FIRSTCARE

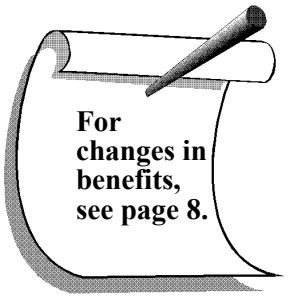
http://www.firstcare.com

2009

A Health Maintenance Organization

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

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



West Texas
Enrollment code for this Plan:
- **CK1 – Self Only**
- **CK2 – Self and Family**

Central Texas
Enrollment code for this Plan:
- **6U1 – Self Only**
- **6U2 – Self and Family**

Authorized for distribution by the:

United States
Office of Personnel Management

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

RI 73-496

Important Notice from FirstCare About

Our Prescription Drug Coverage and Medicare

OPM has determined that the FirstCare prescription drug coverage is, on average, expected to pay out as much as the standard Medicare prescription drug coverage will pay for all plan participants and is considered Creditable Coverage. Thus you do not need to enroll in Medicare Part D and pay extra for prescription drug benefit coverage. 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 with FirstCare.

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

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

Please be advised

If you lose or drop your FEHB coverage and go 63 days or longer without prescription drug coverage that's at least as good as Medicare's prescription drug coverage, your monthly premium will go up at least 1% per month for every month that you did not have that 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 many other people pay. You'll have to pay this higher premium as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the next Annual Coordinated Election Period (November 15th through December 31st) 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 FirstCare under our contract (CS 2321) with the United States Office of Personnel Management, as authorized by the Federal Employees Health Benefits law. The address for FirstCare administrative offices is:

FirstCare
12940 N. Highway 183
Austin, Texas 78750

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

If you are enrolled in this Plan, you are entitled to the benefits described in this brochure. If you are enrolled in Self and Family coverage, each eligible family member is also entitled to these benefits. You do not have a right to benefits that were available before January 1, 2009, unless those benefits are also shown in this brochure.

OPM negotiates benefits and rates with each plan annually. Benefit changes are effective January 1, 2009, 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 FirstCare.
- 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 e-mail OPM at fehbwebcomments@opm.gov. You may also write to OPM at the U.S. Office of Personnel Management, Insurance Services Programs, Program Planning & Evaluation Group, 1900 E Street, NW, Washington, DC 20415-3650.

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) statements that you receive from us.
- Do not ask your doctor to make false entries on certificates, bills or records in order to get us to pay for an item or service.

- If you suspect that a provider has charged you for services you did not receive, billed you twice for the same service, or misrepresented any information, do the following:
  - Call the provider and ask for an explanation. There may be an error.
  - If the provider does not resolve the matter, call us at 800/884-4901 and explain the situation.
  - If we do not resolve the issue:

CALL - THE HEALTH CARE FRAUD HOTLINE

202-418-3300

OR WRITE TO:

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

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

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 websites for more information about patient safety.

- www.ahrq.gov/consumer/path/beactive.htm. The Agency for Healthcare Research and Quality makes available a wide-ranging list of topics not only to inform consumers about patient safety but to help choose quality health care providers and improve the quality of care you receive.
- www.npsf.org. The National Patient Safety Foundation has information on how to ensure safer health care for you and your family.
- www.talkaboutrx.org. The National Council on Patient Information and Education is dedicated to improving communication about the safe, appropriate use of medicines.
- www.leapfroggroup.org. The Leapfrog Group is active in promoting safe practices in hospital care.
- www.ahqa.org. The American Health Quality Association represents organizations and health care professionals working to improve patient safety.
- 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.

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.

- We have been operational since 1986, and we have been providing quality healthcare to Federal employees since January 1, 1988.
- As a state certified and federally qualified health plan, FirstCare is in compliance with all the rules and regulations of these governing bodies.

If you want more information about us, call 800-884-4901, or write to 12940 N. Highway 183, Austin, Texas 78750. You may also contact us by fax at 877-878-8422 or visit our Web site at www.firstcare.com.

Your medical claims records are confidential.

We will keep your medical and claims records confidential. Please note that we may disclose your medical and claims information (including your prescription drug utilization) to any of your treating physicians or dispensing pharmacies.

Service Area

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

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

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

Ordinarily, you must get your care from providers who contract with us. If you receive care outside our service area, we will pay only for emergency care benefits. We will not pay for any other health care services out of our service area unless the services have prior plan approval.

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

Section 2. How we change for 2009

Do not rely only 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.

- Orthopedic and prosthetic devices - the copayment for internal prosthetic devices will increase from no copayment to 20% of charges. The external prosthetic maximum will change from an unlimited benefit to a $15,000 annual maximum. See page 19
- Inpatient Hosptial - the out-of-pocket maximum for Tier 2 inpatient admissions goes from an out-of-pocket maximum of $20,000 to an unlimited out-of-pocket maximum. See page 28.
- Accidental Dental Services - the maximum payable for accidental dental services will now be limited to $10,000. See page 38
- Your share of the non-Postal premium will increase for Self and Family. See page 60

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 800-884-4901 or write to us at 12940 N. Highway 183, Austin, Texas 78750 . You may also request replacement cards through our Web site www.firstcare.com .

Where you get covered care

You get care from "Plan providers" and "Plan facilities." You will only pay copayments, deductibles, and/or coinsurance. If you use our point-of-service program, you can also get care from non-Plan providers but it will cost you more. If you use our Open Access program you can received covered services from a participating provider without a required referral from your primary care physician or by another participating provider in the network.

- **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.firstcare.com.

- **Plan facilities**

Plan facilities are hospitals and other facilities in our service area that we contract with to provide covered services to our members. We list these in the provider directory, which we update periodically. The list is also on our Web site www.firstcare.com.

What you must do to get covered care

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

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

- **Primary care**

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

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

- **Specialty care**

Your primary care physician will refer you to a specialist for needed care. However, you may see an obstetrician/gynecologist (OB/GYN, in-network specialist, or seek emergency care without a referral. Your primary care physician may arrange your referral to a specialist. Referral to a participation specialist is given at a primary care physician's discretion, if non-Plan specialist or consultants are required, the primary care physician will arrange appropriate referrals and must obtain an authorization from FirstCare in advance.

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

- If you need to see a specialist frequently because of a chronic, complex, or serious medical condition, your primary care physician will develop a treatment plan that allows you to see your specialist for a certain number of visits without additional referrals. Your primary care physician will use our criteria when creating your treatment plan (the physician may have to get an authorization or approval beforehand).
- If you are seeing a specialist when you enroll in our Plan, talk to your primary care physician. Your primary care physician will decide what treatment you need. If he or she decides to refer you to a specialist, ask if you can see your current specialist. If your current specialist does not participate with us, you must receive treatment from a specialist who does. Generally, we will not pay for you to see a specialist who does not participate with our Plan.
- If you are seeing a specialist and your specialist leaves the Plan, call your primary care physician, who will arrange for you to see another specialist. You may receive services from your current specialist until we can make arrangements for you to see someone else.
- If you have a chronic and disabling condition and lose access to your specialist because we:
  - Terminate our contract with your specialist for other than cause; or
  - Drop out of the Federal Employees Health Benefits (FEHB) Program and you enroll in another FEHB program Plan; or
  - Reduce our service area and you enroll in another FEHB Plan,

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

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

- **Hospital care**

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

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

We pay for covered services from the effective date of your enrollment. However, if you are in the hospital when your enrollment in our Plan begins, call our customer service department immediately at 800-884-4901. If you are new to the FEHB Program, we will arrange for you to receive care and provide benefits for your covered services while you are in the hospital beginning on 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 case, the hospitalized family member's benefits under the new plan begin on the effective date of enrollment.

