HMO Blue® Texas

2002

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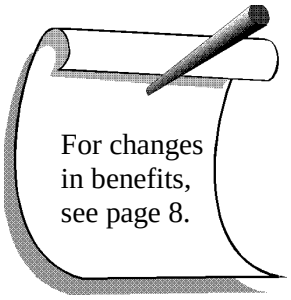
Health Maintenance Organization



Serving: Northeast, West, Southeast and Central Territories

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

The Southwest Texas HMO Plan has full accreditation from the NCQA. See the 2002 Guide for more information on NCQA.

Enrollment codes for this Plan:

Houston, Gulf Coast and Central Texas areas
YM1 Self Only
YM2 Self and Family

Dallas/Ft. Worth, Lubbock, Amarillo, East Texas, and West Texas areas
YX1 Self Only
YX2 Self and Family

Authorized for distribution by the:

United States
Office of Personnel Management
Retirement and Insurance Service
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Federal Employees Health Benefits Program

RI 73-264

Table of Contents

Introduction

Southwest Texas HMO, Inc.
d/b/a HMO Blue Texas
P. O. Box 660044
Dallas, TX 75266-0044

This brochure describes the benefits of HMO Blue Texas under our contract (CS 1951) with the Office of Personnel Management (OPM), as authorized by the Federal Employees Health Benefits law. This brochure is the official statement of benefits. No oral statement can modify or otherwise affect the benefits, limitations and exclusions of this brochure.

If you are enrolled in this Plan, you are entitled to the benefits described in this brochure. If you are enrolled for 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, 2002, unless those benefits are also shown in this brochure.

OPM negotiates benefits and rates with each plan annually. Benefit changes are effective January 1, 2002, and changes are summarized on Page 8. Rates are shown at the end of this brochure.

Plain Language

Teams of Government and health plans' staff worked on all FEHB brochures to make them responsive, accessible, and understandable to the public. For instance,

- Except for necessary technical terms, we use common words. For instance, "you" means the enrollee or family member; "we" means HMO Blue Texas.
- We limit acronyms to ones you know. FEHB is the Federal Employees Health Benefits Program. OPM is the 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 Office of Personnel Management, Office of Insurance Planning and Evaluation Division, 1900 E Street, NW Washington, DC 20415-3650.

Inspector General Advisory

Stop health care fraud!

Fraud increases the cost of health care for everyone. If you suspect that a physician, pharmacy, or hospital has charged you for services you did not receive, billed you twice for the same service, or misrepresented any information, do the following:

- Call the provider and ask for an explanation. There may be an error.
- If the provider does not resolve the matter, call us at (877) 299-2377 and explain the situation.
- If we do not resolve the issue, call or write:

THE HEALTH CARE FRAUD HOTLINE
(202) 418-3300
The United States Office of Personnel Management
Office of the Inspector General Fraud Hotline
1900 E Street, NW, Room 6400
Washington, DC 20415.

Penalties for Fraud

Anyone who falsifies a claim to obtain FEHB Program benefits can be prosecuted for fraud. Also, the Inspector General may investigate anyone who uses an ID card if the person tries to obtain services for someone who is not an eligible family member, or is no longer enrolled in the Plan and tries to obtain benefits. Your agency may also take administrative action against you.

Section 1. Facts about this HMO Plan

This Plan is a health maintenance organization (HMO). We require you to seek care from specific physicians, hospitals and other providers that contract with us. These Plan providers coordinate your health care services.

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

When you receive services from Plan providers, you will not have to submit claim forms or pay bills. You only pay the copayments and coinsurance described in this brochure. When you receive emergency services from non-Plan providers, you may have to submit claim forms.

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

How we pay providers

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

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

Your Rights

OPM requires that all FEHB plans provide certain information to their FEHB members. You may get information about us, our networks, providers and facilities. OPM's FEHB website (www.opm.gov/insure) lists the specific types of information that we must make available to you. Some of the required information is listed below.

- HMO Blue Texas began in 1983 as a for-profit health maintenance organization under the name Sanus Corp Health Systems.
- Sanus Corp received Federal Qualification in 1984.
- Licenses to operate were received for Texas in 1984.
- Southwest Texas HMO received full NCQA accreditation in 1994, 1997, and 2000 for three years each.
- Texas Gulf Coast HMO received full NCQA accreditation in 1997 and 2001 for three years each.
- On July 15, 1998, Aetna U. S. Healthcare purchased NYLCare Health Plans, the parent company of NYLCare Health Plans of the Southwest, Inc. and NYLCare Health Plans of the Gulf Coast, Inc.
- On April 1, 2000, Health Care Service Corporation, which does business in Texas as Blue Cross and Blue Shield of Texas, purchased NYLCare Health Plans of the Southwest, Inc. and NYLCare Health Plans of the Gulf Coast, Inc. The names of the purchased entities were changed, respectively, to Southwest Texas HMO, Inc. d/b/a HMO Blue Texas and Texas Gulf Coast HMO, Inc. d/b/a HMO Blue Texas.
- September 1, 2001, Gulf Coast HMO, Inc. d/b/a HMO Blue Texas, and Rio Grande HMO, Inc. merged with Southwest Texas HMO, Inc. d/b/a HMO Blue Texas. The surviving entity is named Southwest Texas HMO, Inc. and does business as HMO Blue Texas. HMO Blue Texas is a wholly owned subsidiary of Health Care Services Corporation, an independent licensee of the Blue Cross and Blue Shield Association.

If you want more information about us, call (877) 299-2377. Or write to HMO Blue Texas at P. O. Box 660044, Dallas, TX 75266-0044. You may also visit our website at www.bcbstx.com.

Service Area

To enroll in this plan, you must live in or work in our Service Area. This is where our providers practice. Our service areas include the following territories by enrollment code:

Enrollment code:
YX1 Self Only
YX2 Self and Family

Dallas/Ft. Worth and East Texas – Northeast Territory
The Texas counties of: Anderson, Angelina, Bowie, Camp, Cass, Cherokee, Collin, Cooke, Dallas, Delta, Denton, Ellis, Fannin, Franklin, Grayson, Gregg, Harrison, Henderson, Hood, Hopkins, Houston, Hunt, Jack, Jasper, Johnson, Kaufman, Lamar, Marion, Montague, Morris, Nacogdoches, Newton, Panola, Parker, Polk, Rains, Red River, Rockwall, Rusk, Sabine, San Augustine, San Jacinto, Shelby, Smith, Somervell, Tarrant, Titus, Trinity, Tyler, Upshur, Van Zandt, Wise, and Wood.

West Texas, Lubbock and Amarillo – West Territory
The Texas counties of: Andrews, Armstrong, Bailey, Borden, Brewster, Briscoe, Brown, Callahan, Carson, Castro, Childress, Cochran, Coke, Coleman, Collingsworth, Comanche, Concho, Cottle, Crane, Crockett, Crosby, Culberson, Dallam, Dawson, Deaf Smith, Dickens, Donley, Eastland, Ector, El Paso, Erath, Fisher, Floyd, Gaines, Garza, Glasscock, Gray, Hale, Hall, Hansford, Hartley, Haskell, Hemphill, Hockley, Howard, Hudspeth, Hutchinson, Irion, Jeff Davis, Jones, Kent, Kimble, King, Lamb, Lipscomb, Loving, Lubbock, Lynn, Martin, Mason, McCulloch, Menard, Midland, Mills, Mitchell, Moore, Motley, Nolan, Ochiltree, Oldham, Palo Pinto, Parmer, Pecos, Potter, Presidio, Randall, Reagan, Reeves, Roberts, Runnels, San Saba, Schleicher, Scurry, Shackelford, Sherman, Stephens, Sterling, Stonewall, Sutton, Swisher, Taylor, Terrell, Terry, Throckmorton, Tom Green, Upton, Val Verde, Ward, Wheeler, Winkler, Yoakum, and Young.

Enrollment code:
YM1 Self Only
YM2 Self and Family

Houston and Gulf Coast – Southeast Territory
The Texas counties of: Austin, Brazoria, Calhoun, Chambers, Colorado, Fort Bend, Galveston, Grimes, Hardin, Harris, Jackson, Jefferson, Lavaca, Liberty, Matagorda, Montgomery, Orange, Victoria, Walker, Waller, Washington, and Wharton.

Central Texas– Central Territory
The Texas counties of: Aransas, Atascosa, Bastrop, Bee, Bell, Bexar, Blanco, Bosque, Brazos, Brooks, Burleson, Burnet, Caldwell, Cameron, Comal, Fayette, Freestone, Gonzales, Guadalupe, Hays, Hidalgo, Hill, Jim Wells, Karnes, Kendall**,** Kenedy, Kleberg, Lee, Leon, Madison, McLennan, Medina, Milam, Navarro, Nueces, Refugio, Robertson, San Patricio, Starr, Travis, Willacy, Williamson, and Wilson.

