FIRSTCARE

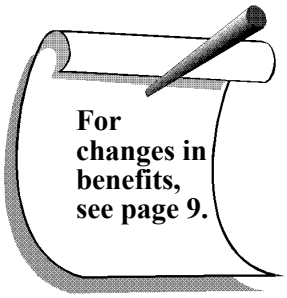
http://www.firstcare.com

2012

A Health Maintenance Organization

Serving: West Texas Counties of Moore, Potter, Randall and Swisher

Enrollment in this plan is limited. You must live or work in the counties of Moore, Potter, Randall and Swisher to enroll. See page 7 for requirements.



West Texas Counties of Moore, Potter, Randall and Swisher
Enrollment code for this Plan:
- **CK1 – High Option Self Only**
- **CK2 – High Option Self and Family**

Authorized for distribution by the:

United States
Office of Personnel Management

Healthcare and Insurance
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 (October 15th through December 7th) 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 (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, 2012, unless those benefits are also shown in this brochure.

OPM negotiates benefits and rates with each plan annually. Benefit changes are effective January 1, 2012, and changes are summarized on page 9. Rates are shown at the end of this brochure.

Plain Language

All FEHB brochures are written in plain language to make them easy to understand. Here are some examples:

- 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 Healthcare and Insurance, Federal Employee Insurance Operations, Program Analysis and Systems Support, 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.
- Please review your claims history periodically for accuracy to ensure services are not being billed to your accounts that were never rendered.

- 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.
- Please review your claims history periodically for accuracy to ensure services are not being billed to your accounts that were never rendered.
- 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 Headline
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 age 26 or over (unless he/she was disabled and incapable of self-support prior to age 26)
- 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.
- Fraud or intentional misrepresentation of material fact is prohibited under the Plan. You can be prosecuted for fraud and your agency may take action against you. Examples of fraud include, falsifying a claim to obtain FEHB benefits, trying to or obtaining services or coverage for yourself or for someone else who is not eligible for coverage, or enrolling in the Plan when you are no longer eligible.
- If your enrollment continues after you are no longer eligible for coverage (i.e., you have separated from Federal service) and premiums are not paid, you will be responsible for all benefits paid during the period in which premiums were not paid. You may be billed by your provider for services received. You may be prosecuted for fraud for knowingly using health insurance benefits for which you have not paid premiums. It is your responsibility to know when you or a family member is no longer eligible to use your health insurance coverage.

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.

Patient Safety Links

- www.ahrq.gov/consumer/. 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.

Never Events

You will not be billed for inpatient services related to treatment of specific hospital acquired conditions or for inpatient services needed to correct never events, if you use FirstCare preferred providers. This policy helps to protect you from preventable medical errors and improve the quality of care you receive.

When you enter the hospital for treatment of one medical problem, you don't expect to leave with additional injuries, infections or other serious conditions that occur during the course of your stay. Although some of these complications may not be avoidable, too often patients suffer from injuries or illnesses that could have been prevented if the hospital had taken proper precautions.

We have a benefit payment policy that encourages hospitals to reduce the likelihood of hospital-acquired conditions such as certain infections, severe bedsores and fractures; and reduce medical errors that should never happen called "Never Events". When a Never Event occurs, neither your FEHB plan or you will incur costs to correct the medical error.

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.

This plan is a "non-grandfathered health plan" under the Affordable Care Act. A non-grandfathered plan must meet immediate health care reforms legislated by the Act. Specifically, this plan must provide preventive services and screenings to you without any cost sharing; you may choose any available primary care provider for adult and pediatric care; visits for obstetrical or gynecological care do not require a referral; and emergency services, both in- and out-of-network, are essentially treated the same (i.e., the same cost sharing, no greater limits or requirements for one over the other; and no prior authorizations).

Questions regarding what protections apply may be directed to us at 1-800-884-4901. You can also read additional information from the U.S. Department of Health and Human Services at www.healthcare.gov .

General features of our High Option

We have Open Access benefits

Our HMO offers Open Access benefits. This means you can receive covered services from a participating provider without a required referral from you primary care physician or by another participating provider in the network.

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 Moore, Potter, Randall, and Swisher.

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 2012

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.

Program-wide Changes

- Sections 3, 7 and 8 have changed to reflect claims processing and disputed claims requirements of the Patient Protection and Affordable Care Act, Public Law 111-148.

Changes to this Plan

- Primary Care Office visit copayment changed to $25 per visit
- Ambulance copayment changed to $100 per trip
- Inpatient copayment changed to $200 per day up to a maximum of $1,000 per hospital stay
- Diagnostic Test copayment changed to $200 per precedure
- Premium rates increased for 2012. See page 70.

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. When you use our Open Access program you can receive 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
  - drop out of the Federal Employees Health Benefits (FEHB) Program and you enroll in another FEHB program Plan
  - 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;
- 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.

Services requiring our prior approval

Your Primary Care Physician or other participating plan provider has the 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!

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.

If you disagree with our pre-service claim decision

If you have a **pre-service claim** and you do not agree with our decision regarding precertification of an inpatient admission or prior approval of other services, you may request a review in accord with the procedures detailed below.