How to get approval for…

- **Your hospital stay** — If you are admitted to the hospital on an emergency basis, be sure to tell the hospital personnel that you are a FirstCare member so they can notify us. You or a family member should notify FirstCare within 24 hours unless it was not reasonably possible to do so. It is your responsibility to ensure that we have been notified in a timely manner. Once we are notified, we will review your case to make sure that your continued stay is medically necessary and arrange for continuing care needs.
- **How to precertify an admission** — For elective hospital admissions, your physician must contact our preauthorization department to get preauthorization of hospital stays prior to your admission date. Before giving approval, we will consider if the service is covered, medically necessary, and follows generally accepted medical practice.
- **Maternity care** — Once you have seen your physician and it is determined that you are pregnant, your physician must contact our preauthorization department to get preauthorization of your hospital stay for your delivery.

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

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

Circumstances beyond our control

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

Services requiring our prior approval

Your primary care physician has authority to refer you for most services. For certain services, however, your physician must obtain approval from us. Before giving approval, we consider if the service is covered, medically necessary, and follows generally accepted medical practice.

We call this review and approval process preauthorization. Your physician must obtain preauthorization for certain services, such as outpatient surgery, inpatient hospital admissions, treatment for morbid obesity, growth hormone therapy (GHT) in children with documented growth hormone deficiency disease, certain prescription drugs, and durable medical equipment (DME) e.g. oxygen and monitoring devices.

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

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 and when you go in the hospital, you pay $150 per day up to a maximum of $750 per admission inside our service area.
Cost-sharing	Cost-sharing is the general term used to refer to your out-of-pocket costs (e.g. deductible, coinsurance, and copayments) for covered care you receive.
Deductible	This plan has no deductible.
Coinsurance	Coinsurance is the percentage of our allowance that you must pay for your care Example: In our Plan, you pay 50% of our allowance for infertility services and 20% for durable medical equipment
Your catastrophic protection out-of-pocket maximum	After your copayments and coinsurance total 200% of annual premium per Self Only enrollment or 200% of annual premium per Self and Family enrollment in calendar year, you do not have to pay any more for covered services. However, copayments for the following services do not count toward your catastrophic protection out-of-pocket maximum, and you must continue to pay copayments for these services: prescription drugs in Tier 1, Tier 2 and Tier 3; and durable medical equipment (DME). Self Injectable and other High Technolgy drugs do apply to the catastrophic protection out-of-pocket maximum. 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. Note: If you change options in this Plan during the year, we will credit the amount of covered expenses already accumulated toward the catastrophic out-of-pocket limit of your old option to the catastrophic protection limit of your new option.
When Government facilities bill us	Facilities of the Department of Veteran Affairs, the Department of Defense and the Indian Health Services are entitled to seek reimbursement from for certain services and supplies they provide to you or a family member. They may not seek more than their governing laws allow.

Section 5. Benefits

See page 8 for how our benefits changed this year and page 57 for a benefits summary.

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Section 5. Benefits Overview

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

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

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan physicians must provide or arrange your care.
- 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.
- 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 • In physician's office	$20 per visit to your primary care physician $55 per visit to a specialist
Professional services of physicians • In an urgent care center • During a hospital stay • In a skilled nursing facility	Included in the applicable copay depending on place of service: $300 copay per outpatient facility visit; or included in inpatient copayment of $150 per day up to $750 maximum copay per admission inside our service area, or A copayment of 20% of the allowable amount with an unlimited out-of-pocket maximum per admission at a contracted facility outside of our service area
• Office medical consultations • Second surgical opinion	$55 per visit
At home	$55 per visit

Benefit Description	You pay
Lab, X-ray and other diagnostic tests	
Tests, such as: • Blood tests • Urinalysis • Non-routine Pap tests • Pathology • X-rays • Non-routine mammograms • Ultrasound • Electrocardiogram and EEG	Nothing
• CAT Scans/MRI	$150 per procedure
Preventive care, adult	
Routine physical every year which includes: Routine screenings, such as: • Total Blood Cholesterol • Colorectal Cancer Screening, including - 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	$20 per visit $55 per specialist visit
Routine Prostate Specific Antigen (PSA) test – one annually for men age 40 and older Routine Pap test	Nothing if you receive these services during your office visit
Routine mammogram – covered for women age 35 and older, as follows: • 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 if you receive these services during your office visit.
Adult routine immunizations endorsed by the Centers for Disease Control and Prevention (CDC).	Nothing if you receive these services during your office visit
Not covered: Physical exams and immunizations required for obtaining or continuing employment or insurance, attending schools or camp, or travel.	*All charges*
Preventive care, children	
• Childhood immunizations recommended by the American Academy of Pediatrics	Nothing
• Well- child care changes for routine examinations, immunizations and care (up to age 22)	$20 per PCP visit $55 per specialist visit
• Examinations, such as: - Eye exams through age 17 to determine the need for vision correction,	Nothing if you receive these services during your office visit

Preventive care, children - continued on next page

Benefit Description	You pay
Preventive care, children (cont.)	
- Hearing exams through age 17 to determine the need for hearing correction, - Examinations done on the day of immunizations (up to age 22)	Nothing if you receive these services during your office visit
Maternity care	
Complete maternity (obstetrical) care, such as: • Prenatal care • Delivery • Postnatal care Note: Here are some things to keep in mind: • You do not need to precertify your normal delivery; see page 10 for other circumstances, such as extended stays for you or your baby. • You may remain in the hospital up to 48 hours after a regular delivery and 96 hours after a cesarean delivery. We will extend your inpatient stay if medically necessary. • We cover routine nursery care of the newborn child during the covered portion of the mother's maternity stay. We will cover other care of an infant who requires non-routine treatment only if we cover the infant under a Self and Family enrollment. • We pay hospitalization and surgeon services (delivery) the same as for illness and injury. See Hospital benefits (Section 5c) and Surgery benefits (Section 5b).	Nothing for pre- and post-natal care; inpatient copayment of $150 per day up to $750 maximum copay per admission inside our service area, or A coinsurance of 20% of the allowable amount with an unlimited out-of-pocket maximum per admission at a contracted facility outside of our service area
Not covered: *Routine sonograms to determine fetal age, size or sex.*	*All charges*
Family planning	
A range of voluntary family planning services, limited to: • Voluntary sterilization (See Surgical procedures Section 5 (b)) • Surgically implanted contraceptives • Injectable contraceptive drugs (such as Depo provera) • Intrauterine devices (IUDs) • Diaphragms Note: We cover oral contraceptives under the prescription drug benefit.	$20 per office visit 20% of changes for all services and procedures related to Family Planning, in addition to the appropriate office visit copayment, if applicable
Not covered: • *Reversal of voluntary surgical sterilization* • *Genetic counseling*	*All charges*

