hospital for 24 hours.</p>	\$20 per PCP visit or \$30 per specialist visit
<i>Not covered:</i>	<i>All Charges.</i>

Reconstructive surgery - continued on next page

Benefit Description	You pay
Reconstructive surgery (cont.)	
<ul style="list-style-type: none"> • <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> • <i>Surgeries related to sex transformation</i> 	<i>All Charges.</i>
Oral and maxillofacial surgery	
<p>Oral surgical procedures, limited to:</p> <ul style="list-style-type: none"> • Reduction of fractures of the jaws or facial bones; • Surgical correction of cleft lip, cleft palate or severe functional malocclusion; • Removal of stones from salivary ducts; • Excision of leukoplakia or malignancies; • Excision of cysts and incision of abscesses when done as independent procedures; and • Other surgical procedures that do not involve the teeth or their supporting structures. • Diagnostic and /or surgical treatment of conditions affecting the temporomandibular joint (including the jaw or craniomandibular joint) as a result of an accident, a trauma, a congenital defect, a development defect or a pathology. 	\$20 per PCP visit or \$30 per specialist visit
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Oral implants and transplants</i> • <i>Procedures that involve the teeth or their supporting structures (such as the periodontal membrane, gingiva, and alveolar bone)</i> • <i>Dental care or dental appliances involved in treatment of TMJ</i> • <i>Procedures to improve the appearance of a functioning structure</i> 	<i>All charges.</i>
Organ/tissue transplants	
<p>Solid organ transplants limited to:</p> <ul style="list-style-type: none"> • Cornea • Heart • Heart/lung • Single, double or lobar lung • Kidney • Kidney/Pancreas • Liver • Pancreas • Autologous pancreas islet cell transplant (as an adjunct to total or near total pancreatectomy) only for patients with chronic pancreatitis 	Nothing

Benefit Description	You pay
Organ/tissue transplants (cont.)	
<ul style="list-style-type: none">• Intestinal transplants<ul style="list-style-type: none">- Small intestine- Small intestine with the liver- Small intestine with multiple organs, such as the liver, stomach, and pancreas<p>Blood or marrow stem cell transplants limited to the stages of the following diagnoses. The medical necessity limitation is considered satisfied if the patient meets the staging description.</p>• Allogenic trasplants for<ul style="list-style-type: none">- Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia- Advanced Hodgkin’s lymphoma,- Advanced non-Hodgkin’s lymphoma,- Chronic myelogenous leukemia- Severe combined immunodeficiency- Severe or very severe aplastic anemia• Autologous transplants for<ul style="list-style-type: none">- Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia- Advanced Hodgkin’s lymphoma,- Advanced non-Hodgkin’s lymphoma,- Advanced neuroblastoma• Autologous tandem transplants for recurrent germ cell tumors (including testicular cancer)	Nothing
<p>Blood or marrow stem cell transplants for</p> <ul style="list-style-type: none">• Allogeneic transplants for<ul style="list-style-type: none">- Phagocytic deficiency diseases (e.g., Wiskott-Aldrich syndrome)- Advanced forms of myelodysplastic syndromes- Advanced neuroblastoma- Infantile malignant osteoporosis- Kostmann’s syndrome- Leukocyte adhesion deficiencies- Mucopolysaccharidosis (e.g., Gaucher’s disease, metachromatic leukodystrophy, adrenoleukodystrophy)- Mucopolysaccharidosis (e.g., Hunter’s syndrome, Hurler’s syndrome, Sanfilippo’s syndrome, Maroteaux-Lamy syndrome variants)- Myeloproliferative disorders- Sickle cell anemia	Nothing

Benefit Description	You pay
Organ/tissue transplants (cont.)	
<ul style="list-style-type: none">- Thalassemia major (homozygous beta-thalassemia)- X-linked lymphoproliferative syndrome• Autologous transplants for<ul style="list-style-type: none">- Multiple myeloma- Testicular, mediastinal, retroperitoneal, and ovarian germ cell tumors- Breast cancer- Epithelial ovarian cancer- Amyloidosis- Ependyoblastoma- Ewing's sarcoma- Medulloblastoma- Pineoblastoma <p>Blood or marrow stem cell transplants covered only in a National Cancer Institute or National Institutes of Health approved clinical trial or a Plan-designated center of excellence and if approved by the Plan's medical director in accordance with the Plan's protocol for</p> <ul style="list-style-type: none">• Allogenic transplants for<ul style="list-style-type: none">- Chronic lymphocytic leukemia- Early stage (indolent or non-advanced) small cell lymphocytic lymphoma- Multiple myeloma	Nothing
<ul style="list-style-type: none">• Nonmyeloablative allogeneic transplants for<ul style="list-style-type: none">- Acute lymphocytic or non-lymphocytic (i.e. myelogenous) leukemia- Advanced forms of myelodysplastic syndromes- Advanced Hodgkin's lymphoma- Chronic lymphocytic leukemia- Chronic myelogenous leukemia- Early stage (indolent or non-advanced) small cell lymphocytic lymphoma- Multiple myeloma- Myeloproliferative disorders• Autologous transplants for<ul style="list-style-type: none">- Chronic lymphocytic leukemia- Chronic myelogenous leukemia- Early stage (indolent or non-advanced) small cell lymphocytic lymphoma- Multiple sclerosis	Nothing