If you have already received the service, supply, or treatment, then you have a **post-service claim** and must follow the entire disputed claims process detailed in Section 8.

To reconsider a non-urgent care claim

Within 6 months of our initial decision, you may ask us in writing to reconsider our initial decision. Follow Step 1 of the disputed claims process detailed in Section 8 of this brochure.

In the case of a pre-service claim and subject to a request for additional information, we have 30 days from the date we receive your written request for reconsideration to

1. Precertify your hospital stay, or, if applicable,arrange for the health care provider to give you the care or grant your request for prior approval for a service, drug, or supply; or

2. Ask you or your provider for more information.

You or your provider must send the information so that we receive it within 60 daysof 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.

3. Write to you and maintain our denial.

To reconsider an urgent care claim

In the case of an appeal of apre-service urgent care claim, within 6 months of our initial decision, you may ask us in writing to reconsider our initial decision. Follow Step 1 of the disputed claims processdetailed in Section 8 of this brochure.

Subject to a request for additional information, we will notify you of our decision within 72 hours after receipt of your reconsideration request. We will hasten the review process, which allows oral or written requests for appeals and the exchange of information by telephone, electronic mail, facsimile, or other expeditious methods.

To file an appeal with OPM

After we reconsider your **pre-service claim**, if you do not agree with our decision, you may ask OPM to review it by following Step 3 of the disputed claims process detailed in Section 8 of this brochure.

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 $25 per office visit and when you go in the hospital, you pay $200 per day up to a maximum of $1,000 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, copayments and any amount over Usual, Customary and Reasonable amounts (UCR))) for covered care you receive. Usual, Customary and Reasonable amount is the costs that do not exceed negotiated schedule of payments developed by Us that are accepted by participating providers with a geographic area specidifed by US as payment in full.
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 the 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; durable medical equipment (DME) and any amount over Usual, Customary and Reasonable (UCR) amounts. 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. You may be responsible to pay for certain services and charges. Contact the government facility directly for more information.

Section 5. Benefits

This Plan offers a High Option. This benefit package is described in Section 5. Make sure that you review the benefits that are available under the option in which you are enrolled.

The High Option in Section 5 is divided into subsections. Please read *Important things you should keep in mind* at the beginning of the subsections. Also, read the General exclusions in Section 6, they apply to the benefits in the following subsections. To obtain claim forms, claims filling advice, or more information about the High Option benefits, contact us at 1-800-884-4901 or at our Web site at www.firstcare.com

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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	**High Option**
Professional services of physicians • In physician's office	$25 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 $200 per day up to $1,000 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
Lab, X-ray and other diagnostic tests	**High Option**
Tests, such as: • Blood tests • Urinalysis • Non-routine Pap tests • Pathology • X-rays • Non-routine mammograms • Ultrasound • Electrocardiogram and EEG	Nothing
• CAT Scans/MRI	$200 per procedure

Benefit Description	You pay
Preventive care, adult	**High Option**
Routine physical 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	Nothing
Routine Prostate Specific Antigen (PSA) test – one annually for men age 40 and older Routine Pap test	Nothing
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.
Adult routine immunizations endorsed by the Centers for Disease Control and Prevention (CDC).	Nothing
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	**High Option**
• Childhood immunizations recommended by the American Academy of Pediatrics	Nothing
• Well- child care changes for routine examinations, immunizations and care (up to age 22)	Nothing
• Examinations, such as: - Eye exams through age 17 to determine the need for vision correction, - Hearing exams through age 17 to determine the need for hearing correction, - Examinations done on the day of immunizations (up to age 22)	Nothing
Maternity care	**High Option**
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.	Nothing for pre- and post-natal care; inpatient copayment of $200 per day up to $1,000 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

Maternity care - continued on next page

Benefit Description	You pay
Maternity care (cont.)	**High Option**
• 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 $200 per day up to $1,000 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.* • *Reversal of voluntary surgical sterilization*	*All charges*
Family planning	**High Option**
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.	$25 per PCPoffice visit. $55 per Specialist 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*
Infertility services	**High Option**
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*	*All charges*

Infertility services - continued on next page

Benefit Description	You pay
Infertility services (cont.)	**High Option**
• *Cost of donor egg* • *Fertility drugs*	*All charges*
Allergy care	**High Option**
• Testing and treatment	$25 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	**High Option**
• 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. 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. We will only cover GHT services and related services and supplies that we determine are medically necessary. See *Services requiring our prior approval* in Section 3.	$25 per PCP visit; $55 per specialist visit; $300 copay per outpatient facility visit; or included in inpatient copayment of $200 per day up to $1,000 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	**High Option**
Physical therapy and occupational therapy services of each of the following: • Qualified Physical Therapists • 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.	$25 per PCP visit; $55 per specialist visit; $300 copay per outpatient facility visit, or included in inpatient copayment of $200 per day up to $1,000 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 - continued on next page

Benefit Description	You pay
Physical and occupational therapies (cont.)	**High Option**
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	**High Option**
Speech therapy services provided by a speech therapist.	$25 per PCP visit; $55 per specialist visit; $300 copay per outpatient facility visit; or included in inpatient copayment of $200 per day up to $1,000 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
Hearing services (testing, treatment, and supplies)	**High Option**
• First hearing aid and testing only when necessitated by accidental injury incurred while insured through FirstCare. • Hearing testing for children through age 17, which include; (see *Preventive care, children)*	$25 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)	**High Option**
• 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*