Benefit Description	You pay
Infertility services	
Diagnosis and treatment of infertility such as: • Artificial insemination: - intravaginal insemination (IVI) - intracervical insemination (ICI) - intrauterine insemination (IUI) • Lab and x - ray services	50% of charges
Not covered: • *Assisted reproductive technology (ART) procedures, such as:* - *in vitro fertilization* - *embryo transfer, gamete intra-fallopian transfer (GIFT) and zygote intra-fallopian transfer (ZIFT)* • *Services and supplies related to ART procedures* • *Surrogate parenting fees* • *Cost of donor sperm* • *Cost of donor egg.* • *Fertility drugs*	*All charges*
Allergy care	
• Testing and treatment	$20 per PCP visit; $55 per specialist visit
• Allergy injections	50% of charges
• Allergy serum	Nothing
Not covered: • *Provocative food testing* • *Sublingual allergy desensitization*	*All charges*
Treatment therapies	
• Chemotherapy and radiation therapy Note: High dose chemotherapy in association with autologous bone marrow transplants is limited to those transplants listed under Organ/Tissue Transplants on page 27. • Respiratory and inhalation therapy • Dialysis – hemodialysis and peritoneal dialysis • Intravenous (IV)/Infusion Therapy – Home IV and antibiotic therapy • Growth hormone therapy (GHT) Note: Growth hormone is covered under the prescription drug benefit.	$20 per PCP visit; $55 per specialist visit; $300 copay per outpatient facility visit; or included in inpatient copayment of $150 per day up to $750 maximum copay per admission inside our service area; or included in coinsurance of 20% of the allowable amount with an unlimited out-of-pocket maximum per admission at a contracted facility outside of our service area

Treatment therapies - continued on next page

Benefit Description	You pay
Treatment therapies (cont.)	
Note: – We only cover GHT when we preauthorize the treatment. We will ask you to submit information that establishes that the GHT is medically necessary. Ask us to authorize GHT before you begin treatment; otherwise, we will only cover GHT services from the date you submit the information. If you do not ask or if we determine GHT is not medically necessary, we will not cover the GHT or related services and supplies. See *Services requiring our prior approval* in Section 3.	$20 per PCP visit; $55 per specialist visit; $300 copay per outpatient facility visit; or included in inpatient copayment of $150 per day up to $750 maximum copay per admission inside our service area; or included in coinsurance of 20% of the allowable amount with an unlimited out-of-pocket maximum per admission at a contracted facility outside of our service area
Physical and occupational therapies	
Physical therapy and occupational therapy services of each of the following: • qualified physical therapists and • occupational therapists Note: We only cover therapy to restore bodily function when there has been a total or partial loss of bodily function due to illness or injury. Cardiac rehabilitation following a heart transplant, bypass surgery or a myocardial infarction must be provided at a Plan facility, and is covered for up to two months per condition, or for up to 60 days per condition per calendar year, whichever is greater, if significant can be expected within that time. Note: Your coverage is limited to services that continue to meet or exceed the treatment goals established for you. For a physically disabled person, treatment goals may include maintenance of functioning or prevention of or slowing of other deterioration.	$20 per visit; $300 copay per outpatient facility visit, or included in inpatient copayment of $150 per day up to $750 maximum copay per admission inside our service area, or included in coinsurance of 20% of the allowable amount with an unlimited out-of-pocket maximum per admission at a contracted facility outside of our service area
Not covered: • *Long-term rehabilitative therapy* • *Exercise programs* • *Aqua therapy, unless associated with a physical therapy modality provided by a licensed physical therapist*	*All charges*
Speech therapy	
Speech therapy services provided by a speech therapist.	$20 per visit; $300 copay per outpatient facility visit; or included in inpatient copayment of $150 per day up to $750 maximum copay per admission inside our service area, or included in coinsurance of 20% of the allowable amount with an unlimited out-of-pocket maximum per admission at a contracted facility outside of our service area

Benefit Description	You pay
Hearing services (testing, treatment, and supplies)	
• First hearing aid and testing only when necessitated by accidental injury • Hearing testing for children through age 17, which include; (see *Preventive care, children)* • Hearing aids.	$20 per PCP visit; $55 per specialist visit
Note: Must be medically necessary as determined by a Plan physician authorized in advance by the Plan, and obtained for a Plan provider.	Nothing up to Plan maximum of $500 per ear once every 36 months; all charges over $500 per ear
Not covered: • *All other hearing testing* • *Repair or replacement of hearing aids due to normal wear and tear and loss or damage.*	*All charges*
Vision services (testing, treatment, and supplies)	
• Eye screening, annually, for children through age 18 to determine vision loss (See Preventive care, children) • Eye screening, biennially, for members age 19 and older to determine vision loss (See Preventive care, adult)	Nothing if you receive these services during your primary care physician office visit.
Not covered: • *Eyeglasses, frames, or contact lenses (including the fitting of contact lenses), except as necessary for the first pair of corrective lenses following cataract removal* • *Eye exercises and orthoptics* • *Radial keratotomy and other refractive surgery* • *Refractions, including lens prescriptions, to determine the need for glasses or contacts*	*All charges*
Foot care	
Routine foot care when you are under active treatment for a metabolic or peripheral vascular disease, such as diabetes.	$20 per PCP visit; $55 per specialist visit.
Not covered: • *Cutting, trimming or removal of corns, calluses, or the free edge of toenails, and similar routine treatment of conditions of the foot, except as stated above* • *Treatment of weak, strained or flat feet or bunions or spurs; and of any instability, imbalance or subluxation of the foot (unless the treatment is by open cutting surgery)*	*All charges*
Orthopedic and prosthetic devices	
• Artificial limbs and eyes; stump hose • Externally worn breast prostheses and surgical bras, including necessary replacements following a mastectomy • Corrective orthopedic appliances for non-dental treatment of temporomandibular joint (TMJ) pain dysfunction syndrome. • Foot orthotics • Podiatric appliances for the prevention of complications associated with diabetes.	20% of all charges External prosthetic maximum is $15,000 per device/limb.

Orthopedic and prosthetic devices - continued on next page

Benefit Description	You pay
Orthopedic and prosthetic devices (cont.)	
Internal prosthetic devices, such as artificial joints, pacemakers and surgically implanted breast implant following mastectomy, and implanted lenses during cataract surgery. Note: Internal prosthetic devices are paid as hospital benefits. See Section 5(c) for payment information. Insertion of the devices is paid as surgery See Section 5(b) for coverage of the surgery to insert the device.	Internal prosthetic devices: 20% of charges External prosthetic devices: $15,000 annual maximum benefit per device/ limb.
Not covered: • *Orthopedic and corrective shoes* • *Arch supports* • *Heel pads and heel cups* • *Lumbosacral supports* • *Corsets, trusses, elastic stockings, support hose, and other supportive devices* • *Prosthetic repairs, maintenance or replacements, except for breast prostheses; and standard replacements needed because of physical growth by dependents under 18 years of age* • *Cochlear implanted device* • *Wigs or prosthetic hair* • *Implanted neurological stimulators, including but not limited to spinal or dorsal column stimulators for relief of pain, Parkinson's movement disorders or seizures.*	*All charges*
Durable medical equipment (DME)	
We cover rental or purchase of durable medical equipment, at our option, including repair and adjustment. Covered items include: • Oxygen • Manual hospital beds; • Manual wheelchairs; • Dialysis equipment; • Crutches; • Walkers; • Braces (limb or back only); • Traction devices; • Nebulizers; • Indwelling urinary catheters; • Blood glucose monitors; and • C-PAP monitoring device (when there is a diagnosis of documented obstructive sleep apnea) • Oxygen, oxygen concentrators, rental of equipment for administration of oxygen, and mechanical equipment necessary for the treatment of chronic or acute respiratory failure; Note: Oxygen and equipment must be prescribed and directed by a Plan provider, and approved in advance by the Plan.	20% of charges limited to $4,000 maximum benefit per year