Benefit Description	You pay
Organ/tissue transplants (cont.)	
<ul style="list-style-type: none">- Systemic lupus erythematosus- Systemic sclerosis• National Transplants (NTP) – A nationally recognized medical facility designated by our Plan must evaluate the case and determine that the proposed transplant is appropriate for treatment of the condition and has agreed to perform the transplant. <p>Limited Benefits – Treatment for breast cancer, multiple myeloma, and epithelial ovarian cancer may be provided in a National Cancer Institute – or National Institutes of Health-approved clinical trial at a Plan-designated center of excellence and if approved by the Plan’s medical director in accordance with the Plan’s protocols.</p> <p>Note: We cover related medical and hospital expenses of the donor when we cover the recipient.</p>	Nothing
<p><i>Not covered:</i></p> <ul style="list-style-type: none">• <i>Donor screening tests and donor search expenses, except those performed for the actual donor</i>• <i>Implants of artificial organs</i>• <i>Transplants not listed as covered</i>	<i>All Charges</i>
Anesthesia	
<p>Professional services provided in</p> <ul style="list-style-type: none">• Hospital (inpatient)• Hospital outpatient department• Skilled nursing facility• Ambulatory surgical center• Office	Nothing

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

Important 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.
- We have no calendar year deductible.
- Be sure to read Section 4, *Your costs for covered services* for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- The amounts listed below are for the charges billed by 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
Note: The calendar year deductible applies only when we say below: “(calendar year deductible applies)”.	
Inpatient hospital	
Room and board, such as <ul style="list-style-type: none"> • Ward, semiprivate, or intensive care accommodations; • General nursing care; and • Meals and special diets. Note: If you want a private room when it is not medically necessary, you pay the additional charge above the semiprivate room rate.	\$150 per day with a maximum of \$750 per admission
Other hospital services and supplies, such as: <ul style="list-style-type: none"> • Operating, recovery, maternity, and other treatment rooms • Prescribed drugs and medicines • Diagnostic laboratory tests and X-rays • Administration of blood and blood products • Blood or blood plasma • Dressings, splints, casts, and sterile tray services • Medical supplies and equipment, including oxygen • Anesthetics, including nurse anesthetist services • Medical supplies, appliances, medical equipment, and any covered items billed by a hospital for use at home Note: Take home drugs are covered under the prescription drug benefit. For more information, see Section 5(f).	Nothing
<i>Not covered:</i>	<i>All Charges</i>

Inpatient hospital - continued on next page

Benefit Description	You pay
Inpatient hospital (cont.)	
<ul style="list-style-type: none"> • Custodial care, rest cures or domiciliary care • Non-covered facilities, such as nursing homes, schools • Personal comfort items, such as telephone, television, barber services, guest meals and beds • Private nursing care 	<i>All Charges</i>
Outpatient hospital or ambulatory surgical center	
<ul style="list-style-type: none"> • Operating, recovery, and other treatment rooms • Prescribed drugs and medicines • Diagnostic laboratory tests, X-rays , and pathology services • Administration of blood, blood plasma, and other biologicals • Blood and blood plasma • Pre-surgical testing • Dressings, casts , and sterile tray services • Medical supplies, including oxygen • Anesthetics and anesthesia service <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 inpatient procedures.</p>	\$150 per surgery
<ul style="list-style-type: none"> • Chemotherapy and radiation therapy • Dialysis – hemodialysis and peritoneal dialysis 	Nothing
<ul style="list-style-type: none"> • Rehabilitation Services 	\$30 per visit
Extended care benefits/Skilled nursing care facility benefits	
<p>Extended care benefit in a Skilled Nursing Facility (SNF):</p> <p>Up to 60 days consecutive days for each illness or injury when:</p> <ul style="list-style-type: none"> • Full-time skilled nursing care is necessary and confinement in a skilled nursing facility is medically appropriate as determined by the Plan doctor. <p>All necessary services are covered, including:</p> <ul style="list-style-type: none"> • Bed, board, general nursing care, drugs, biologicals, supplies, and equipment ordinarily provided or arranged by the skilled nursing facility when prescribed by a Plan doctor. 	\$25 per day

Extended care benefits/Skilled nursing care facility benefits - continued on next page

Benefit Description	You pay
Extended care benefits/Skilled nursing care facility benefits (cont.)	
<i>Not covered: Custodial care, rest cures, care for persistent illness and disorders.</i>	<i>All charges.</i>
Hospice care	
Supportive and palliative care for the terminally ill is covered in the home or hospice facility. Services include inpatient and outpatient care and family counseling; these services are provided under the direction of a Plan doctor who certifies the terminal stages of illness, with a life expectancy of approximately six months or less.	Nothing
<i>Not covered: Independent nursing, homemaker services, custodial care</i>	<i>All Charges</i>
Ambulance	
Local professional ambulance service when medically appropriate	\$25 per service

Section 5(d) Emergency services/accidents

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.
- We have no calendar year deductible.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

What is a medical emergency?

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

What to do in case of emergency:

- Call 911 or your local emergency number or go to the nearest emergency room. If reasonable possible, call your PCP first. In a true emergency, you can use any hospital or emergency room worldwide.
- Show your HMO Blue Texas member ID card to the emergency room staff.
- If you are not sure whether an emergency exists, call your PCP.
- If you need quick medical attention but the situation is not a true emergency, call your PCP, even at night and on the weekends. All HMO Blue Texas PCPs are required to have a 24-hour on-call coverage.
- You or a family member must notify the Plan within 48 hours unless it was not reasonably possible to do so. It is your responsibility to ensure that the Plan has been timely notified.
- Benefits are available for 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.
- If you need to be hospitalized in a non-Plan facility, you or a family member must notify the Plan immediately, unless it was not reasonably possible to do so.
- If you are hospitalized in a non-Plan facility and Plan doctors believe care can be better provided in a Plan hospital, you will be transferred when medically feasible. A \$25 copay for the ambulance services will apply.
- Any follow-up care recommended by non-Plan providers must be approved by the Plan or provided by Plan providers.
- For emergencies outside the service area, benefits are available for any medically necessary health service that is immediately required because of injury or unforeseen illness.