Benefit Description	You pay
Foot care	**High Option**
Routine foot care when you are under active treatment for a metabolic or peripheral vascular disease, such as diabetes.	$25 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	**High Option**
• 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 • External hearing aids	20% of all charges External prosthetic maximum is $15,000 per device/limb.
Internal prosthetic devices, such as artificial joints, pacemakers and surgically implanted breast implant following mastectomy, and implanted lenses during cataract surgery. Note: For information on the professional charges for the surgery to insert an implant, see Section 5(b) Surgical procedures. For information on the hospital and/or ambulatory surgery center benefits, see Section 5(c) Services provided by a hospital or other facility, and ambulance services.	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, foot orthotics, 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*

Benefit Description	You pay
Durable medical equipment (DME)	**High Option**
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 • C-PAP monitoring device (when there is a diagnosis of documented obstructive sleep apnea) • Oxygen, oxygen concentrators, rental of equipment for administration of oxygen, and mechanical equipment necessary for the treatment of chronic or acute respiratory failure Note: Oxygen and equipment must be prescribed and directed by a Plan provider, and approved in advance by the Plan. • Monitoring devices, such as apnea monitors and uterine monitors for use in the home, when prescribed and directed by a Plan provider • Ostomy supplies • Sterile dressing change kits, i.e, tracheostomy suction and dressing kits, and central line dressing kits Note: 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*	*All charges*

Durable medical equipment (DME) - continued on next page

Benefit Description	You pay
Durable medical equipment (DME) (cont.)	**High Option**
• *Hygienic or self help items or equipment* • *Sports cords* • *TENS units* • *Repair or replacement resulting from misuse or abuse*	*All charges*
Home health services	**High Option**
• 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*
Chiropractic	**High Option**
No benefit	All charges
Alternative treatments	**High Option**
• 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. • Anesthesia • Pain Relief	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*

Benefit Description	You pay
Educational classes and programs	**High Option**
Coverage is provided for:	
Diabetes self management training, including counseling and use of diabetic equipment and supplies	$25 per PCP visit: $55 per specialist visit
Tobacco cessation programs, including individual/group/telephone counseling, and for over the counter (OTC) and prescription drugs approved by the FDA to treat tobacco dependence.	Nothing for up to 4 counseling sessions per two quit attempts per year. Nothing for OTC and prescription drugs approved by the FDA to treat tobacco dependence.
Childhood obesity education	Nothing
Diabetic Equipment and Supplies	**High Option**
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 • 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	**High Option**
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 $200 per day up to $1,000 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.)	**High Option**
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 $200 per day up to $1,000 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	**High Option**
• 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 $200 per day up to $1,000 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	**High Option**
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 *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 $200 per day up to $1,000 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	**High Option**
These **solid organ transplants** are covered. These solid organ transplants are subject to medical necessity and experimental/investigational review by the Plan. Refer to *Other services* in Section 3 for prior authorization procedures. • Cornea • Heart • Heart/lung • Intestinal transplants - Small intestine - Small intestine with the liver - Small intestine with multiple organs, such as the liver, stomach, and pancreas • Kidney • Liver • Lung: single/bilateral • Pancreas • Autologous pancreas islet cell transplant (as an adjunct to total or near total pancreatectomy) only for patients with chronic pancreatitis These **tandem blood or marrow stem cell transplants for covered transplants** are subject to medical necessity review by the Plan. Refer to *Other services* in Section 3 for prior authorization procedures. • Autologous tandem transplants for - AL Amyloidosis - Multiple myeloma (de novo and treated)	$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 $200 per day up to $1,000 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.)	**High Option**
- Recurrent germ cell tumors (including testicular cancer) **Blood or marrow stem cell transplants** limited to the stages of the following diagnoses. For the diagnoses listed below, the medical necessity limitation is considered satisfied if the patient meets the staging description. Refer to *Other Services* in Section 3 for prior authorization procedures. • Allogeneic transplants for - Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia - Advanced Hodgkin's lymphoma with reoccurrence (relapsed) - Advanced non-Hodgkin's lymphoma with reoccurrence (relapsed) - Acute myeloid leukemia - Advanced Myeloproliferative Disorders (MPDs) - Amyloidosis - Chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL) - Hemoglobinopathy - Marrow failure and related disorders (i.e., Fanconi's, PNH, Pure Red Cell Aplasia) - Myelodysplasia/Myelodysplastic syndromes - Paroxysmal Nocturnal Hemoglobinuria - Severe combined immunodeficiency - Severe or very severe aplastic anemia • Autologous transplants for - Acute lymphocytic or nonlymphocytic (i.e., myelogenous) leukemia - Advanced Hodgkin's lymphoma with reoccurrence (relapsed) - Advanced non-Hodgkin's lymphoma with reoccurrence (relapsed) - Amyloidosis - Breast Cancer - Epithelial ovarian cancer - Multiple myeloma - Testicular, Mediastinal, Retroperitoneal, and ovarian 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 $200 per day up to $1,000 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.)	**High Option**
Mini-transplants performed in a clinical trial setting (non-myeloablative, reduced intensity conditioning or RIC) for members with a diagnosis listed below are subject to medical necessity review by the Plan. Refer to *Other services* in Section 3 for prior authorization procedures: • Autologous transplants for - Amyloidosis - Multiple myeloma (de nova and treated) - Recurrent germ cell tumors (including testicular cancer) 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 $200 per day up to $1,000 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	**High Option**
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	**High Option**
Room and board, such as • Ward, semiprivate, or intensive care accommodations • General nursing care • 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.	$200 per day up to $1,000 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	**High Option**
• 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	**High Option**
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.	$200 per day up to $1,000 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	**High Option**
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	**High Option**
Local professional ambulance service when medically appropriate	$100 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.
- Payment for emergency care recieved from out-of-plan providers, inside and outside Our Service Area, and out-of-area urgent care is provider in one of two ways;You will be responsible for any amounts over the UCR. (See Section 10 for the definition of our Plan's allowance of UCR charge).
  - We will pay the Usual, Customary and Reasonable (UCR) amount for care received from out-of-plan providers; or
  - We will arrange to pay those providers directly at rates negotiated with the provider by FirstCare.