Durable medical equipment (DME) - continued on next page

Benefit Description	You pay
Durable medical equipment (DME) (cont.)	
• Monitoring devices, such as apnea monitors and uterine monitors for use in the home, when prescribed and directed by a Plan provider; • Ostomy supplies; • Sterile dressing change kits, i.e, tracheostomy suction and dressing kits, and central line dressing kits. Note: Call us at 800-884-4901 as soon as your Plan physician prescribes this equipment. We will arrange with a health care provider to rent or sell you durable medical equipment at discounted rates and will tell you more about this service when you call.	20% of charges limited to $4,000 maximum benefit per year
Not covered: • *Motorized, deluxe, and custom wheelchairs and hospital beds; auto tilt chairs* • *Comfort or convenience items, such as bathtub chairs, whirlpool tubs, safety grab bars, stair gliders or elevators, over-the-bed tables, bed boards, saunas, and exercise equipment.* • *Environmental control equipment, such as air conditioners, purifiers, humidifiers, de-humidifiers, electrostatic machines and heat lamps* • *Institutional equipment, such as fluidized beds and diathermy machines* • *Consumable medical supplies such as over-the –counter bandages ,dressing and other disposable supplies and skin preparations.* • *Foam cervical collars* • *Stethoscopes, sphygmomanometers, reading oximeters* • *Hygienic or self help items or equipment* • *Sports cords* • *TENS units* • *Repair or replacement resulting from misuse or abuse*	*All charges*
Home health services	
• Home health care 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.	Nothing
Not covered: • *Nursing care requested by, or for the convenience of, the patient or the patient's family;* • *Home care primarily for personal assistance that does not include a medical component and is not diagnostic, therapeutic, or rehabilitative.*	*All charges*

Benefit Description	You pay
Chiropractic	
No benefit	All charges
Alternative treatments	
Telemedicine to deliver health care, which includes use of interactive audio, video or other electronic media for diagnosis, consultation, treatment, transfer of medical data, and medical education, but excludes services performed using a telephone or facsimile (FAX) machine.	Nothing
Not covered: • *Naturopathic services* • *Hypnotherapy* • *Acupuncture* • *Biofeedback* • *Equine or Hippo therapy* • *Massage therapy, unless associated with a physical therapy modality provided by a licensed physical therapist*	*All charges*
Educational classes and programs	
Coverage is limited to: Diabetes self management training, including counseling and use of diabetic equipment and supplies Nutritional counseling for morbid obesity	$20 per PCP visit: $55 per specialist visit
Diabetic Equipment and Supplies	
Equipment as follows: • Blood glucose monitors, including monitors designed to be used by blind individuals • Insulin pumps and associated appurtenances • Insulin infusion devices • Podiatric appliances for the prevention of complications associated with diabetes • Injection aids • Insulin cartridges • Infusion sets Supplies included: • Test strips for blood glucose monitors • Visual reading and urine test strips • Lancets and lancet devices • Injections aids • Syringes • Needles • Glucose test tablets and test tape • Benedict's solution or equivalent	20% of charges

Diabetic Equipment and Supplies - continued on next page

Benefit Description	You pay
Diabetic Equipment and Supplies (cont.)	
• Acetone test tablets Note: Supplies limited to 30 day supply	20% of charges

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

Important things you should keep in mind about these benefits:

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

Benefit Description	You pay
Surgical procedures	
A comprehensive range of services, such as: • Operative procedures • Treatment of fractures, including casting • Normal pre- and post-operative care by the surgeon • Correction of amblyopia and strabismus • Endoscopy procedures • Biopsy procedures • Removal of tumors and cysts • Correction of congenital anomalies (see *Reconstructive surgery*) • Surgical treatment of morbid obesity (bariatric surgery) "Morbid Obesity" is defined as an abnormal increase of fat sufficient to prevent normal activity or physiologic function, or to cause the onset of a pathologic condition. FirstCare will consider Bariatric Surgery for Morbid Obesity medically necessary when All of the following criteria are met: Body Mass Index (BMI)>40kg/meter; or >35kg/meter with any of the following co-morbidities; coronary artery disease, type 2 diabetes, documented obstructive sleep apnea, or medically refractive hypertension (blood pressure systolic > 140 and/or diastolic > 90 despite optimal medical management); **AND** Member is > 18 years of age or has documentation of bone growth completion; **AND** Member has failed a medically supervised (MD, DO, or Nurse Practitioner) non-surgical weight loss program within 2 (two) years of the request for surgery. This documented program had to have been greater than 6 (six) months duration consisting of dietician consultation, low calorie diet, increased physical activity, and behavioral modification; **AND**	$50 when performed in a Plan provider's office, or $300 when performed in outpatient surgical facility, or Included in the inpatient admission copay of $150 per day up to $750 maximum copay per admission at a contracted facility within our service area, or included in coinsurance of 20% of the allowable amount with an unlimited out-of-pocket maximum per admission at a contracted facility outside of our service area

Surgical procedures - continued on next page

Benefit Description	You pay
Surgical procedures (cont.)	
Psychological evaluation by an independent licensed psychologist or psychiatrist not affiliated with the surgical group. Covered procedures include Roux-en-Y Gastric Bypass (open or laparoscopic), Vertical Banded Gastroplasty (VBG) and Laparoscopic Adjustable Silicone Gastric Banding (LASBG). • Insertion of internal prosthetic devices . See 5(a) – *Orthopedic and prosthetic devices* for device coverage information • Voluntary sterilization (e.g., tubal ligation, vasectomy) • Treatment of burns Note: Generally, we pay for internal prostheses (devices) according to where the procedure is done. For example, we pay Hospital benefits for a pacemaker	$50 when performed in a Plan provider's office, or $300 when performed in outpatient surgical facility, or Included in the inpatient admission copay of $150 per day up to $750 maximum copay per admission at a contracted facility within our service area, or included in coinsurance of 20% of the allowable amount with an unlimited out-of-pocket maximum per admission at a contracted facility outside of our service area
Not covered: • *Reversal of voluntary sterilization* • *Routine treatment of conditions of the foot; see Foot care* • *Any surgical procedures related to snoring and sleep apnea*	*All Charges*
Reconstructive surgery	
• Surgery to correct a functional defect • Surgery to correct a condition caused by injury or illness if: - the condition produced a major effect on the member's appearance and - the condition can reasonably be expected to be corrected by such surgery • Surgery to correct a condition that existed at or from birth and is a significant deviation from the common form or norm. Examples of congenital anomalies are: protruding ear deformities; cleft lip; cleft palate; birth marks; and webbed fingers and toes. • All stages of breast reconstruction surgery following a mastectomy, such as: - surgery to produce a symmetrical appearance of breasts; - treatment of any physical complications, such as lymphedemas; - breast prostheses and surgical bras and replacements (see *Prosthetic devices*) Note: If you need a mastectomy, you may choose to have the procedure performed on an inpatient basis and remain in the hospital up to 48 hours after the procedure.	$50 when performed in a Plan provider's office, or $300 when performed in outpatient surgical facility, or Included in the inpatient admission copay of $150 per day up to $750 maximum copay per admission at a contracted facility within our service area, or included in coinsurance of 20% of the allowable amount with an unlimited out-of-pocket maximum per admission at a contracted facility outside of our service area.
Not covered: • *Cosmetic surgery – any surgical procedure (or any portion of a procedure) performed primarily to improve physical appearance through change in bodily form, except repair of accidental injury* • *Surgeries related to sex transformation*	*All Charges*