Benefit Description	You pay
Emergency within our service area	
<ul style="list-style-type: none"> Emergency care at a doctor's office 	\$35 per office visit after normal business hours
<ul style="list-style-type: none"> Emergency care at an urgent care center 	\$35 per visit
<ul style="list-style-type: none"> Emergency care as an outpatient or inpatient at a hospital, including doctors' services 	\$100 per visit
<p>Note: Copayment waived when admitted to hospital. If admitted, refer to Section 5(c) on Inpatient Hospitalization.</p>	
<p><i>Not covered: Elective care or non-emergency care</i></p>	<p><i>All Charges.</i></p>
Emergency outside our service area	
<ul style="list-style-type: none"> Emergency care at a doctor's office 	\$35 per office visit after normal business hours
<ul style="list-style-type: none"> Emergency care at an urgent care center 	\$35 per visit
<p>Emergency care as an outpatient or inpatient at a hospital, including doctors' services</p>	\$100 per visit
<p>Note: Copayment waived when admitted to hospital. If admitted, refer to Section 5(c) on Inpatient Hospitalization.</p>	
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <i>Elective care or non-emergency care</i> <i>Emergency care provided outside the service area if the need for care could have been foreseen before leaving the service area</i> <i>Medical and hospital costs resulting from a normal full-term delivery of a baby outside the service area</i> 	<p><i>All charges.</i></p>
Ambulance	
<p>Professional ambulance service when medically appropriate.</p> <p>Air ambulance if medically necessary.</p> <p>Note: See 5(c) for non-emergency service.</p>	\$25 per service

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.
- We have no calendar year deductible.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- **YOU MUST GET PREAUTHORIZATION OF THESE SERVICES.** See the instructions after the benefits description below.

Benefit Description	You pay
Mental health and substance abuse benefits	
<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"> • Professional services, including individual or group therapy by providers such as psychiatrists, psychologists, or clinical social workers • Medication management 	<p>\$20 per visit</p>
<ul style="list-style-type: none"> • Diagnostic tests 	<p>\$20 per office visit</p>
<ul style="list-style-type: none"> • Services provided by a hospital or other facility • Services in approved alternative care settings such as partial hospitalization, residential treatment, full-day hospitalization, facility based intensive outpatient treatment 	<p>\$150 per day with a maximum of \$750 per admission.</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><i>All Charges.</i></p>

	<ul style="list-style-type: none"> • To be eligible to receive these benefits you must obtain a treatment plan and follow all of the following network authorization processes: • If you need treatment, you may contact your PCP and he or she will assist you in obtaining care.
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Preauthorization	<ul style="list-style-type: none">• A referral from your PCP for mental health and chemical dependency services is not needed. Preauthorization for the mental health/chemical dependency provider that delivers these services must be obtained by telephone prior to the delivery of all behavioral health care, including chemical dependency, by calling toll-free (800) 729-2422.• Certain medical groups or Independent Physician Associations (IPAs) may have selected a different provider for mental health/chemical dependency services.• Members who wish to verify that their mental health/chemical dependency provider is a Network Provider need to call Magellan Behavioral Health at (800) 729-2422.
Limitation	We may limit your benefits if you do not obtain a treatment plan.

Section 5(f) Prescription drug benefits

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.
- Please remember that all benefits are subject to the definitions, limitations and exclusions in this brochure and are payable only when we determine they are medically necessary.
- We have no calendar year deductible.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

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

- **Who can write your prescription?** A Plan physician must write the prescription.
- **Where you can obtain them.** You may use the services of a Participating Pharmacy or our Mail Order Pharmacy by presenting or mailing your new prescription (or refill request) prescribed by a Participating Physician or Participating Dentist to the Participating Pharmacy or Mail Order Pharmacy. Texas Law requires that our Mail Order Pharmacy receive the original prescription in order to fill any C-II medication (for example: Ritalin, Tylox, Dexedrine, Demerol, Dilaudid, Percodan or Morphine).
- **We use a preferred drug list.** “Member Preferred Drug List” (also known as a formulary) is a listing published by HMO Blue Texas of prescribed medications listed as Generic Prescription Drugs and Preferred Brand Name Prescription Drugs. Non-preferred Brand Name prescriptions are those not included in the list of Generic Prescription Drugs and Preferred Brand Name Prescription Drugs. These are covered at the highest copayment. HMO Blue Texas Preferred Drug List is subject to periodic review.
- We have an open preferred drug list. If your physician believes a name brand product is necessary or there is not generic available, your physician may prescribe a name brand drug from a preferred drug list. This list of name brand drugs is a preferred list of drugs that we selected to meet patient needs at a lower cost. Name Brand Prescription drugs not on the preferred list are subject to the highest copayment. To request a copy of our Member Preferred Drug List, call Customer Service at (877) 299-2377, or visit our website at www.bcbstx.com/member/pharmacy.
- **These are the dispensing limitations.** Members are limited to a thirty- (30) day supply or 100-unit supply, whichever is less, of Prescription Drugs from the Participating Pharmacy, subject to any applicable copayments listed on the next page. When using the services of our Mail Order Pharmacy for Maintenance Medications, members are limited to the less of a ninety- (90) day supply or the number of days supply from the date the prescription is filled to the termination date of the Group Contract, subject to the copayments listed on Page 39. The initial prescription of certain classes of drugs is limited to a thirty- (30) day supply.
- **A generic equivalent will be dispensed if it is available**, unless your physician specifically requires a name brand. If you receive a name brand drug when a Federally-approved generic drug is available, and your physician has not specified Dispense as Written for the name brand drug, you have to pay the difference in cost between the name brand drug and the generic.