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 charges covered in full. Any follow –up care recommended by non-Plan providers must be approved by the Plan or provided by Plan providers

Benefit Description	You pay
Emergency within our service area	**High Option**
• Emergency care at a doctor's office	$25 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	**High Option**
• Emergency care at a doctor's office	$25 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*

Benefit Description	You pay
Ambulance	**High Option**
Professional ambulance service, including air ambulance, when medically appropriate. Note: See 5(c) for non-emergency service.	$100 per trip

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

You need to get Plan approval (preauthorization) for services and follow a treatment plan we approve in order to get benefits. When you receive services as part of an approved treatment plan, cost-sharing and limitations for Plan mental health and substance abuse benefits are 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.
- The calendar year deductible or, for facility care, the inpatient deductible applies to almost all benefits in this Section. We added "(No deductible)" to show when a deductible does not apply.
- 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. 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. The treatment plan may include services, drugs, and supplies described elsewhere in this brochure. To be eligible to receive full benefits, you must follow the preauthorization process and get Plan approval of your treatment plan:

- We will provide medical review criteria or reasons for treatment plan denials to enrollees, members or providers upon request or as otherwise required.
- 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.

Benefit Description	You pay
Professional services	**High Option**
When part of a treatment plan we approve, we cover professional services by licensed professional mental health and substance abuse practitioners when acting within the scope of their license, such as psychiatrists, psychologists, clinical social workers, licensed professional counselors, or marriage and family therapists.	Your cost-sharing responsibilities are no greater than for other illnesses or conditions.
Diagnosis and treatment of psychiatric conditions, mental illness, or mental disorders. Services include: • Diagnostic evaluation • Crisis intervention and stabilization for acute episodes • Medication evaluation and management (pharmacotherapy) • Psychological and neuropsychological testing necessary to determine the appropriate psychiatric treatment • Treatment and counseling (including individual or group therapy visits) • Diagnosis and treatment of alcoholism and drug abuse, including detoxification, treatment and counseling • Professional charges for intensive outpatient treatment in a provider's office or other professional setting • Electroconvulsive therapy	Included in the applicable copay depending on place of service: $25 per visit to your primary care physician office; or $55 per visit to a specialist office; or $300 copay per outpatient facility visit; or included in inpatient copayment of $200 per day up to $1,000 maximum copay per admission inside our service area; or

Professional services - continued on next page

Benefit Description	You pay
Professional services (cont.)	**High Option**
	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
Diagnostics	**High Option**
• Outpatient diagnostic tests provided and billed by a licensed mental health and substance abuse practitioner • Outpatient diagnostic tests provided and billed by a laboratory, hospital or other covered facility • Inpatient diagnostic tests provided and billed by a hospital or other covered facility	Nothing
Inpatient hospital or other covered facility	**High Option**
Inpatient services provided and billed by a hospital or other covered facility • Room and board, such as semiprivate or intensive accommodations, general nursing care, meals and special diets, and other hospital services	Inpatient copayment of $200 per day up to $1,000 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
Outpatient hospital or other covered facility	**High Option**
Outpatient services provided and billed by a hospital or other covered facility • Services such as partial hospitalization, half-way house, residential treatment, full-day hospitalization, or facility-based intensive outpatient treatment	Included in the applicable copay depending on place of service: $25 per visit to your primary care physician office; or $55 per visit to a specialist office; or $300 copay per outpatient facility visit; or included in inpatient copayment of $200 per day up to $1,000 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

Benefit Description	You pay
Not covered	**High Option**
• Services that are not part of a preauthorized approved treatment plan	All charges

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
- **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	**High Option**
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 • 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:	*All Charges.*

Covered medication and supplies - continued on next page

Benefit Description	You pay
Covered medication and supplies (cont.)	**High Option**
• 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 • Tobacco 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 Note: Over-the-counter and prescription drugs approved by the FDA to treat tobacco dependence are covered under the Smoking cessation benefit. (See page 25.)	*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 payor 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	**High Option**
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	**High Option**
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 it is medically necessary to prevent, diagnose, or treat your illness, disease, injury ,or condition. For information on obtaining prior approval for specific services, such as transplants, see Section 3 *When you need prior Plan approval forcertain services.*

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.
- Services, drugs, or supplies you receive without charge while in active military service.
- Extra care and Research costs related to Clinical Trials.