Ordinarily, if you live within our service area, you must get care from providers who contract with us in this particular service area. If you receive care outside your service area, we will pay only for emergency care. 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 2002

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

Program-wide changes

- We changed the address for sending disputed claims to OPM. (Section 8)

Changes to this Plan

- For members in the Central and Southeast Territories, your share of the non-Postal premium will increase for enrollment code YM by 18.6% for self only, and by 18.5% for Self and Family. For members in the Northeast and West Territories, your share of non-Postal premium will increase for enrollment code YX by 18.0% for Self Only or by 14.8% for Self and Family.
- We clarified the Preventive care, adult benefits by removing the entry for blood lead level testing for adults because it is a test more typically done for children. (Section 5(a))
- We clarified the Family planning and Infertility benefits by providing more examples of covered and not covered benefits. (Section 5(a))
- We changed speech therapy benefits by removing the requirement that services must be required to restore functional speech. (Section 5(a))
- We no longer limit total blood cholesterol tests to certain age groups. (Section 5(a))
- We clarified Surgical procedures to show that we cover a comprehensive range of services, such as operative procedures. (Section 5(b))
- We now cover routine screening for chlamydial infection. (Section 5(a))
- We now cover certain intestinal transplants. (Section 5(b))
- We clarified the brochure to show why we think you should use generic drugs whenever possible. We moved other language around within the Prescription drugs section but didn't change its meaning. (Section 5(f))
- The Reciprocity Program is no longer applicable after January 1, 2002 due to the statewide consolidation and expansion of the HMO Blue Texas service area. Please refer to Section 1 for information regarding our service area. No additional paperwork is required. New service available for 2002: Away From Home Guest Membership allows any covered member to seek medical care outside of Texas when traveling to service area of a Blue Cross and Blue Shield Association affiliate. Please contact Customer Service for more information or to coordinate care until you return home. (Section 5(g))
- We clarified the Medicare Primary Payer Chart to explain how we coordinate benefits for former spouses. (Section 9)
- We clarified other language about coordinating benefits with Medicare. (Section 9)

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 obtain a prescription at a Plan pharmacy. Until you receive your ID card, use your copy of the Health Benefits Election Form, SF-2809, your health benefits enrollment confirmation (for annuitants), or your Employee Express confirmation letter.

If you do not receive your ID card within 30 days after the effective date of your enrollment, or if you need replacement cards, call Customer Service at (877) 299-2377.

Where you get covered care

You get care from "Plan providers" and "Plan facilities." You will only pay copayments and you will not have to file claims.

- **Plan providers**

Plan providers are physicians and other health care professionals in our service areas 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 website, www.bcbstx.com.

- **Plan facilities**

Plan facilities are hospitals and other facilities in our service areas that we contract with to provide covered services to our members. We list these in the provider directory, which we update periodically. The list is also on our website, www.bcbstx.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 (PCP). This decision is important since your PCP provides or arranges for most of your health care. To select a PCP, refer to the provider directory or website to find a doctor that meets your personal criteria and preferences (provider type, location, etc.).

- **Primary care**

Your PCP can be a family practitioner, internist or pediatrician. Your PCP will provide most of your health care or give you a referral to see a specialist.

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

- **Specialty care**

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

Here are other things you should know about specialty care:

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

- If you are seeing a specialist when you enroll in our Plan, talk to your PCP. Your PCP will decide what treatment you need. If he or she decides to refer you to a specialist, ask if you can see your current specialist. If your current specialist does not participate with us, you must receive treatment from a specialist who does. Generally, we will not pay for you to see a specialist who does not participate with our Plan.

- If you are seeing a specialist, and your specialist leaves the Plan, call your PCP to arrange to see another specialist. You may receive services from your current specialist until we can make arrangements for you to see someone else.

- If you have a chronic or disabling condition and lose access to your specialist because we:

  – terminate our contract with your specialist for other than cause; or

  – drop out of the Federal Employees Health Benefits (FEHB) Program, and you enroll in another FEHB plan; or

  – reduce our service area and you enroll in another FEHB plan,

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

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

- **Hospital care**

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

If you are in the hospital when your enrollment in our Plan begins, call our Customer Service department immediately at (877) 299-2377. If you are new to the FEHB Program, we will arrange for you to receive care.

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

- You are discharged, not merely moved to an alternative care center; or

- The day your benefits from your former plan run out; or

- The 92nd day after you become a member of this Plan, whichever happens first.

These provisions apply only to the hospital benefit of the hospitalized person; we cover your other non-hospital care.

Circumstances beyond our control

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

Services requiring our prior approval

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

We call this review and approval process precertification. Your physician must obtain precertification for the following services not limited to:

- Hospitalization
- Outpatient Facility
- Ancillary Facility
- Referral to non-participating provider
- Surgical procedures

Section 4. Your costs for covered services

You must share the cost of some services. You are responsible for:

•**Copayments**	A copayment is a fixed amount of money you pay to the provider, facility, pharmacy, etc. when you receive services. Example: When you see your PCP you pay a copayment of $10 per office visit. When you go in the hospital, you pay $100 per admission.
•**Deductible**	We do not have a deductible.
•**Coinsurance**	We do not have coinsurance.

Your catastrophic protection out-of-pocket maximum for copayments

After your copayments total $650 per person or $1,500 per family enrollment in any calendar year, you do not have to pay any more for covered services. However, copayments for the following services do not count toward your out-of-pocket maximum, and you must continue to pay copayments for these services:

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

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

Section 5. Benefits – OVERVIEW

(See Page 8 for how our benefits changed this year and Page 63 for a benefits summary.)

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

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

IMPORTANT

Here are some important things to keep in mind about these benefits:

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

IMPORTANT

Benefit Description	You pay
Diagnostic and treatment services	
Professional services of physicians • In physician's office • Consultations by specialists • Office medical consultations • Second surgical opinion	$10 per office visit
• In an urgent care center	$15 per office visit
• During a hospital stay • In a skilled nursing facility	Nothing
At home (within Service Area) • House calls provided at Plan doctor's discretion if such case is necessary and appropriate • Visits by nurses and health aides	$10 per visit
Not covered: *Experimental and Investigative Procedures*	*All charges*

Lab, X-ray and other diagnostic tests	You pay
Tests, such as: • Blood tests • Urinalysis • Non-routine pap tests • Pathology • X-rays • Non-routine Mammograms • Cat Scans/MRI • Ultrasound • Electrocardiogram and EEG	Nothing if you receive these services during your office visit or at lab facility; otherwise $10 per office visit
Preventive care, adult	
Routine screenings, such as: • Periodic Health Assessments • Total Blood Cholesterol – once every year • Colorectal Cancer Screening, including -Fecal occult blood test -Sigmoidoscopy, screening – every five years starting at age 50 • Chlamydial infection screening • Prostate Specific Antigen (PSA test) – one annually for men age 40 and older Note: Preventive care is provided on the schedule recommended by the examining physician, based on guidelines we provide the physician.	Nothing, based on physician's recommended schedule
Routine pap test	Nothing, for annual exam; otherwise $10 for each additional visit
Routine mammogram – covered for women age 35 and older as follows: • From age 35 through 39, one during this five year period • From age 40 through 64, one every calendar year • At age 65 and older, one every two consecutive calendar years	Nothing
Not covered: • *Physical exams for obtaining or continuing employment or insurance, attending schools or camp, or travel.* • *Treatment for work related injury (if covered by workman's compensation), educational testing and therapy, and nutritional counseling and diet planning.*	*All charges*
Routine immunizations, limited to: • Tetanus-diphtheria (Td) booster – once every 10 years, ages 19 and over (except as provided for under Childhood immunizations) • Influenza/Pneumococcal vaccines, annually, age 65 and over	Nothing

Preventive care, children	You pay
• Childhood immunizations recommended by the American Academy of Pediatrics	Nothing
• Examinations, such as: - Eye exams through age 17 to determine the need for vision correction. - Ear exams through age 17 to determine the need for hearing correction - Examinations done on the day of immunizations (through age 22) • Well-child care charges for routine examinations, immunizations and care (through age 22). Note: Your PCP decides how frequent and extensive these check-ups should be, based on guidelines we provide the physician.	Nothing
Maternity care	
Complete outpatient maternity (obstetrical) care, such as: • Prenatal care • Postnatal care	$10 for initial visit only
Complete inpatient maternity (obstetrical) care such as: • Delivery Note: Here are some things to keep in mind: • Plan physicians must provide or arrange your care and you must be hospitalized in a Plan facility. • You may remain in the hospital up to 48 hours after a regular delivery and 96 hours after a cesarean delivery. We will extend your inpatient stay if medically necessary. • We cover routine nursery care of the newborn child during the covered portion of the mother's maternity stay. We will cover other care of an infant who requires non-routine treatment only if we cover the infant under a Self and Family enrollment. • We pay hospitalization and surgeon services (delivery) the same as for illness and injury. See Hospital benefits (Section 5c) and Surgery benefits (Section 5b).	$100 per admission
Not covered: • *Routine sonograms to determine fetal age, size or sex.* • *Charges for normal delivery outside of the service area*	*All charges*