Important Contact Information

Participating Pharmacy: 1-877-299-2377 or www.bcbstx.com/member/pharmacy.

Mail Order Pharmacy Program: 1-800-521-2227 or www.bcbstx.com/member/pharmacy.

Why use generic drugs? By using generic instead of brand name products, you keep down your costs and ours, without compromising on quality.

When you do have to file a claim. If you purchase items covered by this benefit from a non-participating pharmacy for out of area emergency care prescriptions, you have to submit a reimbursement request to HMO Blue Texas in order to get your benefits. See *Section 7, Filing a claim for covered services*.

Benefit Description	You pay
Covered medications and supplies	
<p>We cover the following medications and supplies prescribed by a Plan physician and obtained from a Participating pharmacy for up to a 30-day supply</p> <p>Note: Prescriptions purchased at a non-Participating pharmacy will be subject to a \$40 copay for a 30 day supply regardless if it is generic or preferred brand.</p>	<p>\$10 per 30 day supply for generic</p> <p>\$25 per 30 day supply for preferred brand name</p> <p>\$40 per 30 day supply for non-preferred brand name</p> <p>Note: If there is not generic equivalent available, you will still have to pay the brand name copay.</p>
<p>Or</p> <p>through our Mail Order Service for up to a 90-day supply:</p>	<p>\$20 per 90 day supply for generic</p> <p>\$50 per 90 day supply for preferred brand name</p> <p>\$80 per for 90 day supply for non-preferred brand name</p> <p>Note: If there is not generic equivalent available, you will still have to pay the brand name copay.</p>
<ul style="list-style-type: none">• Drugs and medicines that by Federal law of the United States , require a physician’s prescription for their purchases except those listed as <i>Not covered</i>;• Oral contraceptive drugs;• FDA approved prescriptions for birth control;• Intravenous fluids and medications for home use;• Oral fertility drugs;• Smoking cessation drugs, limited to \$185.00 lifetime maximum;• Disposable needles and syringes needed to inject covered prescribed medication;• Drugs to treat sexual dysfunction (limited benefits); and• Insulin (including prescription and non-prescription oral agents for controlling blood glucose levels and glucagons emergency kits);• Formulas fro treatment of PKU or other heritable diseases. <p>Note: Bioequivalent Generic Drugs will be dispensed with this Plan. If the member requests a name brand when a generic is available, the member will pay the generic copayment plus the difference between the cost of the generic and the cost of the name brand product.</p>	

Covered medications and supplies - continued on next page

Benefit Description	You pay
Covered medications and supplies (cont.)	
<p>Note: Drugs to treat sexual dysfunction have limited benefits, contact Plan for dose limits; for these medications, you pay the applicable copay up to the dose limit and all charges thereafter. Injectable contraceptives, birth control devices (except diaphragms) are covered under family planning. Diabetic supplies, equipment and education are covered as basic Plan benefits, even those they may be received from Participating pharmacies. See section on next page.</p>	
<p>Diabetes supplies</p> <ul style="list-style-type: none"> • Blood glucose test strips • Lancets • Lancet devices • Insulin syringes and needles • Urine test strips • Visual reading 	<p>\$10 up to a 30-day supply at participating pharmacy or \$20 for up to a 90-day supply through mail order service</p>
<p>Diabetic equipment</p> <ul style="list-style-type: none"> • Insulin pump and associated appurtenances • Insulin infusion device • Blood glucose monitor • Podiatric appliance for the intervention of complications associated with diabetes 	<p>Nothing</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Drugs and supplies for cosmetic purposes</i> • <i>Vitamins, nutrients and food supplements even if a physician prescribes or administers them</i> • <i>Non-prescription drugs</i> • <i>Drugs obtained at a non-Plan pharmacy; except for out-of-area emergencies</i> • <i>Medical supplies such as dressings and antiseptics</i> • <i>Drugs to enhance athletic performance</i> • <i>Implanted time-release medications, except Norplant</i> • <i>Injectibles, aerosol inhalers and inhalant solutions except when purchased through the Home Delivery Pharmacy Service</i> • <i>Fertility drugs other than oral</i> • <i>Topical fluoride</i> • <i>Prescription Drugs prescribed as anorexients (appetite suppressants) or for weight reduction</i> • <i>Blood and urine testing devices</i> • <i>Oxygen gas</i> 	<p><i>All Charges.</i></p>

Covered medications and supplies - continued on next page

Benefit Description	You pay
Covered medications and supplies (cont.)	
<ul style="list-style-type: none">• <i>Prescription drugs intended for use in a practitioner's office or a clinical setting</i>• <i>Prescription drugs which a member is entitled to receive without charge from any worker's compensation laws, or similar municipal, state or federal programs</i>• <i>Prescription drugs dispensed prior to the effective date of coverage</i>• <i>Therapeutic devices or appliances, including hypodermic needles and syringes, support garments, and drug infusion/metering devices</i>	<i>All Charges.</i>