Benefit Description	You pay
Oral and maxillofacial surgery	
Oral surgical procedures, limited to: • Reduction of fractures of the jaws or facial bones; • Surgical correction of cleft lip, cleft palate or severe functional malocclusion; • Removal of stones from salivary ducts; • Excision of leukoplakia or malignancies; • Excision of cysts and incision of abscesses when done as independent procedures; and *Treatment of temporomandibular joint (TMJ), including surgical and non-Surgical intervention, corrective orthopedic appliances, physical therapy and other surgical procedures that do not involve the teeth or supporting structures.*	$50 when performed in a Plan provider's office, or $300 when performed in outpatient surgical facility, or Included in the inpatient admission copay of $150 per day up to $750 maximum copay per admission at a contracted facility within our service area, or or included in coinsurance of 20% of the allowable amount with an unlimited out-of-pocket maximum per admission at a contracted facility outside of our service area
Not covered: • *Oral implants and transplants* • *Procedures that involve the teeth or their supporting structures (such as the periodontal membrane, gingiva, and alveolar bone)*	*All charges*
Organ/tissue transplants	
Solid organ transplants are subject to medical necessity and experimental/investgational review: Refer to *Other Services* in Section 3 for prior authorization procedures. The medical necessity limitation is considered satisfied for other tissue transplants if the patient meets the staging description. • Cornea • Heart • Heart/lung • Lung: Single/bilateral/lobar • 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 • Intestinal transplants (small intestine) - small intestine - small intestine with the liver - small intestine with multiple organs, susch as the liver, stomach and pancreas • Allogeneic (donor) bone marrow transplants; • Autologous bone marrow transplants (autologous stem cell and peripheral stem cell support for the following conditions: - Acute lymphocytic or nonlymphocytic (i.e. myelogenous) luekemia - Advanced Hodgkin's lymphoma	$50 when performed in a Plan provider's office, or $300 when performed in outpatient surgical facility, or Included in the inpatient admission copay of $150 per day up to $750 maximum copay per admission at a contracted facility within our service area, or or included in coinsurance of 20% of the allowable amount with an unlimited out-of-pocket maximum per admission at a contracted facility outside of our service area

Organ/tissue transplants - continued on next page

Benefit Description	You pay
Organ/tissue transplants (cont.)	
- Advanced non-Hodgkin's lymphoma - Epithelial ovarian cancer; - Breast cancer and testicular - Mediastinal - Multiple myeloma; - Advanced Neuroblastoma; - Retroperitoneal and ovarian germ cell tumors • Autologous tandem transplants for testicular tumors and other germ cell tumors Note: Immuno-suppressive medications necessary to prevent rejection of any transplanted organ listed above are covered subject to no copay while hospitalized. After discharge, these medications are covered under the Prescription drug benefit and subject to the applicable prescription drug copay per 30-day supply. They are not available through the Mail Order Pharmacy. Note: All covered transplants must be evaluated by a nationally recognized medical facility designated by FirstCare and they must agree that the proposed transplant is appropriate for the treatment of your condition. Also, they must agree to perform the transplant. The FirstCare Medical Director must approve all covered transplants. All related medical and hospital expenses of the donor are covered when the recipient is covered by this Plan.	$50 when performed in a Plan provider's office, or $300 when performed in outpatient surgical facility, or Included in the inpatient admission copay of $150 per day up to $750 maximum copay per admission at a contracted facility within our service area, or or included in coinsurance of 20% of the allowable amount with an unlimited out-of-pocket maximum per admission at a contracted facility outside of our service area
Not covered: • *Donor screening tests and donor search expenses, except those performed for the actual donor* • *Implants of artificial organs* • *Transplants not listed as covered*	*All Charges*
Anesthesia	
Professional services provided in – • Hospital (inpatient)	Nothing
Professional services provided in – • Hospital outpatient department • Skilled nursing facility • Ambulatory surgical center • Office	$55 per office visit

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

Important things you should keep in mind about these benefits:

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

Benefit Description	You pay
Inpatient hospital	
Room and board, such as • 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 up to $750 maximum copay per admission at a contracted facility within our service area, or A coinsurance of 20% of the allowable amount with an unlimited out-of-pocket maximum at a contracted facility outside of our service area
Other hospital services and supplies, such as: • Operating, recovery, maternity, and other treatment rooms • Prescribed drugs and medicines • Diagnostic laboratory tests and X-rays • Dressings , splints , casts , and sterile tray services • Medical supplies and equipment, including oxygen	Nothing
• Anesthetics, including nurse anesthetist services • Take-home items • Medical supplies, appliances, medical equipment, and any covered items billed by a hospital for use at home (Note: calendar year deductible applies.)	Nothing
Not covered: • *Custodial 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	*All Charges*

Benefit Description	You pay
Outpatient hospital or ambulatory surgical center	
• Operating, recovery, and other treatment rooms • Prescribed drugs and medicines • Diagnostic laboratory tests, X-rays , and pathology services • Administration of blood, blood plasma, and other biologicals • Blood and blood plasma , if not donated or replaced • Pre-surgical testing • Dressings, casts , and sterile tray services • Medical supplies, including oxygen • Anesthetics and anesthesia service Note: We cover hospital services and supplies related to dental procedures when necessitated by a non-dental physical impairment. We do not cover the dental procedures.	$300 per visit
Not covered: Blood and blood derivatives not replaced by the member	*All charges*
Extended care benefits/Skilled nursing care facility benefits	
Extended care benefit: A comprehensive range of benefits to a maximum of 100 days per calendar year when full-time skilled nursing care is necessary and confinement in a skilled nursing facility is medically appropriate as determined by a Plan doctor and approved by the Plan. • Bed, board and general nursing care. • Drugs, biologicals, supplies, and equipment ordinarily provided or arranged by the skilled nursing facility when prescribed by a Plan doctor.	$150 per day up to $750 maximum copay per admission at a contracted facility within our service area. or A coinsurance of 20% of the allowable amount with an unlimited out-of-pocket maximum at a contracted facility outside of our service area
Skilled nursing facility (SNF):	Nothing
Not covered: • *Custodial care* • *Rest Cures* • *Domiciliary or convalescent care*	*All Charges*
Hospice care	
We cover supportive and palliative care in the home or a hospice facility **Services included** • Inpatient and outpatient care, and • Family counseling. Note: A Plan physician must certify that the patient is in the terminal stages of illness, with a life expectancy of approximately 6 months or less.	Nothing
Not covered: Independent nursing, homemaker services	*All Charges*

Benefit Description	You pay
Ambulance	
Local professional ambulance service when medically appropriate	$75 per trip

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.
- Be sure to read Section 4, *Your costs for covered services,* for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- Our Plan's allowance of Usual, Customary and Reasonable (URC) charges will apply to emergency care received at any doctor's office, outside our Plan's services area, for the services rendered. (See next page and Section 10 for the definition of our Plan's allowance of UCR change).

What is a medical emergency?