Family planning	You pay
A broad range of voluntary family planning services, limited to: • Voluntary sterilization • Injectable contraceptive drugs (such as Depo Provera)water • Intrauterine devices (IUDs)	$10 per office visit plus $25 per procedure
• Surgically implanted contraceptives (such as Norplant)	$10 per office visit plus 50% of the usual and customary charge, as determined by us.
Note: A diaphragm and oral contraceptives are covered under prescription drugs.	See page 34 for prescription drug benefit.
Not covered: • *Reversal of voluntary surgical sterilization, genetic counseling, and elective, non-therapeutic termination of pregnancy.*	*All charges*
Infertility services	
Diagnostic testing to determine the cause of infertility.	$10 per office visit
Treatment of infertility such as: • Artificial insemination: - *intravaginal insemination (IVI)* - *intracervical insemination (ICI)* - *intrauterine insemination (IUI)*	$10 per office visit plus 50% of the usual and customary charges for each service as determined by us, including physician office visit and laboratory testing
• Oral Fertility drugs	Note: See page 34 for prescription drug benefit
Not covered: • *Assisted reproductive technology (ART) procedures, such as:* - *in vitro fertilization* - *embryo transfer, gamete GIFT and zygote ZIFT* - *zygote transfer (ZIFT)* • *Services and supplies related to excluded ART procedures* • *Donation, preservation, analysis and storage of sperm, eggs or embryos* • *Cost of sperm* • *Injectable Fertility Drugs* • *Infertility services after voluntary sterilization*	*All charges*
Allergy care	
Testing and treatment	$25 for each session of testing; $10 copay for treatment
Allergy injection	$10 copay

Allergy care *(continued)*	**You pay**
Allergy serum	Nothing
Not covered: • *Provocative food testing and sublingual allergy desensitization*	*All charges*
Treatment therapies	
• Chemotherapy and radiation therapy Note: High dose chemotherapy in association with autologous bone marrow transplants are limited to those transplants listed under Organ/Tissue Transplants on page 25. • Respiratory and inhalation therapy • Dialysis – Hemodialysis and peritoneal dialysis • Intravenous (IV)/Infusion Therapy – Home IV and antibiotic therapy	$10 per office visit
• Growth hormone therapy (GHT) Note: – We will only cover GHT when we preauthorize the treatment. The attending physician must obtain preauthorization. We will ask your physician to submit information that establishes that the GHT is medically necessary. Ask us to authorize GHT before you begin treatment; otherwise, we will only cover GHT services from the date you submit the information. If you do not ask or if we determine GHT is not medically necessary, we will not cover the GHT or related services and supplies. See *Services requiring our prior approval* in Section 3.	See page 35 for prescription drug benefit.
Physical and occupational therapies	
Services for each of the following: - qualified physical therapists; - occupational therapists, and - chiropractic care as physical therapy Note: Physical and occupational therapy is limited to services that assist the member to achieve and maintain self-care and improved functioning in other activities of daily living. • Cardiac rehabilitation following a heart transplant, bypass surgery or a myocardial infarction is also provided subject to the limitations below. 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. Note: Your coverage is limited to services that continue to meet or exceed the treatment goals established for you by your physician. For the physically disabled maintenance of functioning or prevention of or slowing of further deterioration.	Outpatient: $10 per office visit Inpatient: Nothing – included in admission

Physical and occupational therapies *(continued)*	**You pay**
Not covered: • *Long-term rehabilitative therapy* • *Exercise programs*	*All charges*
Speech therapy	
• Services of a Speech Therapist Note: Speech therapy includes coverage for rehabilitation or developmental medical care. Note: Your coverage is limited to services that continue to be medically necessary.	$10 per office visit
Hearing services (testing, treatment, and supplies)	
• One audiogram if medically indicated per year • Initial placement of hearing aid when medically necessary Note: Limit $800 for hearing aids, one cleaning of the hearing device per year, and replacement every 4 years if medically indicated. • Hearing testing for children through age 17 (see *Preventive care, children*)	Nothing
Not covered: • *Replacement for loss, damage or functional defect*	*All charges*
Vision services (testing, treatment, and supplies)	
• Eye exam (vision screening) to determine the need for vision correction for children through age 17 (see preventive care)	Nothing
• Eyeglasses or contact lenses and examinations for them	See page 41, Non-FEHB Benefits
• Implantable lenses following intraocular surgery for cataracts.	Nothing
Not covered: • *Eye exercises and orthoptics* • *Radial keratotomy and other refractive surgery*	*All charges*
Foot care	
Routine foot care when you are under active treatment for a metabolic or peripheral vascular disease, such as diabetes. See orthopedic and prosthetic devices for information on podiatric shoe inserts.	$10 per office visit

Foot care *(continued)*	**You pay**
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)* • *Corrective orthopedic shoes, arch supports, braces, splints or other foot care items.*	*All charges*
Orthopedic and prosthetic devices	
• Standard artificial limbs and eyes; stump hose • Externally worn breast prostheses and surgical bras, including necessary replacements, following a mastectomy • Terminal devices such as hand or hook. • Braces for arms, legs, back or neck. • External cardiac pacemaker. • Internal prosthetic devices, such as artificial joints, pacemakers, cochlear implants, and surgically implanted breast implant following mastectomy. Note: We pay internal prosthetic devices as hospital benefits; see Section 5 (c) for payment information. See 5(b) for coverage of the surgery to insert the device. • Foot orthotics when medically necessary. Note: Coverage is limited to the initial device.	Nothing
Not covered: • *Corrective and orthopedic shoes (unless built into a leg brace) or other foot care items* • *Arch supports* • *Heel pads and heel cups* • *Lumbosacral supports* • *Corsets, trusses, elastic stockings, support hose, and other supportive devices* • *Replacement of external prosthetic devices, except for standard replacements needed because of physical growth by members who are under 18 years of age* • *Repair or periodic maintenance of any external prosthetic device* • *Devices provided solely for cosmetic purposes that have no functional applications.* • *Dentures* • *Corrective orthopedic appliances for non-dental treatment of temporomandibular joint (TMJ) pain dysfunction syndrome.*	*All charges*

Durable medical equipment (DME)	You pay
Rental or purchase, at our option, including repair and adjustment, of durable medical equipment prescribed by your Plan physician, such as oxygen and dialysis equipment. Under this benefit, we also cover: • Hospital Beds; • Standard Wheelchairs; • Crutches; • Walkers; • Blood Glucose Monitors; • Insulin Pumps; • Bedside Commodes; • Suction Machines; • Orthopedic Tractions; • Oxygen; and • Annual audiogram (if medically indicated) Note: Call the Plan as soon as your physician prescribes the equipment. Blood Glucose Monitors and Insulin Pumps are covered under your pharmacy benefits.	Nothing
Not covered: • *Motorized wheel chairs* • *Deluxe equipment such as motor driven hospital beds.* • *Comfort items* • *Bed boards* • *Bathtub lifts* • *Over bed tables* • *Air Purifiers* • *Disposable supplies* • *Elastic stockings* • *Sauna baths* • *Repair, replacement or maintenance of equipment purchased by Plan* • *Exercise equipment* • *Stethoscopes* • *Sphygmomanometers*	*All charges*
Home health services	
• Home health care ordered by a Plan physician and provided by a registered nurse (R.N.), licensed practical nurse (L.P.N.), licensed vocational nurse (L.V.N.), or home health aide. • Services include oxygen therapy, intravenous therapy and medications.	$10 per visit.

Home health services *(continued)*	**You pay**
Not covered: • *Nursing care requested by, or for the convenience of, the patient or the patient's family;* • *Services primarily for hygiene, feeding, exercising, moving the patient, homemaking, companionship or giving oral medication.* • *Home care primarily for personal assistance that does not include a medical component and is not diagnostic, therapeutic, or rehabilitative.*	*All charges*
Chiropractic	
No benefit Note: Chiropractic care for physical therapy is included in Physical and Occupational Therapies on page 18.	*All charges*
Alternative treatments	
No benefit	*All charges*
Educational classes and programs	
Coverage is limited to classes and programs for the following conditions: • Diabetes • Asthma • Congestive heart failure • Mothers-to-be program (pregnancy management) Note: Programs must be provided or arranged by our Plan.	Nothing

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

IMPORTANT

Here are some important things to keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan physicians must provide or arrange your care (precertification).
- *We have no calendar year deductible.*
- Be sure to read Section 4, *Your costs for covered services,* for valuable information about how cost sharing works. Also read Section 9 about *Coordinating benefits with other coverage,* including with Medicare.
- The amounts listed below are for the charges billed by a physician or other health care professional for your surgical care. Any costs associated with the facility charge (i.e. hospital, surgical center, etc.) are covered in Section 5 (c).
- YOUR PHYSICIAN MUST GET PRECERTIFICATION OF SOME SURGICAL PROCEDURES. Please refer to the precertification information shown in Section 3 to be sure which services require precertification and identify which surgeries require precertification.