Section 5(g) Special features

Feature	Description
Flexible Benefits Option	<p>Under the flexible benefits option, we determine the most effective way to provide services.</p> <ul style="list-style-type: none"> • We may identify medically appropriate alternatives to traditional care and coordinate other benefits as a less costly alternative benefit. • Alternative benefits are subject to our ongoing review. • By approving an alternative benefit, we cannot guarantee you will get it in the future. • The decision to offer an alternative benefit is solely ours, and we may withdraw it at any time and resume regular contract benefits. • Our decision to offer or withdraw alternative benefits is not subject to OPM review under the disputed claims process.
Blue Access® for Members	<p>Personalized information about your health care coverage is immediate and secure on the web. Go to www.bcbstx.com and login to Blue Access for Members. Create a user ID and password for immediate and secure access to your personal information.</p> <p>You can:</p> <ul style="list-style-type: none"> • Confirm who in your family is covered under your plan • Locate a hospital or doctor in your network • Request a new or replacement member ID card or print a temporary member ID card • Access Health & Wellness information from the Mayo Clinic • Compare hospitals • E-mail us <p>You can use Blue Web for Members from 6 a.m. to 3 a.m. (CT), Monday through Friday and 6 a.m. to 12 a.m. (CT) on Saturday and Sunday.</p>
Prenatal Education	<p>Our prenatal education program, Special Beginnings®, is designed to promote specialty care, education, and monitoring to help you toward the goal of delivering a health, full-term baby.</p> <p>Special Beginnings® offers pregnant HMO Blue Texas members;</p> <ul style="list-style-type: none"> • The support of an obstetrical nurse throughout your pregnancy, • Risk screening and ongoing monitoring and evaluation, • Educational materials designed to help you understand each stage of your pregnancy. • Nutritional advice, and • Coordination of your prenatal care under the HMO Blue Texas Plan with your participating doctor.
Coverage Away From Home	<p>HMO Blue Texas and The BlueCard® Program – You have the peace of mind that you’ll always find the care you need. The BlueCard Program gives you the ability to obtain health care services through a Blue Cross and Blue Shield-affiliated physician or hospital when you are traveling outside of Texas and follow the guidelines.</p>

Urgent Care and Follow-up Care Outside of the Service Area– In an emergency, go directly to the nearest hospital. If you will be traveling or living outside of Texas for less than 90 consecutive days, and you need care that cannot be postponed until you return home, please contact BlueCard® Access at 1-800-810-Blue (2583) for detailed information or visit the BlueCard Doctor and Hospital and Hospital Finder Web site at www.bcbs.com.

Guest Membership– If you (or a covered dependent) will be temporarily residing outside of Texas, in a participating location, for at least 90 days, you may be eligible to become a guest member of a Blue Cross and Blue Shield Association-affiliated HMO. Under the Away from Home Care® (AFHC) Program, you retain your coverage under HMO Blue Texas. To apply, call AFHC Program Coordinator at 1-888-522-2396 before you leave your service area. Your coordinator will provide you with detailed information and guidance. It is important to remember that the benefits available and requirements for accessing services outside of Texas may not be identical to those under HMO Blue Texas.

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 have no calendar year deductibles.
- 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.

Benefit Description	You Pay
Accidental injury benefit	
We cover restorative services and supplies necessary to promptly repair (but not replace) sound natural teeth. The need for these services must result from an accidental injury. Treatment must be initiated within 72 hours of the accident.	Outpatient: \$20 per visit. Inpatient: \$150 per day with a maximum of \$750 per admission.

Dental Benefits	You Pay
Service	
Diagnostic/preventive dentistry by Primary Dentist	Nothing
Initial/periodic oral examination	
Treatment Plan	
Oral cancer exam	
Visual aids	
Consultations	
X-rays	\$2
Bitewing	
Single	\$1
Other X-rays (one each 36 months)	\$12
• Full Mouth	
• Panaramic	\$6
Prophylaxis (cleaning every 6 months)	\$5
• Child (to age 15)	
• Adult (age 15+)	\$8
Oral hygiene instruction	Nothing
Flouride treatment (once each 6 months)	
Non-routine and emergency dentistry	\$3

Dental Benefits	You Pay
Service (cont.)	
X-rays, single (per film)	\$3
Non-routine and emergency office visits	\$9
During regular office hours	
Not during regular office hours	\$15
Note: The office visit copayment is in addition to the applicable copayment(s) for treatment.	
Missed appointment (By Primary Dentist)	\$15
Without 24-hour notice except in case of unforeseen emergency	
Restorative (fillings) by Primary Dentist	\$10
Amalgam (silver) restorations	
1 surface (primary or permanent)	
2 surfaces (primary or permanent)	\$15
3 or more surfaces (primary or permanent)	\$18
Composite resin (white) restorations (anterior teeth only)	\$18
1 surface	
2 surfaces	\$21
3 or more surfaces	\$26
Cosmetic by Primary Dentist	\$50
Acid etch bonding for repair of incisal edge	
Endodontics (Root canal therapy) by Primary Dentist	(per tooth)
1 canal (anterior)	\$170
2 canals (bicuspid)	\$200
3 or more canals (molar)	\$260
Oral Surgery by Primary Dentist	(per tooth)
Single tooth extraction	\$35
Each additional tooth	\$35
Surgical extraction – erupted tooth	\$40
Surgical extraction – soft tissue impaction	\$55
Surgical extraction – partial bony impaction	\$75
Surgical extraction – full bony impaction	\$100
Anesthesia by Primary Dentist	\$10
Nitrous Oxide (per ½ hour)	
Local Anesthetic	Nothing
Periodontics (Gum treatment) by Primary Dentist	\$280
Osseous surgery (per quadrant)	

Dental Benefits	You Pay
Service (cont.)	
Occlusal Adjustment – Limited	\$60
Occlusal Adjustment – Complete	\$130
Periodontal scaling and root planning (per quadrant)	\$70
Major restorative dentistry by Primary Dentist	
Crown and Bridge (per unit) All gold is charged at market price.	
Porcelain veneer crown (with non-precious)	\$235
Full-cast crown (non-precious)	\$225
Inlay – 2 surfaces	\$175
Inlay – 3 surfaces	\$200
Re-cement crown/bridge	\$10
Post for crown	\$60
Stainless steel crown	\$60
Prosthodontics (dentures) by Primary Dentist	
Complete Dentures (upper or lower; plus lab fee)	\$235 plus lab fee
Partial Denture (plus lab fee)	\$320 plus lab fee
Orthodontics (braces) by Primary Dentist	75% of our allowance of the Dentist's fee
Note: Patient pays 20% in advance of treatment. The balance is to be paid in equal monthly installment during course of treatment. Treatment schedule for more than 24 months is to be paid at \$65.00 per month.	

