HMO Texas, L.C.

1999

(formerly Kaiser Foundation Health Plan of Texas)

A Health Maintenance Organization

Serving: Dallas/Fort Worth, Texas
Enrollment in this plan is limited; see page 10 for requirements.

Enrollment code:
UK1 Self Only
UK2 Self and Family

Visit the OPM website at http:// www.opm.gov/insure
and
This Plan's website at www.sierrahealth.com

Authorized for distribution by the:

United States Office of Personnel Management

FEHB
Federal Employees Health Benefits Program

RI 73-063

HMO Texas, L.C.

HMO Texas, L.C., 12720 Hillcrest Road, Suite 600, Dallas, Texas 75230 has entered into a contract (CS 1894) with the Office of Personnel Management (OPM) as authorized by the Federal Employees Health Benefits (FEHB) law, to provide a comprehensive medical plan herein called **HMO Texas, L.C.** or the Plan.

This brochure is **the official statement of benefits on which you can rely. A person enrolled in the Plan is entitled to the benefits stated in this brochure.** If enrolled for Self and Family, each eligible family member is also entitled to these benefits.

Premiums are negotiated with each plan annually. Benefit changes are effective January 1, 1999, and are shown on **page 25** of this brochure.

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Inspector General Advisory: Stop Health Care Fraud!

Fraud increases the cost of health care for everyone. Anyone who intentionally makes a false statement or a false claim in order to obtain FEHB benefits, or increase the amount of FEHB benefits, is subject to prosecution for FRAUD. This could result in CRIMINAL PENALTIES. Please review all medical bills, medical records and claims statements carefully. If you find that a provider, such as a doctor, hospital or pharmacy, charged your plan for services you did not receive, billed for the same service twice, or misrepresented any other information, take the following actions:

- Call the provider and ask for an explanation - sometimes the problem is a simple error.
- If the provider does not resolve the matter, or if you remain concerned, call your plan at 972/ 479-5165 and explain the situation.
- If the matter is not resolved after speaking to your plan (and you still suspect fraud has been committed), call or write:

THE HEALTH CARE FRAUD HOTLINE
2023/418-3300

The Office of Personnel Management
Office of the Inspector General Fraud Hotline
1900 E Street, N.W., Room 6400
Washington, D.C. 20415

The inappropriate use of membership identification cards, e.g., to obtain services for a person who is not an eligible family member or after you are no longer enrolled in the Plan, is also subject to review by the Inspector General and may result in an adverse administrative action by your agency.

General Information

Confidentiality

Medical and other information provided to the Plan, including claim files, is kept confidential and will be used only: 1) by the Plan and its subcontractors for internal administration of the Plan, coordination of benefit provisions with other plans, and subrogation of claims; 2) by law enforcement officials with authority to investigate and prosecute alleged civil or criminal actions; 3) by OPM to review a disputed claim or perform its contract administration functions; 4) by OPM and the General Accounting Office when conducting audits as required by the FEHB law; or 5) for bona fide medical research or education. Medical data that does not identify individual members may be disclosed as a result of the bona fide medical research or education.

If you are a new member

Use this brochure as a guide to coverage and obtaining benefits. There may be a delay before you receive your identification card and member information from the Plan. Until you receive your ID card, you may show your copy of the SF 2809 enrollment form or your annuitant confirmation letter from OPM to a provider or Plan facility as proof of enrollment in this Plan. If you do not receive your ID card within 60 days after the effective date of your enrollment, you should contact the Plan.

If you made your open season change by using Employee Express and have not received your new ID card by the effective date of your enrollment, call the Employee Express HELP number to request a confirmation letter. Use that letter to confirm your new coverage with Plan providers.

If you are a new member of this Plan, benefits and rates begin on the effective date of your enrollment, as set by your employing office or retirement system. As a member of this Plan, once your enrollment is effective, you will be covered only for services provided or arranged by a Plan doctor except in the case of emergency as described on pages 17 and 18. If you are confined in a hospital on the effective date, you must notify the Plan so that it may arrange for the transfer of your care to Plan providers. See “If you are hospitalized” on page 4.

FEHB plans may not refuse to provide benefits for any condition you or a covered family member may have solely on the basis that it was a condition that existed before you enrolled in a plan under the FEHB Program.