IMPORTANT

Benefit Description	You pay
Surgical procedures	
A comprehensive range of services, such as: • Operative procedures • Treatment of fractures, including casting • Normal pre- and post-operative care by the surgeon • Correction of amblyopia and strabismus • Endoscopy procedures • Biopsy procedures • Removal of tumors and cysts • Correction of congenital anomalies (see Reconstructive surgery) • Surgical treatment of morbid obesity -- a condition in which an individual weighs 100 pounds or 100% over his or her normal weight according to current underwriting standards; eligible members must be age 18 or over. • Insertion of internal prosthetic devices. See 5(a) – Orthopedic and prosthetic devices for device coverage information. Note: Generally, we pay for internal prostheses (devices) according to where the procedure is done. For example, we pay Hospital benefits for a pacemaker and Surgery benefits for insertion of the pacemaker.	Nothing
• Voluntary sterilization	$10 office visit plus $25 per procedure

Surgical procedures *(continued)*	**You pay**
• Treatment of burns	$10 per office visit
Not covered: • *Reversal of voluntary sterilization* • *Routine treatment of conditions of the foot; see Foot care.*	*All charges*
Reconstructive surgery	
• Surgery to correct a functional defect • Surgery to correct a condition caused by injury or illness if: - the condition produced a major effect on the member's appearance and - the condition can reasonably be expected to be corrected by such surgery • Surgery to correct a condition that existed at or from birth and is a significant deviation from the common form or norm. Examples of congenital anomalies are protruding ear deformities; cleft lip; cleft palate; birthmarks; webbed fingers; and webbed toes.	$10 per office visit
• All stages of breast reconstruction surgery following a mastectomy, such as: - surgery to produce a symmetrical appearance on the other breast; - treatment of any physical complications, such as lymphedemas; - breast prostheses and surgical bras and replacements (see Prosthetic devices) Note If you need a mastectomy, you may choose to have the procedure performed on an inpatient basis and remain in the hospital up to 48 hours after the procedure.	See above
Not covered: • *Cosmetic surgery – any surgical procedure (or any portion of a procedure) performed primarily to improve physical appearance through change in bodily form, except repair of accidental injury* • *Surgeries related to sex transformation*	*All charges*
Oral and maxillofacial surgery	
Oral surgical procedures, limited to: • Reduction of fractures of the jaws or facial bones; • Surgical correction of cleft lip, cleft palate or severe functional malocclusion; • Removal of stones from salivary ducts; • Excision of leukoplakia or malignancies; • Excision of cysts and incision of abscesses when done as independent procedures; and • Other surgical procedures that do not involve the teeth or their supporting structures.	$10 per office visit

Oral and maxillofacial surgery *(continued)*	**You pay**
Not covered: • *Oral implants and transplants* • *Procedures that involve the teeth or their supporting structures (such as the periodontal membrane, gingiva, and alveolar bone)* • *Dental care or dental appliances involved in treatment of TMJ* • *Procedures to improve the appearance of a functioning structure*	*All charges*
Organ/tissue transplants	
Limited to: • Cornea • Heart • Heart/lung • Kidney • Kidney/Pancreas • Liver • Lung: Single –Double • Pancreas • Allogenic (donor) bone marrow transplants • Autologous bone marrow transplants (autologous stem cell and peripheral stem cell support) for the following conditions: acute lymphocytic or non-lymphocytic leukemia; advanced Hodgkin's lymphoma; advanced non-Hodgkin's lymphoma; advanced neuroblastoma; breast cancer; multiple myeloma; epithelial ovarian cancer; and testicular, mediastinal, retroperitoneal and ovarian germ cell tumors • Intestinal transplants (small intestine) and the small intestine with the liver or small intestine with multiple organs such as the liver, and pancreas. • National Transplant Program (NTP) – A nationally recognized medical facility designated by our Plan must evaluate the case and determine that the proposed transplant is appropriate for treatment of the condition and has agreed to perform the transplant. Limited Benefits - Treatment for breast cancer, multiple myeloma, and epithelial ovarian cancer may be provided in an NCI- or NIH-approved clinical trial at a Plan-designated center of excellence and if approved by the Plan's medical director in accordance with the Plan's protocols. Note: We cover related medical and hospital expenses of a live donor when we cover the recipient.	Nothing
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 (i.e. intestinal/small instestine)*	*All charges*

Anesthesia	You pay
Professional services provided in – • Hospital (inpatient) • Hospital outpatient department • Skilled nursing facility • Ambulatory surgical center • Office	Nothing

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

IMPORTANT

Here are some important things to remember about these benefits:

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

IMPORTANT

Benefit Description	You pay
Inpatient hospital	
Room and board, such as • Ward, Semiprivate, Or Intensive Care Accommodations; • General Nursing Care; and • Meals and special diets. Note: If you want a private room when it is not medically necessary, you pay the additional charge above the semiprivate room rate.	$100 per admission
Other hospital services and supplies, such as: • Operating, recovery, maternity, and other treatment rooms • Prescribed drugs and medicines • Diagnostic laboratory tests and X-rays • Administration of blood and blood products • Blood or blood plasma • Dressings, splints, casts, and sterile tray services • Medical supplies and equipment, including oxygen • Anesthetics, including nurse anesthetist services • Medical supplies, appliances, medical equipment, and any covered items billed by a hospital for use at home. Note: Take home drugs are covered under the prescription drug benefit. For more information, see Section 5(f).	Nothing

Inpatient hospital *(continued)*	**You pay**
Not covered: • *Custodial care, rest cures, or domiciliary care.* • *Non-covered facilities, such as nursing homes, schools* • *Personal comfort items, such as telephone, television, barber services, guest meals and beds* • *Private nursing care*	*All charges*
Outpatient hospital or ambulatory surgical center	
• Operating, recovery, and other treatment rooms • Prescribed drugs and medicines • Diagnostic laboratory tests, X-rays, and pathology services • Administration of blood, blood plasma, and other biologicals • Blood and blood plasma • Pre-surgical testing • Dressings, casts, and sterile tray services • Medical supplies, including oxygen • Anesthetics and anesthesia service Note: We cover hospital services and supplies related to dental procedures when necessitated by a non-dental physical impairment. We do not cover other dental inpatient procedures.	Nothing
Extended care benefits/skilled nursing care facility benefits	
Extended care benefit in a Skilled Nursing Facility (SNF): Up to 60 days consecutive days for each illness or injury when: • Full-time skilled nursing care is necessary and confinement in a skilled nursing facility is medically appropriate as determined by the Plan doctor. All necessary services are covered, including: • Bed, board, general nursing care, drugs, biologicals, supplies, and equipment ordinarily provided or arranged by the skilled nursing facility when prescribed by a Plan doctor.	$25 per day
Not covered: • *Custodial care, rest cures, care for persistent illness and disorders.*	*All charges*
Hospice care	
Supportive and palliative care for the terminally ill is covered in the home or hospice facility. Services include inpatient and outpatient care and family counseling; these services are provided under the direction of a Plan doctor who certifies the terminal stages of illness, with a life expectancy of approximately six months or less.	Nothing

Hospice care *(continued)*	**You pay**
Not covered: • *Independent nursing, homemaker services, custodial care.*	*All charges*
Ambulance	
• Local professional ambulance service when medically appropriate.	$25 per service

Section 5 (d). Emergency services/accidents

IMPORTANT

Here are some important things to keep in mind about these benefits:

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

IMPORTANT

What is a medical emergency?

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

What to do in case of emergency:

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

Benefit Description	You pay
Emergency within our service area	
• Emergency care at a doctor's office	$15 per office visit after normal business hours
• Emergency care at an urgent care center	$15 per office visit
• Emergency care as an outpatient or inpatient at a hospital, including doctors' services	$75 per office visit
Note: Copayment waived when admitted to a hospital. If admitted, refer to Section 5(c) on Inpatient Hospitalization.	
Not covered: • *Elective care or non-emergency care.*	*All charges*
Emergency outside our service area	
• Emergency care at a doctor's office	$15 per office visit after normal business hours.
• Emergency care at an urgent care center	$15 per office visit.
• Emergency care as an outpatient or inpatient at a hospital, including doctors' services	$75 per office visit.
Note: Copayment waived when admitted to hospital. If admitted, refer to Section 5(c) on Inpatient Hospitalization.	
Not covered: • *Elective care or non-emergency care* • *Emergency care provided outside the service area if the need for care could have been foreseen before leaving the service area* • *Medical and hospital costs resulting from a normal full-term delivery of a baby outside the service area*	*All charges*
Ambulance	
Professional ambulance service when medically appropriate. Air Ambulance if medically necessary. See Section 5(c) on Non-emergency services.	$25 per service.

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

IMPORTANT

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

Here are some important things to keep in mind about these benefits:

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

IMPORTANT

Benefit Description	You pay
Mental health and substance abuse benefits	
All diagnostic and treatment services recommended by a Plan provider and contained in a treatment plan that we approve. The treatment plan may include services, drugs, and supplies described elsewhere in this brochure. Note: Plan benefits are payable only when we determine the care is clinically appropriate to treat your condition and only when you receive the care as part of a treatment plan that we approve.	Your cost sharing responsibilities are no greater than for other illness or conditions.
• Professional services, including individual or group therapy by providers such as psychiatrists, psychologists, or clinical social workers • Medication management	$10 per office visit.
• Diagnostic tests	$10 per office visit.
• Services provided by a hospital or other facility • Services in approved alternative care settings such as partial hospitalization, half-way house, residential treatment, full-day hospitalization, facility based intensive outpatient treatment	$100 per admission.

Mental health and substance abuse benefits *(continued)*	**You pay**
Not covered: • *Services we have not approved.* *Note: OPM will base its review of disputes about treatment plans on the treatment plan's clinical appropriateness. OPM will generally not order us to pay or provide one clinically appropriate treatment plan in favor of another.*	*All charges*

Preauthorization

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

- If you need treatment, you may contact your PCP and he or she will assist you in obtaining care.
- A referral from your PCP for mental health and chemical dependency services is not needed. Precertification for the mental health/chemical dependency provider that delivers these services must be obtained by telephone prior to the delivery of all behavioral health care, including chemical dependency, by calling toll-free (800) 729-2422.
- Certain medical groups or Independent Physician Associations (IPAs) may have selected a different provider for mental health/chemical dependency services.
- Members who wish to verify that their mental health/chemical dependency provider is a Network Provider need to call Magellan Behavioral Health at (800) 729-2422.