Dental benefits

- The copayments listed above apply when services are performed by your Primary Dentist
- Any unlisted procedures and services provided by your Primary Dentist will be charged to the Member at 75% of the Plan's allowance.
- All procedures and services provided by a Specialist Dentist will be charged to you at 75% of the Plan allowance for the Specialist Dentist's fees.
- Primary and Specialist Dentist services may not be available in your immediate area. Refer to your provider directory or call Customer Service at (877) 854-2583 to find out where Primary and Specialist Dentists are located.

General Provisions

- No referral is needed to see a Participating Specialist Dentist.
- Each family member may select a different Primary Dentist.
- Schedule appointments must be canceled at least 24 hours in advance or the member may be liable for a missed appointment fee, as charged by the dentist.

In case of an emergency, contact your Primary Dentist if possible or obtain services from any licensed dentist. HMO Blue Texas will reimburse the member for the actual cost of such emergency dental services, less applicable copayments, and are limited to palliative treatment to control pain, bleeding or infection. (See "exclusions")

Not covered

- *Emergency services provided at a hospital, outpatient care facility or otherwise than in a dentist's office.*
- *Non-emergency services provided by a non-participant dentist.*
- *Services and related fees for services performed any place other than a dental office, except the oral surgery services described in the Schedule of Dental Benefits*
- *Services and supplies ordered or received when the person is not a member.*

Non-FEHB benefits available to Plan members

The benefits on this page are not part of the FEHB contract or premium, **and you cannot file an FEHB disputed claim about them.** Fees you pay for these services do not count toward FEHB catastrophic protection out-of-pocket maximums.

Vision Benefits

Enrollees are entitled to the following vision benefits from Plan optometrists:

- One eye examination for eyeglasses every 12 months; you pay a \$10 copay;
- Eyeglass lenses and frames available at discount prices;
- Contact lenses and materials are also available at discount prices; and
- One eye examination for contact lenses every 12 months; you pay a \$20 copay.

Note: Coverage is for routine eye examination only when conducted in a single visit. Benefits for medical treatment of eye disease are provided under your basic medical plan when deemed medically necessary by your PCP. Your Davis Vision, Inc. provider will provide you with information regarding the cost of contact lenses and fitting services.

Vision Providers

To be covered, the exam must be provided by a Davis Vision provider. The prescription for lenses (or contacts) must be filled by a participating Davis Vision provider in order to receive the reduced rates. A referral from your PCP is not necessary.

What to do ...

When vision services are needed, access the Davis Vision Web site at www.davisvision.com (enter *control code 2295*) and click on "Find a Doctor," or call Davis Vision at (800) 501-1459 for assistance in locating a participating vision provider close to you.

Schedule an appointment if you need an eye exam by calling a participating provider. Identify yourself as a Davis Vision plan participant and BCBSTX member or covered dependent. Provide the office with your BCBSTX ID card and the name and date of birth of any covered children needing services. Your Davis Vision ID number will be the same as your member number on your BCBSTX ID card.

Areas Not Included in Your Coverage

- Medical treatment of eyes or special procedures, such as orthoptics training;
- Eyeglass lenses, eyeglass frames or contact lenses;
- Contact lens fitting services;
- Eye examinations required by an employer or services for which no charge is made;
- Vision examinations performed more frequently than every twelve (12) months;
- Vision examinations performed by non participating providers; and

Special purpose vision aids.

Section 6 General exclusions – things we don't cover

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

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.

Section 7 Filing a claim for covered services

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

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

Medical 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 877-299-2377.

When you must file a claim – such as for services you received 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:

HMO Blue Texas
Claims Dept.
P. O. Box 660044
Dallas, TX 75266-0044

Prescription drugs

If you purchase items covered by this benefit from a non-participating pharmacy, you have to submit a reimbursement request to HMO Blue Texas in order to get your benefits.

Submit your claims to:

Blue Cross and Blue Shield of Texas
c/o Prime Therapeutics LLC
P. O. Box 64812
St. Paul , MN 55164-0812

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 benefits for your claim if you do not respond.

Section 8 The disputed claims process

Follow this Federal Employees Health Benefits Program disputed claims process if you disagree with our decision on your claim or request for services, drugs, or supplies – including a request for preauthorization/prior approval required by Section 3:

- 1** Ask us in writing to reconsider our initial decision. You must:
- a) Write to us within 6 months from the date of our decision; and
 - b) Send your request to us at: P.O. Box 660044, Dallas, TX 75266-0044, Attn: Appeals; and
 - c) Include a statement about why you believe our initial decision was wrong, based on specific benefit provisions in this brochure; and
- d) Include copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms.

- 2** We have 30 days from the date we receive your request to:
- a) Pay the claim (or, if applicable, arrange for the health care provider to give you the care); or
 - b) Write to you and maintain our denial - go to step 4; or
 - c) Ask you or your provider for more information. If we ask your provider, we will send you a copy of our request—go to step 3.

- 3** You or your provider must send the information so that we receive it within 60 days of our request. We will then decide within 30 more days.