Section 7. Filing a claim for covered services

This Section primarily deals with post-service claims (claims for services, drugs or supplies you have already received). See Section 3 for information on pre-service claims procedures (services, drugs or supplies requiring prior Plan approval), including urgent care claims procedures. 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 CMS-1500, Health Insurance Claim Form. Your facility will file on the UB-04 form. For claims questions and assistance, contact us at 800-884-4901, or at our Web site, www.firstcare.com.

When you must file a claim – such as for services you received outside the Plan's service area – submit it on the CMS-1500 or a claim form that includes the information shown below. Bills and receipts should be itemized and show:

- Covered member's name, date of birth, address, phone number, 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 payor – such as the Medicare Summary Notice (MSN)
- Receipts, if you paid for your services

Note: Canceled checks, cashregister receipts, or balance due statements are not acceptable substitutes foritemized bills.

Submit your claims to: FirstCare, 12940 N. Highway 183, Austin, Texas 78750 Telephone 1-800-884-4901

Prescription Drugs

Submit your claims to: FirstCare, 12940 N. Highway 183, Austin, Texas 78750 Telephone 1-800-884-4901

Other supplies or services

Submit your claims to: FirstCare, 12940 N. Highway 183, Austin, Texas 78750 Telephone 1-800-884-4901

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.

Urgent care claim procedures

If you have an urgent care claim, please contact our Customer Service Department at 1-800-884-4901. Urgent care claims must meet the definition found in Section 10 of this brochure, and most urgent care claims will be claims for access to care rather than claims for care already received. We will notify you of our decision not later than 24 hours after we receive the claim as long as you provide us with sufficient information to decide the claim. If you or your authorized representative fails to provide sufficient information, we will inform you or your authorized representative of the specific information necessary to complete the claim not later than 24 hours after we receive the claim and a time frame for our receipt of this information. We will decide the claim within 48 hours of (i) receiving the information or (ii) the end of the time frame, whichever is earlier.

We may provide our decision orally within these time frames, but we will follow up with a written or electronic notification within three days of oral notification.

Pre-service claims procedures

As indicated in Section 3, certain care requires Plan approval in advance. We will notify you of our decision within 15 days after the receipt of the pre-service claim. If matters beyond our control require an extension of time, we may take up to an additional 15 days for review and we will notify you before the expiration of the original 15-day period. Our notice will include the circumstances underlying the request for the extension and the date when a decision is expected.

If we need an extension because we have not received necessary information from you, our notice will describe the specific information required and we will allow you up to 60 days from the receipt of the notice to provide the information.

If you fail to follow these pre-service claim procedures, then we will notify you of your failure to follow these procedures as long as (1) your request is made to our customer service department and (2) your request names you, your medical condition or symptom, and the specific treatment, service, procedure, or product requested. We will provide this notice within five days following the failure or 24 hours if your pre-service claim is for urgent care. Notification may be oral, unless you request written correspondence.

Post-service claims procedures

We will notify you of our decision within 30 days after we receive your post-service claim. If matters beyond our control require an extension of time, we may take up to an additional 15 days for review and we will notify you before the expiration of the original 30-day period. Our notice will include the circumstances underlying the request for the extension and the date when a decision is expected.

If we need an extension because we have not received necessary information from you, our notice will describe the specific information required and we will allow you up to 45 days from the receipt of the notice to provide the information.

If you do not agree with our initial decision, you may ask us to review it by following the disputed claims process detailed in Section 8 of this brochure.

Concurrent care claims procedures

A concurrent care claim involves care provided over a period of time or over a number of treatments. We will treat any reduction or termination of our pre-approved course of treatment as an appealable decision. If we believe a reduction or termination is warranted we will allow you sufficient time to appeal and obtain a decision from us before the reduction or termination takes effect.

If you request an extension of an ongoing course of treatment at least 24 hours prior to the expiration of the approved time period and this is also an urgent care claim, then we will make a decision within 24 hours after we receive the claim.

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. Our deadline for responding to your claim is stayed while we await all of the additional information needed to process your claim.

Authorized Representative

You may designate anauthorized representative to act on your behalf for filing a claim or to appeal claims decisions to us. For urgent care claims, we will permit a health care professional with knowledge of your medical condition to act as your authorized representative without your express consent. For the purposes of this section, we are also referring to your authorized representative when we refer to you.

Section 8. The disputed claims process

You may be able to appeal directly to the Office of Personnel Management (OPM) if we do not follow required claims processes. For more information about situations in which you are entitled to immediately appeal to OPM, including additional requirements not listed in Sections 3, 7 and 8 of this brochure, please visit https://www.tpabenefits.com/firstcare/logon/member/member.asp.