Section 5 (f). Prescription drug benefits

IMPORTANT

Here are some important things to keep in mind about these benefits:

- We cover prescribed drugs and medications, as described in the chart beginning on the next page.
- All benefits are subject to the definitions, limitations and exclusions in this brochure and are payable only when we determine they are medically necessary.
- We have no calendar year deductible.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works. Also read Section 9 about *Coordinating benefits with other coverage*, including with Medicare.

IMPORTANT

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

- **Who can write your prescription.** A Plan physician must write the prescription except for emergency care.
- **Where you can obtain them.** You may use the services of a Participating Pharmacy or our Mail Order Pharmacy by presenting or mailing your new prescription (or refill request) prescribed by a Participating Physician or Participating Dentist to the Participating Pharmacy or Mail Order Pharmacy. Texas Law requires that our Mail Order Pharmacy receive the original prescription in order to fill any C-II medication (for example: Ritalin, Tylox, Dexedrine, Demerol, Dilaudid, Percodan or Morphine).
- **We use a preferred drug list.** "Member Preferred Drug List" (also known as a formulary) is a listing published by HMO Blue Texas of prescribed medications listed as Generic Prescription Drugs and Preferred Brand Name Prescription Drugs. Non-preferred Brand Name prescriptions are those not included in the list of Generic Prescription Drugs and Preferred Brand Name Prescription Drugs. These are covered at the highest copayment. HMO Blue Texas Preferred Drug List is subject to periodic review.

  We have an open preferred drug list. If your physician believes a name brand product is necessary or there is no generic available, your physician may prescribe a name brand drug from a preferred drug list. This list of name brand drugs is a preferred list of drugs that we selected to meet patient needs at a lower cost. Name Brand Prescription drugs not on the preferred list are subject to the highest copayment. To request a copy of our Member Preferred Drug List, call Customer Service at (877) 299-2377, or it may be called up on the website www.bcbstx.com.

- **These are the dispensing limitations.** Members are limited to a thirty- (30) day supply or 100-unit supply, whichever is less, of Prescription Drugs from the Participating Pharmacy, subject to any applicable copayments listed on the next page. When using the services of our Mail Order Pharmacy for Maintenance Medications, members are limited to the lesser of a ninety- (90) day supply or the number of days supply from the date the prescription is filled to the termination date of the Group Contract, subject to the copayments listed on Page 35. The initial prescription of certain classes of drugs is limited to a thirty- (30) day supply.

Note: Medications purchased as a result of a medical emergency that occurs outside the Plan's service area will be reimbursed for up to a 10 day supply, minus the applicable copay.

- **Why use generic drugs?** By using generic instead of brand name products, you keep down your costs and ours, without compromising on quality.
- **When you have to file a claim.** If you purchase items covered by this benefit from a non-participating pharmacy for out of area emergency care prescriptions, you have to submit a reimbursement request to HMO Blue Texas in order to get your benefits. See Section 7, *Filing a claim for covered services.*

Note: Coverage for items obtained from non-participating pharmacies is limited to items obtained in connection with covered Emergency and Out-of-Area Urgent Care services.

Benefit Description	You pay
Covered medications and supplies	
We cover the following medications and supplies prescribed by a Plan physician and obtained from Participating pharmacies for up to a 30-day supply or through our mail order service for up to a 90-day supply: • Drugs for which a prescription is required by State law; • Oral contraceptive drugs; • FDA approved prescriptions for birth control; • Intravenous fluids and medications for home use; • Oral fertility drugs; • Smoking cessation drugs, limited to $185.00 lifetime maximum; • Disposable needles and syringes needed to inject covered prescribed medication; • Drugs to treat sexual dysfunction (limited benefits); and • Insulin (including prescription and non-prescription oral agents for controlling blood glucose levels, and glucagon emergency kits). Note: Drugs to treat sexual dysfunction have limited benefits, contact Plan for dose limits; for these medications, you pay the applicable copay up to the dose limit and all charges thereafter. Injectible contraceptives, birth control devices (except diaphrams) covered under family planning.Diabetic supplies, equipment, and education are covered as basic Plan benefits, even though they may be received from Participating pharmacies. See section below.	$5 per generic $10 per preferred brand name $25 per non-preferred brand name
Diabetic supplies • Blood glucose test strips • Lancets • Lancet devices • Insulin syringes and needles • Urine test strips • Visual reading	$10 up to a 30-day supply at participating pharmacy or up to a 90-day supply through mail order service
Diabetic equipment • Insulin pump and associated appurtenances • Insulin infusion device • Blood glucose monitor • Podiatric appliance for the intervention of complications associated with diabetes.	Nothing

Covered medications and supplies *(continued)*	**You pay**
Not covered: • *Drugs and supplies for cosmetic purposes* • *Vitamins, nutrients and food supplements even if a physician prescribes or administers them* • *Non-prescription drugs* • *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* • *Implanted time-release medications, except Norplant* • *Injectables, aerosol inhalers and inhalant solutions except when purchased through the Home Delivery Pharmacy Service* • *Fertility drugs other than oral* • *Topical fluoride* • *Prescription Drugs prescribed as anorexients (appetite suppressants) or for weight reduction* • *Blood and urine testing devices* • *Oxygen gas* • *Prescription drugs intended for use in a practitioner's office or a clinical setting* • *Prescription drugs which a member is entitled to receive without charge from any worker's compensation laws, or similar municipal, state or federal programs* • *Prescription drugs dispensed prior to the effective date of coverage* • *Therapeutic devices or appliances, including hypodermic needles and syringes, support garments, and drug infusion/metering devices*	*All charges*

Section 5 (g). Special features

Feature	Description
Flexible benefits option	Under the flexible benefits option, we determine the most effective way to provide services. • We may identify medically appropriate alternatives to traditional care and coordinate other benefits as a less costly alternative benefit. • Alternative benefits are subject to our ongoing review. • By approving an alternative benefit, we cannot guarantee you will get it in the future. • The decision to offer an alternative benefit is solely ours, and we may withdraw it at any time and resume regular contract benefits. Our decision to offer or withdraw alternative benefits is not subject to OPM review under the disputed claims process.
Prenatal Education	Our prenatal education program, Special Beginnings®, is designed to promote specialty care, education, and monitoring to help you toward the goal of delivering a healthy, full-term baby. Special Beginnings® offers pregnant HMO Blue Texas members: • the support of an obstetrical nurse throughout your pregnancy, • risk screening and ongoing monitoring and evaluation, • educational materials designed to help you understand each stage of your pregnancy, • nutritional advice, and • coordination of your prenatal care under the HMO Blue Texas Plan with your participating doctor.

Section 5 (h). Dental benefits

IMPORTANT

Here are some important things to keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan dentists must provide or arrange your care.
- We cover hospitalization for dental procedures only when a nondental physical impairment exists which makes hospitalization necessary to safeguard the health of the patient; we do not cover the dental procedure unless it is described below.
- There are no calendar year deductibles.
- Be sure to read Section 4, *Your costs for covered services,* for valuable information about how cost sharing works. Also read Section 9 about *Coordinating benefits with other coverage*, including with Medicare.

IMPORTANT

Accidental injury benefit	You pay
We cover restorative services and supplies necessary to promptly repair (but not replace) sound, natural teeth. The need for these services must directly result from an accidental injury, not biting or chewing. Treatment must be initiated within 72 hours of the accident.	Outpatient: $10 per visit. Inpatient: $100 per admission

Dental Benefits	
Service	**You pay**
Diagnostic/preventive dentistry by Primary Dentist Initial/ periodic oral examination Treatment Plan Oral cancer exam Visual aids Consultations	Nothing
X-rays Bitewing Single Other X-rays (one each 36 months) • Full Mouth • Panoramic	 $2 $1 $12 $6
Prophylaxis (cleaning every 6 months) Child (to age 15) Adult (age 15+)	 $5 $8
Oral hygiene instruction Fluoride treatment (once each 6 months)	Nothing
Sealant treatment (per tooth)	$7
Infection control fee (per visit) (By Primary Dentist)	$6

Dental Benefits	
Service	**You pay**
Non-routine and emergency dentistry	
X-rays, single (per film)	$3
Non-routine and emergency office visits	
During regular office hours	$9
Not during regular office hours	$15
Note: The office visit copayment is in addition to the applicable copayment(s) for treatment	
Missed appointment (By Primary Dentist)	
Without 24-hour notice except in case of unforeseen emergency	$15
Restorative (fillings) by Primary Dentist	
Amalgam (silver) restorations	
1 surface (primary of permanent)	$10
2 surfaces (primary or permanent)	$15
3 or more surfaces (primary or permanent)	$18
Composite resin (white) restorations (anterior teeth only)	
1 surface	$18
2 surfaces	$21
3 or more surfaces	$26
Cosmetic by Primary Dentist	
Acid etch bonding for repair of incisal edge	$50
Endodontics (Root canal therapy) by Primary Dentist	(per tooth)
1 canal (anterior)	$170
2 canals (bicuspid)	$200
3 or more canals (molar)	$260
Oral surgery by Primary Dentist	(per tooth)
Single tooth extraction	$35
Each additional tooth	$35
Surgical extraction –erupted tooth	$40
Surgical extraction –soft tissue impaction	$55
Surgical extraction –partial bony impaction	$75
Surgical extraction –full bony impaction	$100
Anesthesia by Primary Dentist	
Nitrous Oxide (per 1/ 2 hour)	$10
Local Anesthetic	Nothing
Periodontics (Gum treatment) by Primary Dentist	
Osseous surgery (per quadrant)	$280
Occlusal Adjustment –Limited	$60
Occlusal Adjustment –Complete	$130
Periodontal scaling and root planing (per quadrant)	$70
Major restorative dentistry by Primary Dentist	
Crown and Bridge (per unit)	
All gold is charged at market price	
Porcelain veneer crown (with non-precious)	$235
Full-cast crown (non-precious)	$225
Inlay –2 surfaces	$175
Inlay –3 surfaces	$200
Re-cement crown/ bridge	$10
Post for crown	$60
Stainless steel crown	$60

