FirstCare HEALTH PLANS

FirstCare *mySeries*

Benefit Overview

myHMO VIII

This Consumer Choice of Benefits Health Maintenance Organization health care plan, either in whole or part, does not provide state-mandated health benefits normally required in evidences of coverage in Texas. This standard health benefit plan may provide a more affordable health plan for you, although, at the same time, it may provide you with fewer health plan benefits than those normally included as state-mandated health benefits in Texas. Please consult with your insurance agent to discover which state-mandated health benefits are excluded in this evidence of coverage. The following is a summary of the Copay amounts You and any Dependents must pay when receiving the services listed below. These services must be performed, prescribed, or directed by Your Primary Care Physician or designated OB/GYN Physician. Please refer to Your Evidence of Coverage for a detailed explanation of covered and non-covered services.

COVERED SERVICE	COPAYMENT
CALENDAR YEAR DEDUCTIBLE	**$1,500 per Member** **$3,000 per Family**
OUT-OF-POCKET MAXIMUM (Does NOT include Deductible)	**$3,000 per Member** **$6,000 per Family**
AGGREGATE LIFETIME MAXIMUM	**$2,000,000**
INPATIENT SERVICES Inpatient Services Include: • Semi-Private Room and Board Charges • Surgical Procedures • Pre-Admission Testing • Physician Hospital Visits • Intensive Care & Coronary Care Units • Operating/Recovering Room • Physician Services • Skilled Nursing Facility: *Limited to 30 days per Calendar Year* • Laboratory Tests and X-ray • Reconstructive Surgery	20% Copay – After Deductible
Observation Unit	20% Copay – After Deductible
OUTPATIENT SERVICES Outpatient Services/Surgery Include: • Facility Charges • Surgical Procedures • Physician Services	20% Copay – After Deductible
Acute/Non-Chronic/Short-Term Mental Illness: *Limited to 20 Outpatient days per Calendar Year*	50% Copay – After Deductible
Laboratory Tests and X-ray performed in an outpatient setting	No Copay – After Deductible
MRI, CT Scans, Sleep Study, Nuclear Stress Tests and PET Scan performed in an outpatient setting	20% Copay – After Deductible

COVERED SERVICE	COPAYMENT
PHYSICIAN OFFICE SERVICES Physician Office Services Include: • Physician Office Visits • Medications, supplies and materials administered in the office • Second Surgical Opinion	$30 per visit to the PCP – Deductible Waived $50 per visit to the Specialist – Deductible Waived
Laboratory Tests and X-Ray performed in the Physician's office	No Copay – After Deductible
MRI, CT Scans, Sleep Study, Nuclear Stress Tests and PET Scan performed in the Physician's office	20% Copay – After Deductible
Allergy Services • Office Visits	$30 per visit to the PCP – Deductible Waived $50 per visit to the Specialist – Deductible Waived
• Allergy Testing • Serum • Injection Administration	50% of the Allowable Amount – After Deductible 50% of the Allowable Amount – After Deductible 50% of the Allowable Amount– After Deductible
Surgical Procedures performed in the Physician's Office	20% Copay – After Deductible
PREVENTIVE SERVICES Preventive Services Include: • Annual Routine Physicals • Well Baby and Well Child Care • Routine Eye, Speech and Hearing Screenings for Children when performed during an office visit • Routine Immunizations for ages 6 and older • Examinations and Testing for the detection of Prostate Cancer • Routine Laboratory and X-Ray	$30 per visit to the PCP – Deductible Waived $50 per visit to the Specialist – Deductible Waived
Immunizations for Newborns (birth to 6-years of age)	No Copay – Deductible Waived
Newborn Child Hearing Screenings (birth to 30-days old)	No Copay – Deductible Waived
Well Woman Exam including Routine Annual Physicals including low dose mammography screening.	$30 per office visit – Deductible Waived
Preventive Diagnostics and Testing: • Non-routine screening mammograms including Digital, X-ray and Ultrasound • Screening for the detection of Colorectal Cancer (*If other procedures are needed during the screening, additional Copayments, Deductible, and/or Coinsurance will apply.*) • Bone Mass Measurement	20% Copay – After Deductible