If we do not receive the information within 60 days, we will decide within 30 days of the date the information was due. We will base our decision on the information we already have.

We will write to you with our decision.

- 4** If you do not agree with our decision, you may ask OPM to review it.

You must write to OPM within

- 90 days after the date of our letter upholding our initial decision; or
- 120 days after you first wrote to us - if we did not answer that request in some way within 30 days; or
- 120 days after we asked for additional information.

Write to OPM at: United States Office of Personnel Management, Insurance Services Programs, Health Insurance Group 2, 1900 E Street, NW, Washington, DC 20415-3620.

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.

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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 us at (800) 441-9188 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 2 at 202/606-3818 between 8 a.m. and 5 p.m. Eastern time.

Section 9 Coordinating benefits with other coverage

When you have other health coverage

You must tell us if you or a covered family member have coverage under any other 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; and
- 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. (If you were a Federal employee at any time both before and during January 1983, you will receive credit for your Federal employment before January 1983.) 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 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, 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 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 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 will probably not need 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 (877) 299-2377 or see Web site at www.bcbstx.com/fep/hbtx.

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.

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

This Plan and our Medicare Advantage plan: Blue Medicare PPO is a Medicare Advantage plan offered to Medicare eligibles in the following counties: Harris, Jefferson, Montgomery and Galveston (except zip codes 77550, 77551 & 77554). You must be entitled to Medicare under Part A and enrolled in Part B and live in one of these counties. Individuals with end-stage renal disease are not eligible to enroll. For more information see our web site at www.bcbstx.com.

Blue Medicare PPO is a Medicare Advantage plan offered by HCSC Insurance Services, an independent licensee of the Blue Cross and Blue Shield Association.

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.

Primary Payer Chart		
A. When you - or your covered spouse - are age 65 or over and have Medicare and you?	The primary payer for the individual with Medicare is?	
	Medicare	This Plan
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. When you or a covered family member?		
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		✓ for 30-month coordination period
• Medicare was the primary payer before eligibility due to ESRD	✓	
C. When either you or a covered family member are eligible for Medicare solely due to disability and you?		
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	✓	
D. When you are covered under the FEHB Spouse Equity provision as a former spouse		
	✓	

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

Section 10 Definitions of terms we use in this brochure

Calendar year	January 1 through December 31 of the same year. For new enrollees, the calendar year begins on the effective date of their enrollment and ends on December 31 of the same year.
Coinsurance	Coinsurance is the percentage of our allowance that you must pay for your care. You may also be responsible for additional amounts. See page 12.
Copayment	A copayment is a fixed amount of money you pay when you receive covered services. See page 12.
Covered services	Care we provide benefits for, as described in this brochure.
Custodial care	Care that primarily helps with or supports daily living activities (such as bathing, dressing, eating and eliminating body wastes) and can be given by people other than trained medical personnel. Custodial care that lasts 90 days or more is sometimes known as Long Term Care.
Experimental or investigational service	<p>Experimental or Investigational drugs, devices, treatments or procedures include any drug, device, treatment or procedure that would not be used in the absence of the experimental or investigational drug, device, treatment or procedure. We consider a drug, device, treatment or procedure to be experimental or investigational if:</p> <ul style="list-style-type: none">• It cannot be lawfully marketed without the approval of the U.S. Food and Drug Administration and approval for marketing has been given at the time it is provided; or• It was reviewed and approved by the treating facility’s Institutional Review Board or similar committee, or if federal laws requires it to be reviewed and approved by that committee. This exclusion also applies if the informed consent form used with the drug, device, treatment or procedure was (or was required by federal law to be) reviewed and approved by that committee; or• Reliable evidence shows that the drug, device, treatment or procedure is the subject of ongoing Phase I or Phase II clinical trials; is the research, experimental, study or investigational arm of ongoing Phase III clinical trials; or is otherwise under study to determine its maximum tolerated dose, its toxicity, its safety, its effectiveness, or its effectiveness compared to a standard method of treatment or diagnosis.• Reliable evidence shows that the prevailing opinion among experts is that further studies or clinical trials of the drug, device, treatment or procedure are needed to determine its maximum tolerated dose, its toxicity, its safety, its effectiveness, or its ineffectiveness compared to a standard method of treatment or diagnosis. <p>(“Reliable evidence” includes only published reports and articles in authoritative medical and scientific literature and written protocols and informed consent forms used by the treating facility or by another facility studying substantially the same drug, device, treatment or procedure.)</p>
Medical necessity	<p>By “medically necessary”, we mean that the service meets <i>all</i> of the following conditions:</p> <ul style="list-style-type: none">• The service is required for diagnosis, treating or preventing an illness or injury, or a medical condition such as pregnancy;• If you are ill or injured, it is a service you need in order to improve your condition or to keep your condition from getting worse;• It is generally accepted as safe and effective under standard medical practice in your community; and• The service is provided in the most cost-efficient way, while still giving you an appropriate level of care.

Not every service that fits this definition is covered under your Plan. To be covered, a service that is medically necessary must also be described in this document. For example, we *do not* cover any preventative, family planning or infertility services that are not specified. Just because a physician or other health care provider has performed, prescribed or recommended a service does not mean it is necessary or that it is covered under your Plan.

Us/We

Us and We refer to HMO Blue Texas.

You

You refers to the enrollee and each covered family member.

Section 11 FEHB Facts

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 for enrollment information 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 family members are added or lose coverage for any reason including your marriage, divorce, annulment, or when your child under age 22 turns age 22 or has a change in marital status.

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 2007 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 2006 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.