Dental Benefits	
Service	**You pay**
Prosthodontics (dentures) by Primary Dentist Complete Dentures (upper or lower; plus lab fee) Partial Denture (plus lab fee)	 $235 plus lab fee $320 plus lab fee
Orthodontics (braces) by Primary Dentist Note: Patient pays 20% in advance of treatment. The balance is to be paid in equal monthly installment during course of treatment. Treatment schedule for more than 24 months is to be paid at $65.00 per month.	75% of Dentist's Usual and customary fee**

- The copayments listed above apply when services are performed by your Primary Dentist.
- Any unlisted procedures and services provided by your Primary Dentist will be charged to the Member at 75% of the Dentist's usual and customary fees.
- All procedures and services provided by a Specialist Dentist will be charged to you at 75% of the Specialist Dentist's usual and customary fees.
- Primary and Specialist Dentist services may not be available in your immediate area. If you reside in the Corpus Christi vicinity, you may travel to other provider locations within the Southeast regional service area to receive dental services from affiliated providers. Refer to your provider directory or call Customer Service at (877) 299-2377 to find out where Primary and Specialist Dentists are located.

General Provisions

- No referral is needed to see a Participating Specialist Dentist.
- Each family member may select a different Primary Dentist.
- Scheduled appointments must be canceled at least 24 hours in advance or the member may be liable for a missed appointment fee, as charged by the dentist.
- In case of an emergency, contact your Primary Dentist if possible or obtain services from any licensed dentist. HMO Blue Texas will reimburse the member for the actual cost of such emergency dental services, less applicable copayments, and are limited to palliative treatment to control pain, bleeding or infection. (See "exclusions")

Not covered

The following are not covered:

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

Section 5 (i). Non-FEHB benefits available to Plan members

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

Vision Benefits

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

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

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

Vision Providers

To be covered, the exam must be provided by a Cole Managed Vision provider unless your designated PCP is with a Medical Group/IPA that is responsible for providing that service. The prescription for lenses (or contacts) must be filled by a participating Cole Managed Vision provider in order to receive the reduced rates. A referral from your PCP is not necessary. However, if your designated PCP is with a Medical Group/IPA that provided the exam, you must obtain the eyeglass prescription from the Medical Group/IPA vision provider to present to a participating Cole Managed Vision provider in order to receive glasses or contacts at the reduced rates.

What to do …

When vision services are needed, call Customer Service at (877) 299-2377 or Cole Managed Vision at (800) 228-2020 for assistance in locating a participating vision provider close to you. Again, if you are assigned to a Medical Group/IPA that is responsible for providing the eye exam, you must obtain your eye exam through the Medical Group/IPA vision provider.

Schedule an appointment if you need an eye exam by calling a participating provider, otherwise simply go to the provider's office for services.

Areas Not Included in Your Coverage

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

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

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

We do not cover the following:

- Care by non-Plan providers except for authorized referrals or emergencies (see Emergency Benefits);
- Services, drugs, or supplies you receive while you are not enrolled in this Plan;
- Services, drugs, or supplies that are not medically necessary;
- Services, drugs, or supplies not required according to accepted standards of medical, dental, or psychiatric practice;
- Experimental or Investigational procedures, treatments, drugs or devices;
- Services, drugs, or supplies related to abortions, except when the life of the mother would be endangered if the fetus were carried to term or when the pregnancy is the result of an act of rape or incest;
- Services, drugs, or supplies related to sex transformations;
- Services, drugs, or supplies you receive from a provider or facility barred from the FEHB Program; or
- Expenses you incurred while you were not enrolled in this Plan.

Section 7. Filing a claim for covered services

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

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

Medical and hospital benefits

In most cases, providers and facilities file claims for you. Physicians must file on the form HCFA-1500, Health Insurance Claim Form. Facilities will file on the UB-92 form. For claims questions and assistance, call us at (877) 299-2377.

When you must file a claim -- such as for out-of-area care -- submit it on the HCFA-1500 or a claim form that includes the information shown below. Bills and receipts should be itemized and show:

- Covered member's name and ID number;
- Name and address of the physician or facility that provided the service or supply;
- Dates you received the services or supplies;
- Diagnosis;
- Type of each service or supply;
- The charge for each service or supply;
- A copy of the explanation of benefits, payments, or denial from any primary payer --such as the Medicare Summary Notice (MSN); and
- Receipts, if you paid for your services.

Submit your claims to:

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

Prescription drugs

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

Submit your claims to:

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

Deadline for filing your claim

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

When we need more information

Please reply promptly when we ask for additional information. We may delay processing or deny your claim if you do not respond.

Section 8. The disputed claims process

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

Step	Description
1	Ask us in writing to reconsider our initial decision. You must: (a) Write to us within 6 months from the date of our decision; and (b) Send your request to us at: P. O. Box 25916 Houston, TX 77265; and (c) Include a statement about why you believe our initial decision was wrong, based on specific benefit provisions in this brochure; and (d) Include copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms.
2	We have 30 days from the date we receive your request to: (a) Pay the claim (or, if applicable, arrange for the health care provider to give you the care); or (b) Write to you and maintain our denial -- go to step 4; or (c) Ask you or your provider for more information. If we ask your provider, we will send you a copy of our request—go to step 3.
3	You or your provider must send the information so that we receive it within 60 days of our request. We will then decide within 30 more days. If we do not receive the information within 60 days, we will decide within 30 days of the date the information was due. We will base our decision on the information we already have. We will write to you with our decision.
4	If you do not agree with our decision, you may ask OPM to review it. You must write to OPM within: • 90 days after the date of our letter upholding our initial decision; or • 120 days after you first wrote to us -- if we did not answer that request in some way within 30 days; or • 120 days after we asked for additional information. Write to OPM at: Office of Personnel Management, Office of Insurance Programs, Contracts Division 2, 1900 E Street, NW, Washington, DC 20415-3630.

The disputed claims process *(continued)*

Send OPM the following information:

- A statement about why you believe our decision was wrong, based on specific benefit provisions in this brochure;
- Copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms;
- Copies of all letters you sent to us about the claim;
- Copies of all letters we sent to you about the claim; and
- Your daytime phone number and the best time to call.

Note: If you want OPM to review different claims, you must clearly identify which documents apply to which claim.

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

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

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

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

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

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

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

(a) We haven't responded yet to your initial request for care or preauthorization/prior approval, then call (800) 441-9188. We will expedite our review; or

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

- If we expedite our review and maintain our denial, we will inform OPM so that they can give your claim expedited treatment too, or
- You can call OPM's Health Benefits Contracts Division 2 at (202) 606-3818 between 8 a.m. and 5 p.m. eastern time.

Section 9. Coordinating benefits with other coverage

When you have other health coverage

You must tell us if you are covered or a family member is covered under another group health plan or have automobile insurance that pays health care expenses without regard to fault. This is called "double coverage."

When you have double coverage, one plan normally pays its benefits in full as the primary payer and the other plan pays a reduced benefit as the secondary payer. We, like other insurers, determine which coverage is primary according to the National Association of Insurance Commissioners' guidelines.

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

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

What is Medicare?

Medicare is a Health Insurance Program for:

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

Medicare has two parts:

- Part A (Hospital Insurance). Most people do not have to pay for Part A. If you or your spouse worked for at least 10 years in Medicare-covered employment, you should be able to qualify for premium-free Part A insurance. (Someone who was a Federal employee on January 1, 1983 or since automatically qualifies.) Otherwise, if you are age 65 or older, you may be able to buy it. Contact 1-800-MEDICARE for more information.
- Part B (Medical Insurance). Most people pay monthly for Part B. Generally, Part B premiums are withheld from your monthly Social Security check or your retirement check.

If you are eligible for Medicare, you may have choices in how you get your health care. Medicare + Choice is the term used to describe the various health plan choices available to Medicare beneficiaries. The information in the next few pages shows how we coordinate benefits with Medicare, depending on the type of Medicare managed care plan you have.

•The Original Medicare Plan (Part A or Part B)

The Original Medicare Plan (Original Medicare) is 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. Some things are not covered under Original Medicare, like prescription drugs.

When you are enrolled in Original Medicare along with this plan, you still need to follow the rules in this brochure for us to cover your care. Your care must continue to be authorized by your Plan PCP, or precertified as required.

(Primary payer chart begins on next page.)