If you are hospitalized

If you change plans or options, benefits under your prior plan or option cease on the effective date of your enrollment in your new plan or option, unless you or a covered family member are confined in a hospital or other covered facility or are receiving medical care in an alternative care setting on the last day of your enrollment under the prior plan or option. In that case, the confined person will continue to receive benefits under the former plan or option until the earliest of (1) the day the person is discharged from the hospital or other covered facility (a move to an alternative care setting does not constitute a discharge under this provision), or (2) the day after the day all inpatient benefits have been exhausted under the prior plan or option, or (3) the 92nd day after the last day of coverage under the prior plan or option. However, benefits for other family members under the new plan will begin on the effective date. If your plan terminates participation in the FEHB Program in whole or in part, or if the Associate Director for Retirement and Insurance orders an enrollment change, this continuation of coverage provision does not apply; in such case, the hospitalized family member's benefits under the new plan begin on the effective date of enrollment.

Your responsibility

It is your responsibility to be informed about your health benefits. Your employing office or retirement system can provide information about: when you may change your enrollment; who "family members" are; what happens when you transfer, go on leave without pay, enter military service, or retire; when your enrollment terminates; and the next open season for enrollment. Your employing office or retirement system will also make available to you an FEHB Guide, brochures and other materials you need to make an informed decision.

Things to keep in mind

- The benefits in this brochure are effective on January 1 for those already enrolled in this Plan; if you changed plans or plan options, see "If you are a new member" above. In both cases, however, the Plan's new rates are effective the first day of the enrollee's first full pay period that begins on or after January 1 (January 1 for all annuitants).
- Generally, you must be continuously enrolled in the FEHB Program for the last five years before you retire to continue your enrollment for you and any eligible family members after you retire.
- The FEHB Program provides Self Only coverage for the enrollee alone or Self and Family coverage for the enrollee, his or her spouse, and unmarried dependent children under age 22. Under certain circumstances, coverage will also be provided under a family enrollment for a disabled child 22 years of age or older who is incapable of self-support.
- An enrollee with Self Only coverage who is expecting a baby or the addition of a child may change to a Self and Family enrollment up to 60 days after the birth or addition. The effective date of the enrollment change is the first day of the pay period in which the child was born or became an eligible family member. The enrollee is responsible for his or her share of the Self and Family premium for that time period; both parent and child are covered only for care received from Plan providers, except for emergency benefits.
- You will not be informed by your employing office (or your retirement system) or your Plan when a family member loses eligibility.
- You must direct questions about enrollment and eligibility, including whether a dependent age 22 or older is eligible for coverage, to your employing office or retirement system. The Plan does not determine eligibility and cannot change an enrollment status without the necessary information from the employing agency or retirement system.
- An employee, annuitant, or family member enrolled in one FEHB plan is not entitled to receive benefits under any other FEHB plan.
- Report additions and deletions (including divorces) of covered family members to the Plan promptly.
- If you are an annuitant or former spouse with FEHB coverage and you are also covered by Medicare Part B, you may drop your FEHB coverage and enroll in a Medicare prepaid plan when one is available in your area. If you later change your mind and want to reenroll in FEHB, you may do so at the next open season, or whenever you involuntarily lose coverage in the Medicare prepaid plan or move out of the area it serves.

Things to keep in mind **continued**

- Most Federal annuitants have Medicare Part A. If you do not have Medicare Part A, you may enroll in a Medicare prepaid plan, but you will probably have to pay for hospital coverage in addition to the Part B premium. Before you join the plan, ask whether they will provide hospital benefits and, if so, what you will have to pay.
- You may also remain enrolled in this Plan when you join a Medicare prepaid plan.
- Contact your local Social Security Administration (SSA) office for information on local Medicare prepaid plans (also known as Coordinated Care Plans or Medicare HMOs) or request it from SSA at 1-800/638-6833. Contact your retirement system for information on dropping your FEHB enrollment and changing to a Medicare prepaid plan.
- Federal annuitants are not required to enroll in Medicare Part B (or Part A) in order to be covered under the FEHB Program nor are their FEHB benefits reduced if they do not have Medicare Part B (or Part A).

Coverage after enrollment ends

When an employee's enrollment terminates because of separation from Federal service or when a family member is no longer eligible for coverage under an employee or annuitant enrollment, and the person is not otherwise eligible for FEHB coverage, he or she generally will be eligible for a free 31-day extension of coverage. The employee or family member may also be eligible for one of the following:

Former spouse coverage

When a Federal employee or annuitant divorces, the former spouse may be eligible to elect coverage under the spouse equity law. If you are recently divorced or anticipate divorcing, contact the employee's employing office (personnel office) or retiree's retirement system to get more facts about electing coverage.