Please follow this Federal Employees Health Benefits Program disputed claims process if you disagree with our decision on your post-service claim (a claim where services, drugs or supplies have already been provided). In Section 3 *If you disagree with our pre-service claim decision,* we describe the process you need to follow if you have a claim for services, referrals, drugs or supplies that must have prior Plan approval, such as inpatient hospital admissions.

To help you prepare your appeal, you may arrange with us to review and copy, free of charge, all relevant materials and Plan documents under our control relating to your claim, including those that involve any expert review(s) of your claim.

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 79407; and c) Include a statement about why you believe our initial decision was wrong, based on specific benefit provisions in this brochure; and d) Include copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms. e) Include your email address (optional for member), if you would like to receive our decision via email. Please note that by giving us your email, we may be able to provide our decision more quickly. We will provide you, free of charge and in a timely manner, with any new or additional evidence considered, relied upon, or generated by us or at our direction in connection with your claim and any new rationale for our claim decision. We will provide you with this information sufficiently in advance of the date that we are required to provide you with our reconsideration decision to allow you a reasonable opportunity to respond to us before that date. However, our failure to provide you with new evidence or rationale in sufficient time to allow you to timely respond shall not invalidate our decision on reconsideration. You may respond to that new evidence or rationale at the OPM review stage described in step 4.
2	In the case of a post-service claim, we have 30 days from the date we receive your request to: a) Pay the claim or b) Write to you and maintain our denial or c) Ask you or your provider for more information. 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.
3	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 dateof 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,Healthcare and Insurance, Federal Employee Insurance Operations, Health Insurance, 1900 E Street, NW, Washington, DC 20415.

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.
- Your email address, if you would like to receive OPM's decision via email. Please note that by providing your email address, you may receive OPM's decision more quickly.

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. However, for urgent care claims, a health care professional with knowledge of your medical condition may act as your authorized representative without your express consent.

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

4 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 you did not indicate that your claim was a claim for urgent care, then call us at (800) 804-4901. We will hasten our review (if we have not yet responded to your claim); or we will inform OPM so they can quickly review your claim on appeal. You may call OPM's Health Insurance x at (202) 606-xxxx between 8 a.m. and 5 p.m. eastern time.

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 you did not indicate that your claim was a claim for urgent care, then call us at 1-800-884-4901. We will hasten our review (if we have not yet responded to your claim); or we will inform OPM so they can quickly review your claim on appeal. You may call OPM's Health Insurance 3 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 payor and the other plan pays a reduced benefit as the secondary payor. We, like other insurers, determine which coverage is primary according to the National Association of Insurance Commissioners' guidelines.

When we are the primary payor, we will pay the benefits described in this brochure.

When we are the secondary payor, we will determine our allowance. After the primary plan pays, we will pay what is left of our allowance, up to our regular benefit. We will not pay more than our allowance.

What is Medicare?

Medicare is a Health Insurance Program for:

- People 65 years of age or older
- Some people with disabilities under 65 years of age
- People with End-Stage Renal Disease (permanent kidney failure requiring dialysis or a transplant)

Medicare has four parts:

- Part A (Hospital Insurance). Most people do not have to pay for Part A. If you or your spouse worked for at least 10 years in Medicare-covered employment, you should be able to qualify for premium-free Part A insurance. (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 (1-800-633-4227), (TTY 1-877-486-2048) 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 (TTY 1-800-325-0778) 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 do not sign up for Medicare Part B when you are first eligible, you may be charged a Medicare Part B late enrollment penalty of a 10 % increase in premium for every 12 months you are not enrolled. If you didn't take Part B at age 65 because you were covered under FEHB as an active employee (or you were covered under your spouse's group health insurance plan and he/she was an active employee), you may sign up for Part B (generally without an increased premium) within 8 months from the time you or your spouse stop working or are no longer covered by the group plan. You also can sign up at any time while you are covered by the group plan.

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.

All physicians and other providers are required by law to file claims directly to Medicare for members with Medicare Part B, when Medicare is primary. This is true whether or not they accept Medicare.

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

Claims process when you have the Original Medicare Plan – You will probably not need to file a claim form when you have both our Plan and the Original Medicare Plan.

When we are the primary payor, we process the claim first.

When Original Medicare is the primary payor, 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 1-800-884-4901 or see our Web site at www.firstcare.com.

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

- **Tell us about your Medicare Coverage**

You must tell us if you or a covered family member has Medicare coverage and let us obtain information about services denied or paid under Medicare if we ask. You must also tell us about other coverage you or your covered family members may have as this coverage may affect the primary/secondary status of this Plan and Medicare.

- **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), (TTY 1-877-486-2048) 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 payor. The following chart illustrates whether Medicare or this Plan should be the primary payor 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 Payor Chart		
A. When you - or your covered spouse - are age 65 or over and have Medicare and you...	**The primary payor 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 payor before eligibility due to ESRD **(for 30 month coordination period)**		✓
• Medicare was the primary payor 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 (or a covered family member) 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.

Clinical Trials

If you participate in a clinical trail, this health plan will provide related care as follows, if it is not provided by the clinical trial:

- Routine care costs - costs for routine services such as doctor's visits, lab tests, x-rays and scans, and hospitalizations related to treating the patient's condition, whether the patient is in a clinical trial or is receiving standard therapy. These costs are covered by the plan.