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

Primary Payer Chart		
A. When either you -- or your covered spouse -- are age 65 or over and …	**Then the primary payer is…**	
	Original Medicare	**This Plan**
1) Are an active employee with the Federal government (including when you or a family member are eligible for Medicare solely because of a disability),		✓
2) Are an annuitant,	✓	
3) Are a re-employed annuitant with the Federal government when…		
a) The position is excluded from FEHB, or	✓	
b) The position is not excluded from FEHB		✓
(Ask your employing office which of these applies to you.)		
4) Are a Federal judge who retired under title 28, U.S.C., or a Tax Court judge who retired under Section 7447 of title 26, U.S.C. (or if your covered spouse is this type of judge),	✓	
5) Are enrolled in Part B only, regardless of your employment status,	✓ (for Part B services)	✓ (for other services)
6) Are a former Federal employee receiving Workers' Compensation and the Office of Workers' Compensation Programs has determined that you are unable to return to duty,	✓ (except for claims related to Workers' Compensation.)	
B. When you -- or a covered family member -- have Medicare based on end stage renal disease (ESRD) and…		
1) Are within the first 30 months of eligibility to receive Part A benefits solely because of ESRD,		✓
2) Have completed the 30-month ESRD coordination period and are still eligible for Medicare due to ESRD,	✓	
3) Become eligible for Medicare due to ESRD after Medicare became primary for you under another provision,	✓	
C. When you or a covered family member have FEHB and…		
1) Are eligible for Medicare based on disability, and		
a) Are an annuitant,	✓	
b) Are an active employee, or		✓
c) Are a former spouse of an annuitant, or	✓	
d) Are a former spouse of an active employee		✓

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

Claims process when you have the Original Medicare Plan -- You probably will never have to file a claim form when you have both our Plan and the Original Medicare Plan.

- When we are the primary payer, we process the claim first.
- When Original Medicare is the primary payer, Medicare processes your claim first. In most cases, your claims will be coordinated automatically and we will pay the balance of covered charges. You will not need to do anything. To find out if you need to do something about filing your claims, call Customer Service at (877) 299-2377 or at our website, www.bcbstx.com.

•Medicare managed care plan

If you are eligible for Medicare, you may choose to enroll in and get your Medicare benefits from another type of Medicare+Choice plan -- a Medicare managed care plan. These are health care choices (like HMOs) in some areas of the country. In most Medicare managed care plans, you can only go to doctors, specialists, or hospitals that are part of the Plan. Medicare managed care plans provide all the benefits that Original Medicare covers.. Some cover extras, like prescription drugs. To learn more about enrolling in a Medicare managed care plan, contact Medicare at 1-800-MEDICARE (1-800-633-4227) or at www.medicare.gov.

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

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

Suspended FEHB coverage to enroll in Medicare managed care plan: If you are an annuitant or former spouse, you can suspend your FEHB coverage to enroll in a Medicare managed care plan, eliminating your FEHB premium. (OPM does not contribute to your Medicare managed care plan premium.) For information on suspending your FEHB enrollment, contact your retirement office. If you later want to re-enroll in the FEHB Program, generally you may do so only at the next open season unless you involuntarily lose coverage or move out of the Medicare managed care plan's service area.

- **If you do not enroll in Medicare Part A or Part B**

If you do not have one or both Parts of Medicare, you can still be covered under the FEHB Program. We will not require you to enroll in Medicare Part B and, if you can't get premium-free Part A, we will not ask you to enroll in it.

TRICARE

TRICARE is the health care program for eligible dependants of military persons and retirees of the military. TRICARE includes the CHAMPUS program. If both TRICARE and this Plan cover you, we pay first. See your TRICARE Health Benefits Advisor if you have questions about TRICARE coverage.

Workers' Compensation

We do not cover services that:

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

Once OWCP or similar agency pays its maximum benefits for your treatment, we will cover your care. You must use our providers.

Medicaid

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

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.

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.

Copayment

A copayment is a fixed amount of money you pay when you receive covered services. See page 12.

Covered services

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

Custodial care

Care that primarily helps with or supports daily living activities (such as bathing, dressing, eating and eliminating body wastes) and can be given by people other than trained medical personnel.

Experimental or Investigational services

Experimental or Investigational drugs, devices, treatments or procedures includes any drug, device, treatment or procedure that would not be used in the absence of the experimental or investigation al drug, device, treatment or procedure. We consider a drug, device, treatment or procedure to be experimental or investigational if:

- It cannot be lawfully marketed without the approval of the U.S. Food and Drug Administration, and approval for marketing has been given at the time it is provided; or
- It was reviewed and approved by the treating facility's Institutional Review Board or similar committee, or if federal law requires it to be reviewed and approved by that committee. This exclusion also applies if the informed consent form used with the drug, device, treatment or procedure was (or was required by federal law to be) reviewed and approved by that committee; or
- Reliable evidence shows that the drug, device, treatment or procedure is the subject of ongoing Phase I or Phase II clinical trials; is the research, experimental, study or investigational arm of ongoing Phase III clinical trials; or is otherwise under study to determine its maximum tolerated dose, its toxicity, its safety, its effectiveness, or its effectiveness compared to a standard method of treatment or diagnosis.
- Reliable evidence shows that the prevailing opinion among experts is that further studies or clinical trials of the drug, device, treatment or procedure are needed to determine its maximum tolerated dose, its toxicity, its safety, its effectiveness, or its ineffectiveness compared to a standard method of treatment or diagnosis.

("Reliable evidence" includes only published reports and articles in authoritative medical and scientific literature, and written protocols and informed consent forms used by the treating facility or by another facility studying substantially the same drug, device, treatment or procedure.)

Medical necessity

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

Us/We

Us and we refer to HMO Blue Texas.

You

You refers to the enrollee and each covered family member.

Section 11. FEHB facts

No pre-existing condition limitation

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

Where you can get information about enrolling in the FEHB Program

See www.opm.gov/insure. Also, your employing or retirement office can answer your questions, and give you *a Guide to Federal Employees Health Benefits Plans*, brochures for other plans, and other materials you need to make an informed decision about:

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

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

Types of coverage available for you and your family

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

If you have a Self Only enrollment, you may change to a Self and Family enrollment if you marry, give birth, or add a child to your family. You may change your enrollment 31 days before to 60 days after that event. The Self and Family enrollment begins on the first day of the pay period in which the child is born or becomes an eligible family member. When you change to Self and Family because you marry, the change is effective on the first day of the pay period that begins after your employing office receives your enrollment form.

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

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

When benefits and premiums start

The benefits in this brochure are effective on January 1. If you joined this Plan during Open Season, your coverage begins on the first day of your first pay period that starts on or after January 1. Annuitants' 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.

Your medical and claims records are confidential

We will keep your medical and claims information confidential. Only the following will have access to it:

- OPM, this Plan, and subcontractors when they administer this contract;
- This Plan and appropriate third parties, such as other insurance plans and the Office of Workers' Compensation Programs (OWCP), when coordinating benefit payments and subrogating claims;
- Law enforcement officials when investigating and/or prosecuting alleged civil or criminal actions;
- OPM and the General Accounting Office when conducting audits;
- Individuals involved in bona fide medical research or education that does not disclose your identity; or
- OPM, when reviewing a disputed claim or defending litigation about a claim.

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 continuation (TCC).

When you lose benefits

- **When FEHB coverage ends**

You will receive an additional 31 days of coverage, for no additional premium, when:

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

You may be eligible for spouse equity coverage or Temporary Continuation of Coverage.

- **Spouse equity coverage**

If you are divorced from a Federal employee or annuitant, you may not continue to get benefits under your former spouse's enrollment. But, you may be eligible for your own FEHB coverage under the spouse equity law. If you are recently divorced or are anticipating a divorce, contact your ex-spouse's employing or retirement office to get RI 70-5, the *Guide to Federal Employees Health Benefits Plans for Temporary Continuation of Coverage and Former Spouse Enrollees*, or other information about your coverage choices.

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

If you leave Federal service, or if you lose coverage because you no longer qualify as a family member, you may be eligible for Temporary Continuation of Coverage (TCC). For example, you can receive TCC if you are not able to continue your FEHB enrollment after you retire, if you lose your job, if you are a covered dependent child and you turn 22 or marry, etc.

You may not elect TCC if you are fired from your Federal job due to gross misconduct.

Enrolling in TCC. Get the RI 79-27, which describes TCC, and the RI 70-5, the *Guide to Federal Employees Health Benefits Plans for Temporary Continuation of Coverage and Former Spouse Enrollees*, from your employing or retirement office or from www.opm.gov/insure. It explains what you have to do to enroll.

- **Converting to individual coverage**

You may convert to a non-FEHB individual policy if:

- Your coverage under TCC or the spouse equity law ends. (If you canceled your coverage or did not pay your premium, you cannot convert);
- You decided not to receive coverage under TCC or the spouse equity law; or
- You are not eligible for coverage under TCC or the spouse equity law.

If you leave Federal service, your employing office will notify you of your right to convert. You must apply in writing to us within 31 days after you receive this notice. However, if you are a family member who is losing coverage, the employing or retirement office will **not** notify you. You must apply in writing to us within 31 days after you are no longer eligible for coverage.

Your benefits and rates will differ from those under the FEHB Program; however, you will not have to answer questions about your health, and we will not impose a waiting period or limit your coverage due to pre-existing conditions.