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

What to do in case of emergency:

Emergencies within our service area

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

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

Emergency care includes the following services:

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

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

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

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

Emergencies outside our service area

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

If you need to be hospitalized, FirstCare must be notified within 24 hours or on the first working day following your admission, unless it was not reasonably possible to notify Us within that time. If a Plan doctor believes care can be better provided in a Plan hospital, you will be transferred when medically feasible with any ambulance changes covered in full. Any follow –up care recommended by non-Plan providers must be approved by the Plan or provided by Plan providers

Benefit Description	You pay
Emergency within our service area	
• Emergency care at a doctor's office	$20 per PCP visit; $55 per specialist visit.
Emergency care at an urgent care center	$55 per visit.
• Emergency care as an outpatient at a hospital, including doctors' services Note: We waive the ER copay if you are admitted to the hospital.	$100 per visit
Not covered: Elective care or non-emergency care	*All Charges*
Emergency outside our service area	
• Emergency care at a doctor's office	$20 per PCP visit; $55 per specialist visit, plus all amounts over the Usual, customary and Reasonable (URC) change for the services rendered.
• Emergency care at an urgent care center	$55 per visit
• Emergency care as an outpatient at a hospital, including doctors' services Note: We waive the ER copay if you are admitted to the hospital.	$100 per visit
Not covered: • *Elective care or non-emergency care and follow-up care recommended by non-Plan providers that has not been approved by the Plan or provided by Plan providers* • *Emergency care provided outside the service area if the need for care could have been foreseen before leaving the service area* • *Medical and hospital costs resulting from a normal full-term delivery of a baby outside the service area*	*All Charges*
Ambulance	
Professional ambulance service, including air ambulance, when medically appropriate. Note: See 5(c) for non-emergency service.	$75 per trip

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

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

Important things you should keep in mind about these benefits:

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

Benefit Description	You pay
Mental health and substance abuse benefits	
All diagnostic and treatment services recommended by a Plan provider and contained in a treatment plan that we approve. The treatment plan may include services, drugs, and supplies described elsewhere in this brochure. Note: Plan benefits are payable only when we determine the care is clinically appropriate to treat your condition and only when you receive the care as part of a treatment plan that we approve.	Your cost sharing responsibilities are no greater than for other illnesses or conditions.
• Professional services, including individual or group therapy by providers such as psychiatrists, psychologists, or clinical social workers • Medication management	$55 per visit
• Diagnostic tests	Nothing
• Services provided by a hospital or other facility • Services in approved alternative care settings such as partial hospitalization, half-way house, residential treatment, full-day hospitalization, facility based intensive outpatient treatment	$150 per day up to $750 maximum copay per admission at a contracted facility within our service area, or included in coinsurance of 20% of the allowable amount with an unlimited out-of-pocket maximum per admission at a contracted facility outside our service area.
Not covered: Services we have not approved. *Note: OPM will base its review of disputes about treatment plans on the treatment plan's clinical appropriateness. OPM will generally not order us to pay or provide one clinically appropriate treatment plan in favor of another.*	*All Charges.*

Preauthorization

To be eligible to receive these benefits you must obtain a treatment plan and follow all of the following network authorization processes: These include:

Mental health and substance abuse services are provided through these behavioral health benefits manager:

- In the Amarillo and Lubbock regions (which includes Midland/Odessa) – Magellan Health Services Call FirstCare Customer Services at 800-884-4901

- In the Central Texas area – MHNet, Inc . – Call FirstCare Customer Services at 800-884-4901

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

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

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

- **Who can write your prescription.** A Plan physician or dentist, or an out-of –Plan doctor when you have been referred must write the prescription.
- **Where you can obtain them**.
  - **Retail Pharmacy**
  - You may fill the prescription at a retail Plan pharmacy,
  - **Mail Order Pharmacy**
  - You may obtain a medication for chronic conditions through the Plan mail order pharmacy. Medications for chronic conditions are defined as those that you have taken for at least six months. Our mail order pharmacies are:
    - West Texas Counties is Maxor 800-884-4901
    - Central Texas Counties is Express Scripts 800-884-4901
- **We use a Drug Coverage List (DCL).** Our Drug Coverage List includes all generic drugs and a comprehensive list of Name Brand drugs approved by our Pharmacy and Therapeutics (P&T) Committee, and used by Plan physicians to be dispensed through our Plan pharmacies to meet patient needs at a lower cost. In order to take advantage of the best combination of safety, effectiveness and cost savings, you must use drugs included on the Drug Coverage List. Our Drug Coverage List is divided into three tiers: Tier 1: Lowest co-payment for Generic Drugs; Tier 2: Higher co-payment for Limited Listed Brand Name Drugs; and Tier 3: Higher co-payment than Tier 2 for Other Brand Name Drugs. We cover non-Drug Coverage List drugs prescribed by a plan doctor at a higher copayment. If you need to order a Drug Coverage List or have any questions, please call our Customer Service Department at 800-884-4901 or visit our website at www.firstcare.com .
- **These are the dispensing limitations.** FirstCare requires prior authorization and imposes dispensing limitations on certain drugs, due to specific therapeutic indications or requirements for closer monitoring to help insure appropriate dispensing. The criteria used in administering these programs follow FDA approved dosing guidelines. For specific information about your prescription coverage, please consult a Customer Services Representative at 800-884-4901.
- Prescriptions are limited to a 30-day supply, except medications for chronic conditions that may be filled up to a 90-day supply but only when filled through a Participating Mail Service Pharmacy.
- If you or your physician request a Name Brand drug when a Generic equivalent is available, you will be responsible for the Generic Drug Copayment plus the difference between the cost of the Generic Drug and the cost of the Name Brand Drug.
- **Why use generic drugs ?** Generic drugs are lower-priced drugs that are pharmaceutically and therapeutically equivalent in strength and dosage to the more expensive original Name Brand product. The U.S. Food and Drug Administration closely regulates both generic and Name Brand drugs to ensure they meet the same standards for safety, purity, strength and effectiveness. Generic drugs are less expensive for you – and us – and can reduce your out-of-pocket expenses.
- **When you do have to file a claim. ?** When you have to file a claim. You may have to file a claim for reimbursement if you are out of the service area and have to pay for an emergency prescription filled at an out-of-network pharmacy. To obtain these forms, call our Customer Service Department at 800-884-4901.

- **What you should do if you are called to active duty or in case of a national emergency.** FirstCare will make special arrangements for emergency supplies of medications for our members that are called to active duty or during a national emergency. For information in obtaining this supply of medication, call our Customer Service Department.
- **Some things to keep in mind about our prescription drug program:**
  - A generic equivalent will be dispensed if it is available. If you or your prescriber request a Name Brand drug when a Federally approved generic drug is available, you have to pay the Generic copay plus the difference in cost between the Name Brand and the Generic drug.
  - Prescribing Generic drugs is encouraged. Prescribing Limited Listed Name Brand drugs is encouraged over Other Name Brand drugs.
  - A Generic or Limited Listed Name Brand drug may not always be available or appropriate to treat a condition. In that case, another Name Brand drug is covered at the Other Name Brand Copayment when used to treat a covered medical condition.
  - Injectable medications recognized by the FDA as appropriate for self-administration (referred to as "Self-Injectable" Drugs), regardless of your ability to self-administer are covered at a 20% coinsurance. This benefit does not apply to diabetic medications or allergy serum.
  - Prescriptions will not be refilled until 70% of the prescription has been used. Why use generic drugs?

Benefit Description	You pay
Covered medication and supplies	
We cover the following medications and supplies prescribed by a Plan physician and obtained from a Plan pharmacy or through our mail order program: • Drugs and medicines that by Federal law of the United States require a physician's prescription for their purchase, except those listed as Not covered. • Formulas necessary for the treatment of a heritable disease, such as phenylketonuria (PKU) • Drugs for sexual dysfunction are subject to dosage limits set by the Plan. Contact the Plan for details • Oral contraceptive drugs • Prescription and non-prescription oral agents for controlling blood sugar levels • Insulin, insulin analogs, glucagons emergency kits Growth hormone drugs for children under 18 years of age. Growth hormone therapy for the treatment of documented growth hormone deficiency in children for which epiphyseal closure has not occurred, are covered when pre-authorized	Retail Pharmacy, for a 30-day supply per prescription unit or refill; A $15 copay for Tier 1 generic drugs; A $35 copay for Tier 2 Limited Listed Name Brands drugs when a generic equivalent is not available; A $65 copay for Tier 3 Other Name Brand drugs; Mail Order Pharmacy, up to a 90-day supply per prescription until or refill. $45 copay for Tier 1 generic drugs; A $105 copay for Tier 2 Limited Listed; Name brand drugs when a generic equivalent is not available; A $195 copay for Tier 3 Other Name Brand drugs.
• Self-injectable drugs (except insulin and glucagons) • Other high-technology drugs • Contraceptive devices, such as; - Diaphragms - Intrauterine devices (IUDs) - Implantable drugs, such as Norplant - Injectable drugs, such as Depo Provera	20% of all charges for self-injectable drugs (except insulin and glucagons) and other High Technology drugs, not to exceed 200% of the annual premium.