- Extra care costs - costs related to taking part in a clinical trial such as additional tests that a patient may need as part of the trial, but not as part of the patient's routine care. This plan does not cover these costs.
- Research costs - costs related to conducting the clinical trial such as research physician and nurse time, analysis of results, and clinical test performed only for research purposes. These costs are generally covered by the clinical trials, this plan does not cover these costs.

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.

Clinical Trials Cost Categories

- Routine Care costs - costs for routine services such as doctor visits, lab tests, x-rays and scans, and hospitalizations related to treating the patient's condition, whether the patient is in a clinical trial or is receiving standard therapy.
- Extra Care costs - costs related to taking part in a clinical trial such as additional tests that a patient may need as part of the trial, but not as part of the patient's routine care.
- Research costs - costs related to conducting the clinical trial such as research physician and nurse time, analysis of results and clinical tests performed only for research purposes.

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 14.

Copayment

A copayment is a fixed amount of money you pay when you receive covered services. See page 14.

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.

Health care professional A physician or other health care professional licensed, accredited, or certified to perform specified health services consistent with state law.

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

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

- If you are ill or injured, it is a service you need in order to improve your condition or to keep your condition from getting worse;
- It is generally accepted as safe and effective under standard medical practice in your community; and
- The service is provided in the most cost-efficient way, while still giving you an appropriate level of care.

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

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

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

Post-service claim Any claims that are not pre-service claims. In other words, post-service claims are those claims where treatment has been performed and the claims have been sent to us in order to apply for benefits.

Pre-service claims Those claims (1) that require precertification, prior approval, or a referral and (2) where failure to obtain precertification, prior approval, or a referral results in a reduction of benefits.

Urgent care claims A claim for medical care or treatment is an urgent care claim if waiting for the regular time limit for non-urgent care claims could have one of the following impacts:

- Waiting could seriously jeopardize your life or health;
- Waiting could seriously jeopardize your ability to regain maximum function; or
- In the opinion of a physician with knowledge of your medical condition, waiting would subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

Urgent care claims usually involve Pre-service claims and not Post-service claims. We will judge whether a claim is an urgent care claim by applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine.

If you believe your claim qualifies as an urgent care claim, please contact our Customer Service Department at 1-800-884-4901. You may also prove that your claim is an urgent care claim by providing evidence that a physician with knowledge of your medical condition has determined that your claim involves urgent care..

Usual, Reasonable and Customary (UCR) charge	Costs that do not exceed negotiated schedule of payments developed by Us that are accepted by Participating Providers within a geographic area specificed by Us as payment in full. Non-Preferred providers may bill members for charges over Our determination of the UCR amount. The member is responsible for these charges, in addition to all applicable copayments and coinsurance.
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
- 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. For information on your premium deductions, you must also contact 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 dependent children under age 26, including any foster children your employing or retirement office authorizes coverage for. Under certain circumstances, you may also continue coverage for a disabled child 26 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 of changes in family member status, including your marriage, divorce, annulment, or when your child reaches age 26.

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.

Family Member Coverage

Family members coveredunder your Self and Family enrollment are your spouse (including a valid commonlaw marriage) and children as described in the chart below.

Children	Coverage
Natural, adopted children, and stepchildren	Natural, adopted childrenand stepchildren are covered until their 26th birthday.
Foster Children	Foster children are eligible for coverage until their 26th birthday if you provide documentation of your regular and substantial support of the child and sign a certification stating that your foster child meets all the requirements. Contact your human resources office or retirement system for additionalinformation.
Children Incapable of Self-Support	Children who are incapableof self-support because of a mental or physical disability that began before age 26 are eligible to continue coverage. Contact your human resources office or retirement system for additional information.
Married Children	Married children (but **NOT** their spouse or their own children) are covered until their 26th birthday.
Children with or eligible for employer-provided health insurance	Children who are eligible for or have their own employer-provided health insurance are covered until their 26th birthday.

You can find additionalinformation at www.opm.gov/insure.

- **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 2012 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 2011 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.

If your enrollment continues after you are no longer eligible for coverage (i.e. you have separated from Federal service) and premiums are not paid, you will be responsible for all benefits paid during the period in which premiums were not paid. You may be billed for services received directly from your provider. You may be prosecuted for fraud for knowingly using health insurance benefits for which you have not paid premiums. It is your responsibility to know when you or a family member are no longer eligible to use your health insurance 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 anadditional 31 days of coverage, for no additional premium, when:

- Your enrollment ends, unless you cancel yourenrollment; or
- You are a family member no longer eligible for coverage.

Any person covered underthe 31 day extension of coverage who is confined in a hospital or otherinstitution for care or treatment on the 31st day of thetemporary extension is entitled to continuation of the benefits of the Plan duringthe continuance of the confinement but not beyond the 60th dayafter the end of the 31 day temporary extension.