Any person covered under the 31 day extension of coverage who is confined in a hospital or other institution for care or treatment on the 31st day of the temporary extension is entitled to continuation of the benefits of the Plan during the continuance of the confinement but not beyond the 60th day after the end of the 31 day temporary extension.

You may be eligible for spouse equity coverage or Temporary Continuation of Coverage (TCC), or a conversion policy (a non-FEHB individual policy.)

Upon divorce

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. However, you may be eligible for your own FEHB coverage under either 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.

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. 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; 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.

Section 12 Three Federal Programs complement FEHB benefits

Important information

OPM wants to be sure you are aware of three Federal programs that complement the FEHB Program.

First, the **Federal Long Term Care Insurance Program (FLTCIP)** helps cover long term care costs, which are not covered under the FEHB Program.

Second, the **Federal Flexible Spending Account 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.

Third, the new **Federal Employees Dental and Vision Insurance Program (FEDVIP)**, offers a variety of dental plans and vision plans to anyone who is eligible to enroll in the Federal Employees Health Benefits Program. Under **FEDVIP** you may choose self only, self plus one, or self and family coverage for yourself and any qualified dependents. Premiums are on an enrollee-pays-all basis

The Federal Long Term Care Insurance Program – *FLTCIP*

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.

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.

There are four types of FSAs offered by FSAFEDS. The maximum election is \$5,000 per year.

- **Health Care FSA (HCFSA)** – Pays for eligible health care expenses for you and your dependents which are not covered by FEHBP coverage or other insurance.
- **Dependent Care FSA (DCFSA)** – Pays for eligible dependent care expenses that allow you (and your spouse if married) to work, look for work (as long as you have earned income for the year), or attend school full-time.
- **Limited Expense Health Care FSA (LEX HCFSA)** – Designed for employees enrolled in or covered by a High Deductible Health Plan with a Health Savings Account. Eligible expenses are limited to dental and vision care expenses for you and your dependents.

Limited Enrollment Health Care FSA (LEN HCFSA) – Designed for
XX-
XXXXXXXXXXXXXXXXXXXX (we will provide information for the next draft)

What expenses can I pay with an FSAFEDS account?

For the HCFSA and LEN HCFSA – Health plan copayments, deductibles, over-the-counter medications and products, sunscreen, eyeglasses, contacts, other vision and dental expenses (but not insurance premiums).

For the LEX HCFSA – Dental and vision care expenses (but not insurance premiums)

For the DCFSA – daycare expenses (including summer camp) for your child(ren) under age 13, dependent care expenses for dependents unable to care for themselves

AND MUCH MORE! Visit www.FSAFEDS.com

Who is eligible to enroll?

Most Federal employees in the Executive branch and many in non-Executive branch agencies are eligible. For specifics on eligibility, visit www.FSAFEDS.com or call an FSAFEDS Benefits Counselor toll-free at 1-877-FSAFEDS (1-877-372-3337), Monday through Friday, 9 a.m. until 9 p.m., EST. TTY: 1-800-952-0450.

When can I enroll?

If you wish to participate, you must make an election to enroll each year by visiting www.FSAFEDS.com or calling the number above during the FEHB Open Season or within 60 days of employment (for new employees).

Even if you enrolled for 2006, you must make a new election to continue participating in 2007. Enrollment DOES NOT carry over from year to year.

What is an FSAFEDS Debit Card?

XXXXXXXXXXXXXXXXXXXX (we will put in information the next round)

Who is SHPS?

SHPS is the Third Party Administrator hired by OPM to manage the FSAFEDS Program. SHPS is responsible for enrollment, claims processing, customer service, and day-to-day operations of FSAFEDS.

Who is BENEFEDS?

BENEFEDS is the name of the voluntary benefits portal hired by OPM to work with the FSAFEDS Program to set up payroll deductions for FSAFEDS allotments.

The Federal Employees Dental and Vision Insurance Program – FEDVIP

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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 the HMO Blue Texas - 2007

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

Benefits	You Pay	Page
Medical services provided by physicians:		
Diagnostic and treatment services provided in the office	Office visit copay: \$20 primary care; \$30 specialist	16
Services provided by a hospital:		
• Inpatient	\$150 per day with a maximum of \$750 per admission	33
• Outpatient	\$150 per surgery	34
Emergency benefits:		
• In-area	\$100 per visit	36
• Out-of-area	\$100 per visit	36
Mental health and substance abuse treatment:		
	Regular cost sharing	38
Prescription drugs:		
• Retail pharmacy	\$10 per generic \$25 per preferred brand \$40 per non-preferred brand	41
• Mail order	\$20 per generic \$50 per preferred brand \$80 per non-preferred brand	41
Dental care:		
	Nothing for preventive services; scheduled cost for other services	45
Vision care: One eye examination for eyeglasses every 12 months. Eyeglass lenses and frames available at discount prices; One eye examination for contact lenses every 12 months. Contact lenses and materials are also available at discount prices.	\$10 copay \$20 copay	49
Special features: Flexible benefits option, Blue Access for Members, Prenatal Education and Away From Home Care		
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Protection against catastrophic costs (out-of-pocket maximum):	Nothing after \$1,000/Self Only or \$3,000/ Family enrollment per year Some costs do not count toward this protection	12
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2007 Rate Information for HMO Blue Texas

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	Non-Postal Premium				Postal Premium	
		Biweekly		Monthly		Biweekly	
		Gov't Share	Your Share	Gov't Share	Your Share	USPS Share	Your Share

Houston area

High Option Self Only	YM1	141.92	89.10	307.49	193.05	167.54	63.48
High Option Self and Family	YM2	321.89	243.61	697.43	527.82	380.01	185.49