Covered medication and supplies - continued on next page

Benefit Description	You pay
Covered medication and supplies (cont.)	
• Disposable needles and syringes for the administration of covered medications • Allergy syringes	20% of all charges for self-injectable drugs (except insulin and glucagons) and other High Technology drugs, not to exceed 200% of the annual premium.
Not covered: • Drugs and supplies for cosmetic purposes, including medications such as Lamisil or Sporanox for the treatment of uncomplicated nail fungus, and drugs for hair loss, growth or removal. • Vitamins, and nutritional substances that can be purchased without a prescription, except for pre-natal vitamins • Nonprescription medicines, except for the treatment of diabetes • Drugs available without a prescription or for which there is a nonprescription equivalent available • Drugs obtained at a non-Plan pharmacy except for out-of-area emergencies • Medical supplies such as dressings and antiseptics • Drugs to enhance athletic performance • Fertility drugs • Smoking cessation drugs and medication, including nicotine patches • Drugs prescribed for weight loss and appetite suppressants, except for medications prescribed for morbid obesity • Prescription refills in excess of the number specified by the Physician and any refill dispensed more than one year after the Physician's order • Any prescription drug for which the actual cost is less than the required copayment is not covered and you will be responsible for the cost of the drug • Prescriptions or refills that replace lost, stolen, spoiled, expired, spilled or are otherwise misplaced or mishandled by the Member.	*All Charges.*

Section 5(g). Dental benefits

Important things you should keep in mind about these benefits:

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

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.	Applicable copay depending on where services are rendered. Maximum benefit for accidental dental services is $10,000.
Dental benefits	
We have no other dental benefits.	

Section 5(h). Special features

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

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

The exclusions in this section apply to all benefits. There may be other exclusions and limitations listed in Section 5 of this brochure. **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; (see specifics regarding transplants)
- 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, coinsurance, or deductible.

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

Medical and hospital benefits

In most cases, providers and facilities file claims for you. Physicians must file on the form HCFA-1500, Health Insurance Claim Form. Your facility will file on the UB-92 form. For claims questions and assistance, call us at 800-884-4901.

When you must file a claim – such as for services you 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: FirstCare, 12940 N. Highway 183, Austin, Texas 78750

Deadline for filing your claim

Send us all of the documents for your claim as soon as possible. You must submit the claim by December 31 of the year after the year you received the service, unless timely filing was prevented by administrative operations of Government or legal incapacity, provided the claim was submitted as soon as reasonably possible.

When we need more information

Please reply promptly when we ask for additional information. We may delay processing or deny 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.

Step	Description
1	Ask us in writing to reconsider our initial decision. You must: a) Write to us within 6 months from the date of our decision; and b) Send your request to our Complaints and Appeals Department at 1901 West Loop 289, Suite 9, Lubbock, Texas 79407and; 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 3, 1900 E Street, NW, Washington, DC 20415-3630. Send OPM the following information: • A statement about why you believe our decision was wrong, based on specific benefit provisions in this brochure; • Copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms; • Copies of all letters you sent to us about the claim; • Copies of all letters we sent to you about the claim; and • Your daytime phone number and the best time to call. Note: If you want OPM to review more than one claim, you must clearly identify which documents apply to which claim.

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

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

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

If you do not agree with OPM's decision, your only recourse is to sue. If you decide to sue, you must file the suit against OPM in Federal court by December 31 of the third year after the year in which you received the disputed services, drugs, or supplies or from the year in which you were denied precertification or prior approval. This is the only deadline that may not be extended.

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

You may not sue until you have completed the disputed claims process. Further, Federal law governs your lawsuit, benefits, and payment of benefits. The Federal court will base its review on the record that was before OPM when OPM decided to uphold or overturn our decision. You may recover only the amount of benefits in dispute.

Note: **If you have a serious or life threatening condition** (one that may cause permanent loss of bodily functions or death if not treated as soon as possible), and

a) We haven't responded yet to your initial request for care or preauthorization/prior approval, then call us at 800-884-4901 and we will expedite our review; or

b) We denied your initial request for care or preauthorization/prior approval, then:

- If we expedite our review and maintain our denial, we will inform OPM so that they can give your claim expedited treatment too, or
- You may call OPM's Health Insurance Group3 at 202/606-0737 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 has coverage under any other health plan or has 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 private health plan choices available to Medicare beneficiaries. The information in the next few pages shows how we coordinate benefits with Medicare, depending on whether you are in the Original Medicare Plan or a private Medicare Advantage plan.

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

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

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

If your Plan physician does not participate in Medicare, you will have to file a claim with Medicare.

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. To find out if you need to do something to file your claim, call us at 800-884-4901 or see our Web site at www.firstcare.com.

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 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. **(Having coverage under more than two health plans may change the order of benefits determined on this chart.)**

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		✓
2) Have FEHB coverage on your own as an annuitant or through your spouse who is an annuitant	✓	
3) Have FEHB through your spouse who is an active employee		✓
4) 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 #3 above	✓	
5) 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	✓	
6) 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 #3 above	✓	
7) Are enrolled in Part B only, regardless of your employment status	✓ for Part B services	✓ for other services
8) Are a Federal employee receiving Workers' Compensation disability benefits for six months or more	✓*	
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	✓	
3) Have Temporary Continuation of Coverage (TCC) and...		
• Medicare based on age and disability	✓	
• Medicare based on ESRD **(for the 30 month coordination period)**		✓
• Medicare based on ESRD **(after the 30 month coordination period)**	✓	
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.

TRICARE and CHAMPVA

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

Suspended FEHB coverage to enroll in TRICARE or CHAMPVA: If you are an annuitant or former spouse, you can suspend your FEHB coverage to enroll in one of these programs, eliminating your FEHB premium. (OPM does not contribute to any applicable plan premiums.) For information on suspending your FEHB enrollment, contact your retirement office. If you later want to re-enroll in the FEHB Program, generally you may do so only at the next Open Season unless you involuntarily lose coverage under TRICARE or CHAMPVA.

Workers' Compensation

We do not cover services that:

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

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

Medicaid

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

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

When other Government agencies are responsible for your care

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

When others are responsible for injuries

When you receive money to compensate you for medical or hospital care for injuries or illness caused by another person, you must reimburse us for any expenses we paid. However, we will cover the cost of treatment that exceeds the amount you received in the settlement.

If you do not seek damages you must agree to let us try. This is called subrogation. If you need more information, contact us for our subrogation procedures.

When you have Federal Employees Dental and Vision Insurance Plan (FEDVIP) coverage

Some FEHB plans already cover some dental and vision services. When you are covered by more than one vision/dental plan, coverage provided under your FEHB plan remains as your primary coverage. FEDVIP coverage pays secondary to that coverage. When you enroll in a dental and/or vision plan on BENEFEDS.com, you will be asked to provide information on your FEHB plan so that your plans can coordinate benefits. Providing your FEHB information may reduce your out-of-pocket cost.

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.