You may be eligible forspouse equity coverage or Temporary Continuation of Coverage (TCC), or aconversion 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 26, 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. Other Federal Programs

Important information about 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)** – Reimburses you for eligible health care expenses (such as copayments, deductibles, insulin, products, physician prescribed over-the-counter drugs and medications, vision and dental expenses, and much more) for you and your tax dependents, including adult children (through the end of the calendar year in which they turn 26) which are not covered or reimbursed by FEHBP or FEDVIP coverage or any 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 tax dependents including adult children (through the end of the calendar year in which they turn 26) which are not covered or reimbursed by FEHBP or FEDVIP coverage or any other insurance.
- **Dependent Care FSA (DCFSA)** – Reimburses you for eligible **non-medical** day care expenses for your child(ren) under age 13 and/or for any person you claim as a dependent on your Federal Income Tax return who is mentally or physically incapable of self-care. You (and your spouse if married) must be working, looking for work (income must be earned during the year), or attending school full-time to be eligible for a DCFSA.
- If you are a new or newly eligible employee you have 60 days from your hire date to enroll in an HCFSA or LEX HCFSA and/or DCFSA, but you must enroll before October 1. If you are hired or become eligible on or after October 1 you must wait and enroll during the Federal Benefits Open Season held each fall.

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 separate and different from the FEHB Program, and was established by the Federal Employee Dental and Vision Benefits Enhancement Act of 2004. This Program has no pre-existing condition limitations for enrollment.
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

All dental plans provide a comprehensive range of services, including:

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 for dependent children up to age 19.

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

Vision Insurance

All 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/vision and www.opmgov/insure/dental. These sites also provide 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, 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 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 such as Alzheimer's disease. For example, long term care can be received in your home from a home health aide, in a nursing home, in an assisted living facility or in adult day care. To qualify for coverage under the FLTCIP, you must apply and pass a medical screening (called underwriting). Federal and U.S. Postal Service employees and annuitants, active and retired members of the uniformed services, and qualified relatives, are eligible to apply. Certain medical conditions, or combinations of conditions, will prevent some people from being approved for coverage. You must apply to know if you will be approved for enrollment. For more information, call 1-800-LTC-FEDS (1-800-582-3337) (TTY 1-800-843-3557) or visit www.ltcfeds.com .

Pre-existing Condition Insurance Program– *PCIP*

Do you know someone who needs health insurance but can't get it? The Pre-Existing Condition Insurance Plan (PCIP) may help.

An individual is eligible to buy coverage in PCIP if:

- He or she has a pre-existing medical condition or has been denied coverage because of the health condition;
- He or she has been without health coverage for at least the last six months. (If the individual currently has insurance coverage that does not cover the pre-existing condition or is enrolled in a state high risk pool then that person is not eligible for PCIP.);
- He or she is a citizen or national of the United States or resides in the U.S. legally.

The Federal government administers PCIP in the following states: Alabama, Arizona, District of Columbia, Delaware, Florida, Georgia, Hawaii, Idaho, Indiana, Kentucky, Louisiana, Massachusetts, Minnesota, Mississippi, North Dakota, Nebraska, Nevada, South Carolina, Tennessee, Texas, Vermont, Virginia, West Virginia, and Wyoming. To find out about eligibility, visit www.pcip.gov and/or www.healthcare.gov or call1-866-717-5826 (TTY): 1-866-561-1604.

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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 High Option benefits for FirstCare - 2012

- 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: $25 primary care; $55 specialist	18
Services provided by a hospital:		
• Inpatient	$200 per day up to a maximum of $1,000 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

2012 Rate Information for FirstCare

Postal Category 1 rates apply to career employees covered by the NationalPostal Mail Handlers Union (NPMHU), National Association of Letter Carriers(NALC) and Postal Police bargaining units.

Postal Category 2 rates apply to other non-APWU, non-PCES, non-lawenforcement Postal Service career employees, including management employees,and employees covered by the National Rural Letter Carriers' Association bargaining unit.

Special Guides are published for American Postal Workers Union (APWU) employees (see RI 70-2A) including Material Distribution Center, Operating Services and Information Technology/Accounting Services employees and Nurses; PostalService Inspectors and Office of Inspector General (OIG) law enforcementemployees (see RI 70-2IN), Postal Career Executive Service (PCES) employees(see RI 70-2EX), and noncareer employees (see RI 70-8PS).

Career APWU employees hired before May 23, 2011, will have the same rates as the Category 2 rates shown below. In the Guide to Benefits for APWU Employees (RI 70-2A) this will be referred to as the "Current" rate; otherwise, "New" rates apply.

For further assistance, Postal Service employees should call:

Human Resources Shared Service Center

1-877-477-3273, option 5

TTY: 1-866-260-7507

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. Referto the applicable *Guide to FederalBenefits*.

Type of Enrollment	Enrollment Code	Non-Postal Premium				Postal Premium	
		Biweekly		Monthly		Biweekly	
		Gov't Share	Your Share	Gov't Share	Your Share	Category 1 Your Share	Category 2 Your Share
West Texas counties of Moore, Potter, Randall, and Swisher							
High Option Self Only	CK1	$169.90	$56.63	$368.12	$122.70	$37.38	$35.11
High Option Self and Family	CK2	$414.35	$265.27	$897.76	$574.75	$219.23	$213.47