COVERED SERVICE	COPAYMENT
FAMILY PLANNING SERVICES Family Planning and Counseling	$30 per visit to the PCP – Deductible Waived $50 per visit to the Specialist – Deductible Waived
Contraceptive Devices, Implants and Injections including: • Diaphragm • IUD • Subdermal Contraceptive Implants & Removal • Depo-Provera™ Injections	50% of the Allowable Amount for all charges – After Deductible. Applies to materials, procedures, and services.
STERILIZATION PROCEDURES (Vasectomy & Tubal Ligation) • When performed in an Outpatient Facility • When performed in the Physician's Office • When performed in an Inpatient Facility	 20% Copay – After Deductible 20% Copay – After Deductible See Inpatient Services
DIABETIC SERVICES Diabetic Self-Management Education	$30 per visit to the PCP – Deductible Waived $50 per visit to the Specialist – Deductible Waived

Insulin and Diabetic Insulin
• 30 Day Supply
  o 1st tier - Generic Drugs
  o 2nd tier - Brand name drugs on drug list
  o 3rd tier - Brand name drugs not on drug list
	
	$20 per prescription – After Deductible
	$50 per prescription – After Deductible
	$100 per prescription – After Deductible

• Mail Order (up to 90- day supply)
  o 1st tier - Generic Drugs
  o 2nd tier - Brand name drugs on drug list
  o 3rd tier - Brand name drugs not on drug list
	
	$60 per prescription – After Deductible
	$150 per prescription – After Deductible
	$300 per prescription – After Deductible

Test Strips • Level 1 Strips • Level 2 Strips	 10% per item – After Deductible 20% per item – After Deductible
Other Diabetic Supplies and Equipment (30 Day Supply)	20% per item – After Deductible
SPECIALTY SERVICES/PHARMACY Specialty Services/Pharmacy Include: • Medical Injectable Drugs (excluding Depo-Provera™ injectables) • Defined Hybrid Injectables • Radiation Therapy • Transplant Anti-rejection Therapy • Home Infusion Medications (excluding "self-injectable" drugs) • Specified Cancer Chemotherapy • Defined Associated Agents	• When covered service cost is $500 or less: *See physician office services, outpatient services/surgery, or inpatient services for applicable copayments.* • When covered service cost is more than $500: *30% Copay – After Deductible, not to exceed $3,000 Out-of-Pocket Maximum for these specific services. See Section 10, Definitions in Your Evidence of Coverage*

COVERED SERVICE	COPAYMENT
EMERGENCY ROOM SERVICES Emergency Room	20% Copay – After Deductible Emergency Room Copay is waived if admitted to Hospital
Minor Emergency/Urgent Care Center	20% Copay – After Deductible
Ambulance	20% Copay – After Deductible
OTHER HEALTH CARE SERVCES Limited Accidental Dental Care and Medically Related Oral Surgeries: *Limited to $1,000 Calendar Year Maximum Benefit*	20% Copay – After Deductible
Therapy Services: *Limited to 20 visits per Therapy Service per Calendar Year* • Rehabilitation Therapy • Speech Therapy • Occupational Therapy • Physical Therapy	$30 per visit to the PCP – Deductible Waived $50 per visit to the Specialist – Deductible Waived
Hospice Care: *Lifetime Maximum of $10,000*	20% Copay – After Deductible
Spinal Manipulation*: Limited to 10 visits per Calendar Year*	$50 per visit – Deductible Waived
Pain Management Services	Included in the physician office services, outpatient services/surgery, or inpatient services copayment.
Durable Medical Equipment (DME): *DME is limited to $2,000 per Calendar Year. DME used in the treatment of diabetes, oxygen and monitoring devices are not included in the $2,000 maximum.*	50% of the Allowable Amount per piece of equipment or supply – After Deductible
Medical Supplies	50% of the Allowable Amount per piece of equipment or supply – After Deductible
Prosthetics: External Devices: *Lifetime Maximum of $4,000 per Device/Limb*	50% of the Allowable Amount per device – After Deductible
Orthotics	50% of the Allowable Amount per device – After Deductible
Internal Implantable Devices	50% of the Allowable Amount per device – After Deductible
Dialysis Services (Inpatient & Outpatient)	Included in the physician office services, outpatient services/surgery, or inpatient services copayment.

COVERED SERVICE	COPAYMENT
Organ Transplant Services (Inpatient & Outpatient) *Lifetime Maximum of $300,000*	Included in the physician office services, outpatient services/surgery, or inpatient services copayment.
Home Health Services: *Limited to 20 visits per Covered Service per Calendar Year* • Includes treatment of covered illness or injury in your home • EXCLUDES speech, physical, and occupational therapy	20% Copay – After Deductible

NOTE: This benefit plan does not include maternity coverage.