Getting a Certificate of Group Health Plan Coverage

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is a Federal law that offers limited Federal protections for health coverage availability and continuity to people who lose employer group coverage. If you leave the FEHB Program, we will give you a Certificate of Group Health Plan Coverage that indicates how long you have been enrolled with us. You can use this certificate when getting health insurance or other health care coverage. Your new plan must reduce or eliminate waiting periods, limitations, or exclusions for health related conditions based on the information in the certificate, as long as you enroll within 63 days of losing coverage under this Plan. If you have been enrolled with us for less than 12 months, but were previously enrolled in other FEHB plans, you may also request a certificate from those plans.

For more information, get OPM pamphlet RI 79-27, Temporary Continuation of Coverage (TCC) under the FEHB Program. See also the FEHB web site (www.opm.gov/insure/health); refer to the "TCC and HIPAA" frequently asked question. These highlight HIPAA rules, such as the requirement that Federal employees must exhaust any TCC eligibility as one condition for guaranteed access to individual health coverage under HIPAA, and have information about Federal and State agencies you can contact for more information.

Long Term Care Insurance Is Coming Later in 2002!

- Many FEHB enrollees think their health plan and/or Medicare covers long-term care. Unfortunately, they are *WRONG*!
- How are YOU planning to pay for the future custodial or chronic care you may need? Consider buying long term care insurance.

The Office of Personnel Management (OPM) will sponsor a high-quality long term care insurance program effective in October 2002. As part of its educational effort, OPM asks you to consider these questions:

What is long term care (LTC) insurance?

- It's insurance to help pay for long term care services you may need if you can't take care of yourself because of an extended illness or injury, or an age-related disease such as Alzheimer's.
- LTC insurance can provide broad, flexible benefits for care in a nursing home, in an assisted living facility, in your home, adult day care, hospice care, and more. *LTC insurance can supplement care provided by family members, reducing the burden you place on them.*

I'm healthy. I won't need long term care. Or, will I?

- 76% of Americans believe they will never need long term care, but the facts are that about half of them will. And it's not just the old folks. About 40% of people needing long term care are under age 65. They may need chronic care due to a serious accident, a stroke, or developing multiple sclerosis, etc.
- We hope you will never need long term care, but you should have a plan just in case. *LTC insurance may be vital to your financial and retirement planning.*

Is long term care expensive?

- Yes. A year in a nursing home can exceed $50,000 and only three 8- hour shifts a week can exceed $20,000 a year, that's before inflation!
- LTC can easily exhaust your savings but LTC insurance can protect it.

But won't my FEHB plan, Medicare or Medicaid cover my long term care?

- Not FEHB. Look under "*Not covered*" in sections 5(a) and 5(c) of your FEHB brochure. Custodial care, assisted living, or continuing home health care for activities of daily living are not covered. Limited stays in skilled nursing facilities can be covered in some circumstances.
- Medicare only covers skilled nursing home care after a hospitalization with a 100 day limit.
- Medicaid covers LTC for those who meet their state's guidelines, but restricts covered services and where they can be received. LTC insurance can provide choices of care and preserve your independence.

When will I get more information?

- Employees will get more information from their agencies during the late summer/early fall of 2002.
- Retirees will receive information at home.

How can I find out more about the program NOW?

A toll-free telephone number will begin in mid-2002. You can learn more about the program now at www.opm.gov/insure/ltc.

Department of Defense/FEHB Demonstration Project

What is it?

HMO Blue Texas participates in this program. The Department of Defense/FEHB Demonstration Project allows some active and retired uniformed service members and their dependents to enroll in the FEHB Program. The demonstration will last for three years and began with the 1999 open season for the year 2000. Open season enrollments will be effective January 1, 2002. DoD and OPM have set up some special procedures to implement the Demonstration Project, noted below. Otherwise, the provisions described in this brochure apply.

Who is eligible

DoD determines who is eligible to enroll in the FEHB Program. Generally, you may enroll if:

- You are an active or retired uniformed service member and are eligible for Medicare;
- You are a dependent of an active or retired uniformed service member and are eligible for Medicare;
- You are a qualified former spouse of an active or retired uniformed service member and you have not remarried; or
- You are a survivor dependent of a deceased active or retired uniformed service member; and
- You live in one of the geographic demonstration areas.

If you are eligible to enroll in a plan under the regular Federal Employees Health Benefits Program, you are not eligible to enroll under the DoD/FEHBP Demonstration Project.

The demonstration areas

- Dover AFB, DE
- Fort Knox, KY
- Dallas, TX
- New Orleans, LA
- Adair County, IA
- Commonwealth of Puerto Rico
- Greensboro/Winston Salem/High Point, NC
- Humboldt County, CA area
- Naval Hospital, Camp Pendleton, CA
- Coffee County, GA

When you can join

You may enroll under the FEHB/DoD Demonstration Project during the 2001 open season, November 12, 2001, through December 10, 2001. Your coverage will begin January 1, 2002. DoD has set-up an Information Processing Center (IPC) in Iowa to provide you with information about how to enroll. IPC staff will verify your eligibility and provide you with FEHB Program information, plan brochures, enrollment instructions and forms. The toll-free phone number for the IPC is (877) DOD-FEHB –((877) 363-3342).

You may select coverage for yourself (Self Only) or for you and your family (Self and Family) during open season. Your coverage will begin January 1, 2002. If you become eligible for the DoD/FEHB Demonstration Project outside of open season, contact the IPC to find out how to enroll and when your coverage will begin.

DoD has a web site devoted to the Demonstration Project. You can view information such as their Marketing/Beneficiary Education Plan, Frequently Asked Questions, demonstration area locations and zip code lists at www.tricare.osd.mil/fehbp. You can also view information about the demonstration project, including "The 2002 Guide to Federal Employees Health Benefits Plans Participating in the DoD/FEHB Demonstration Project," on the OPM web site at www.opm.gov.

Temporary Continuation of Coverage (TCC)

See Section 11, FEHB Facts; it explains temporary continuation of coverage (TCC). Under this DoD/FEHB Demonstration Project the **only** individual eligible for TCC is one who ceases to be eligible as a "member of family" under your self and family enrollment. This occurs when a child turns 22, for example, or if you divorce and your spouse does not qualify to enroll as an unremarried former spouse under title 10, United States Code. For these individuals, TCC begins the day after their enrollment in the DoD/FEHB Demonstration Project ends. TCC enrollment terminates after 36 months or the end of the Demonstration Project, whichever occurs first. You, your child, or another person must notify the IPC when a family member loses eligibility for coverage under the DoD/FEHB Demonstration Project.

TCC is not available if you move out of a DoD/FEHB Demonstration Project area, you cancel your coverage, or your coverage is terminated for any reason. TCC is not available when the demonstration project ends.

Other features

The 31-day extension of coverage and right to convert do not apply to the DoD/FEHB Demonstration Project.

NOTES:

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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.

NOTES:

Summary of benefits for HMO Blue Texas – 2002

- **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: $10 primary care; $10 specialist	14
Services provided by a hospital:		
• Inpatient.....	$100 per admission copay	27
• Outpatient.....	Nothing	28
Emergency benefits:		
• In-area.....	$75 per visit	31
• Out-of-area	$75 per visit	31
Mental health and substance abuse treatment.....	Regular cost sharing	32
Prescription drugs	$5 per generic $10 per preferred brand $25 per non-preferred brand	35
Dental Care	Nothing for preventive services; scheduled allowance for other services	38
Vision Care	One eye examination for eyeglasses every 12 months; you pay a $10 copay; Eyeglass lenses and frames available at discount prices; Contact lenses and materials are also available at discount prices; and One eye examination for contact lenses every 12 months; you pay a $20 copay.	41
Special features: Reciprocity Program and High Risk Pregnancies Program		37
Protection against catastrophic costs (your out-of-pocket maximum).....	Nothing after $650/Self Only or $1,500/Family enrollment per year Some costs do not count toward this protection	12

2002 Rate Information for
HMO Blue Texas

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

Postal rates apply to career Postal Service employees. Most employees should refer to the FEHB Guide for United States Postal Service Employees, RI 70-2. Different postal rates apply and special FEHB guides are published for Postal Service Nurses and Tool & Die employees (see RI 70-2B); and for Postal Service Inspectors and Office of Inspector General (OIG) employees (see RI 70-2IN).

Postal rates do not apply to non-career postal employees, postal retirees, or associate members of any postal employee organization. Refer to the applicable FEHB Guide.

		Non-Postal Premium				Postal Premium	
		Biweekly		Monthly		Biweekly	
Type of Enrollment	Code	Gov't Share	Your Share	Gov't Share	Your Share	USPS Share	Your Share
Northeast and West Territories							
Self Only	**YX1**	**97.86**	**35.62**	**212.03**	**77.18**	**115.52**	**17.96**
Self and Family	**YX2**	**223.41**	**100.32**	**484.06**	**217.36**	**263.75**	**59.98**
Southeast and Central Territories							
Self Only	**YM1**	**89.69**	**29.90**	**194.33**	**64.78**	**106.14**	**13.45**
Self and Family	**YM2**	**219.56**	**73.18**	**475.70**	**158.57**	**259.81**	**32.93**

*Blue Cross and Blue Shield of Texas, a Division of Health Care Service Corporation, a Mutual Legal Reserve Company**
*HMO plans offered by **Southwest Texas HMO, Inc.*** d/b/a HMO Blue Texas*
**Independent Licensees of the Blue Cross and Blue Shield Association*