Cost-sharing

Cost-sharing is the general term used to refer to your out-of-pocket costs (e. g., coinsurance, and copayment) for the covered care you receive.

Covered services

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

Custodial care

Custodial care is care that:

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

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

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

Deductible

This plan has no deductible.

Experimental or investigational service

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

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

Group health coverage

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

Medical necessity

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

The service is required for diagnosing, treating or preventing an illness or injury, or a medical condition such as pregnancy;

- If you are ill or injured, it is a service you need in order to improve your condition or to keep your condition from getting worse;
- It is generally accepted as safe and effective under standard medical practice in your community; and

- The service is provided in the most cost-efficient way, while still giving you an appropriate level of care.

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

Plan allowance

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

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

Usual, Reasonable and Customary (UCR) charge

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

Us/We

Us and We refer to FirstCare.

You

You refers to the enrollee and each covered family member.

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 Benefits*, 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, or when your child under age 22 turns age 22 or has a change in marital status, divorce, or when your child under age 22 marries.

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 2009 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 2008 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 Benefits 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 Benefits 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 PlanCoverage**

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 from your salary to reimburse you for eligible dependeare care and and health care expenses. You pay less in taxes so you save money. The result can be a discount of 20% to more than 40% on services you routinely pay for out-of-pocket.

Third, the **Federal Employees Dental and Vision Insurance Program (FEDVIP**) provides comprehensive dental and vision insurance at competitive group rates. Under **FEDVIP** you may choose self only, self plus one, or self and family coverage for yourself and any qualified dependents.

The Federal Flexible Spending Account Program – *FSAFEDS*

What is an FSA?

It is a account where you contribute money from your salary **BEFORE** taxes are withheld, then incur eligible expenses and get reimbursed. You pay less taxes so you save money. . **Annuitants are not eligible to enroll.**

There are three types of FSAs offered by FSAFEDS. Each type has a minimum annual election of $250 and a maximum annual election of $5,000.

- **Health Care FSA (HCFSA)** –Pays for eligible health care expenses for you and your dependents which are not covered or reimbursed by FEHBP coverage or other insurance.
- **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, which are not covered or reimbursed, by FEHBP or FEDVIP 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.

Where can I get more information about FSAFEDS?

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., Eastern Time. TTY: 1-800-952-0450.

The Federal Employees Dental and Vision Insurance Program – *FEDVIP*

Important Information

The Federal Employees Dental and Vision Insurance Program (FEDVIP) is a program, separate and different from the FEHB Program, established by the Federal Employee Dental and Vision Benefits Enhancement Act of 2004. This Program has no pre-existing condition limitations. FEDVIP is available to eligible Federal and Postal Service employees, retirees, and their eligible family members on an enroll-pay-all basis. Premiums are withheld from salary on a pre-tax basis.

Dental Insurance

Dental plans provide a comprehensive range of services, including the following:

Class A (Basic) services, which include oral examinations, prophylaxis, diagnostic evaluations, sealants and x-rays.

Class B (Intermediate) services, which include restorative procedures such as fillings, prefabricated stainless steel crowns, periodontal scaling, tooth extractions, and denture adjustments.

Class C (Major) services, which include endodontic services such as root canals, periodontal services such as gingivectomy, major restorative services such as crowns, oral surgery, bridges and prosthodontic services such as complete dentures.

Class D (Orthodontic) services with up to a 24-month waiting period

Please review the dental plans' benefits material for detailed information on the benefits covered, cost-sharing requirements, and preferred provider listings.

Vision Insurance

Vision plans provide comprehensive eye examinations and coverage for lenses, frames and contact lenses. Other benefits such as discounts on LASIK surgery may also be available.

Please review the vision plans' benefits material for detailed information on the benefits covered, cost-sharing requirements, and preferred provider listings.

Additional Information

You can find a comparison of the plans available and their premiums on the OPM website at www.opm.gov/insure/dentalvision. This site also provides links to each plan's website, where you can view detailed information about benefits and preferred providers.

How do I enroll?

You enroll on the Internet at www.BENEFEDS.com. For those without access to a computer, call 1-877-888-3337 (TTY number, 1-877-889-5680).

The Federal Long Term Care Insurance Program – *FLTCIP*

It's important protection

The Federal Long Term Care Insurance Program (FLTCIP) can help you pay for the potentially high cost of long term care services, which are not covered by FEHB plans. 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. To qualify for coverage under the FLTCIP, you must apply and pass a medical screening (called underwriting). To request an Information Kit and application, call 1-800-LTC-FEDS (1-800-582-3337) (TTY 1-800-843-3557) or visit www.ltcfeds.com.

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

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Summary of benefits for FirstCare - 2009

- 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; $55 specialist	15
Services provided by a hospital:		
• Inpatient	$150 per day up to a maximum of $750 per admission at a contracted facility within our 108 county service area; or A coinsurance of 20% of the allowable amount with an unlimited out-of-pocket maximum per admission at a contracted facility outside our 108 county service area	29
• Outpatient	$300 per visit	29
Emergency benefits:		
• In-area	$100 per visit.	32
• Out-of-area	$100 per visit.	33
Mental health and substance abuse treatment:	Regular cost sharing	34
Prescription drugs:		37
• Retail pharmacy (up to a 30-day supply per prescription unit or refill)	A $15 copay for Tier 1 generic drugs A $35 copay for Tier 2 Limited listed Name Brand drugs when a generic equivalent is not available; A $65 copay for Tier 3 Other Name Brand drugs; and A 20% coinsurance per prescription for Self-injectable drugs (except for insulin and glucagons) and other High Technology Drugs, not to exceed the out-of-pocket maximum of 200% of the annual premium per calendar year.	37
• Mail order (up to a 90-day supply per prescription unit or refill)	A $45 copay for Tier 1 generic drugs; A $105 copay for tier 2 Name brand drugs when a generic equivalent is not available;	37

	A $195 copay for tier 3 Name Brand drugs; and A 20% coinsurance per prescription for Self-injectable drugs (except insulin and glucagons) and other High Technology drugs, not to exceed the out-of-pocket maximum of 200% of the annual premium per calendar year.	
Dental care:	No benefit.	39
Vision care:	Nothing during office visit.	20
Special features	Services for deaf and hearing impaired; Centers of excellence for transplants/heart surgery/etc.	41
Protection against catastrophic costs (out-of-pocket maximum)**:**	Nothing after 200% of annual premium/Self only or 200% of annual premium/ Family enrollment. Some costs do not count toward this protection	12

2009 Rate Information for FirstCare

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

Postal rates apply to certain Postal Service employees. Most employees should refer to the Guide to Benefits for Career United States Postal Service Employees.

The rates shown below do not apply to Postal Service Inspectors. Office of Inspector General (OIG) employees and Postal Service Nurses. Rates for members of these groups are published in special Guides. Postal Service Inspectors and OIG employees should refer to the *Guide to Benefits for United States Postal Inspectors and Office of Inspector General Employeess* (RI 70-21N). Postal Service Nurses should refer to the *Guide to Benefits for United States Postal Nurses* (RI 70-2NU).

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 Guide to *Federal Benefits*.

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
Central Texas							
High Option Self Only	6U1	$133.94	$44.65	$290.21	$96.74	$154.48	$24.11
High Option Self and Family	6U2	$287.98	$95.99	$623.96	$207.98	$332.13	$51.84
West Texas							
High Option Self Only	CK1	$155.66	$88.92	$337.26	$192.66	$179.45	$65.13
High Option Self and Family	CK2	$352.56	$173.27	$763.88	$375.42	$406.42	$119.41