Temporary continuation of coverage (TCC)

If you are an employee whose enrollment is terminated because you separate from service, you may be eligible to temporarily continue your health benefits coverage under the FEHB Program in any plan for which you are eligible. Ask your employing office for RI 79-27, which describes TCC, and for RI 70-5, the FEHB Guide for individuals eligible for TCC. Unless you are separated for gross misconduct, TCC is available to you if you are not otherwise eligible for continued coverage under the Program. For example, you are eligible for TCC when you retire if you are unable to meet the five-year enrollment requirement for continuation of enrollment after retirement.

Your TCC begins after the initial free 31-day extension of coverage ends and continues for up to 18 months after your separation from service (that is, if you use TCC until it expires 18 months following separation, you will only pay for 17 months of coverage). Generally, you must pay the total premium (both the Government and employee shares) plus a 2 percent administrative charge. If you use your TCC until it expires, you are entitled to another free 31-day extension of coverage when you may convert to nongroup coverage. If you cancel your TCC or stop paying premiums, the free 31-day extension of coverage and conversion option are not available.

Children or former spouses who lose eligibility for coverage because they no longer qualify as family members (and who are not eligible for benefits under the FEHB Program as employees or under the spouse equity law) also may qualify for TCC. They also must pay the total premium plus the 2 percent administrative charge. TCC for former family members continues for up to 36 months after the qualifying event occurs, for example, the child reaches age 22 or the date of the divorce. This includes the free 31-day extension of coverage. When their TCC ends (except by cancellation or nonpayment of premium), they are entitled to another free 31-day extension of coverage when they may convert to nongroup coverage.

NOTE: If there is a delay in processing the TCC enrollment, the effective date of the enrollment is still the 32nd day after regular coverage ends. The TCC enrollee is responsible for premium payments retroactive to the effective date and coverage may not exceed the 18 or 36 month period noted above.

Notification and election requirements

Separating employees — Within 61 days after an employee's enrollment terminates because of separation from service, his or her employing office must notify the employee of the opportunity to elect TCC. The employee has 60 days after separation (or after receiving the notice from the employing office, if later) to elect TCC.

Children — You must notify your employing office or retirement system when a child becomes eligible for TCC within 60 days after the qualifying event occurs, for example, the child reaches age 22 or marries.

Former spouses — You or your former spouse must notify the employing office or retirement system of the former spouse's eligibility for TCC within 60 days after the termination of the marriage. A former spouse may also qualify for TCC if, during the 36-month period of TCC eligibility, he or she loses spouse equity eligibility because of remarriage before age 55 or loss of the qualifying court order. This applies even if he or she did not elect TCC while waiting for spouse equity coverage to begin. The former spouse must contact the employing office within 60 days of losing spouse equity eligibility to apply for the remaining months of TCC to which he or she is entitled.

The employing office or retirement system has 14 days after receiving notice from you or the former spouse to notify the child or the former spouse of his or her rights under TCC. If a child wants TCC, he or she must elect it within 60 days after the date of the qualifying event (or after receiving the notice, if later). If a former spouse wants TCC, he or she must elect it within 60 days after any of the following events: the date of the qualifying event or the date he or she receives the notice, whichever is later; or the date he or she loses coverage under the spouse equity law because of remarriage before age 55 or loss of the qualifying court order.

Important: The employing office or retirement system must be notified of a child's or former spouse's eligibility for TCC within the 60-day time limit. If the employing office or retirement system is not notified, the opportunity to elect TCC ends 60 days after the qualifying event in the case of a child and 60 days after the change in status in the case of a former spouse.

Conversion to individual coverage

When none of the above choices are available – or chosen – when coverage as an employee or family member ends, or when TCC coverage ends (except by cancellation or nonpayment of premium), you may be eligible to convert to an individual, nongroup contract. You will not be required to provide evidence of good health and the plan is not permitted to impose a waiting period or limit coverage for preexisting conditions. If you wish to convert to an individual contract, you must apply in writing to the carrier of the plan in which you are enrolled within 31 days after receiving notice of the conversion right from your employing agency. A family member must apply to convert within the 31-day free extension of coverage that follows the event that terminates coverage, e.g., divorce or reaching age 22. Benefits and rates under the individual contract may differ from those under the FEHB Program.

Certificate of creditable coverage

Under Federal law, if you lose coverage under the FEHB Program, you should automatically receive a Certificate of Group Health Plan Coverage from the last FEHB Plan to cover you. This certificate, along with any certificates you receive from other FEHB plans you may have enrolled in, may reduce or eliminate the length of time a preexisting condition clause can be applied to you by a new non-FEHB insurer. If you do not receive a certificate automatically, you must be given one on request.

Facts about this Plan

This Plan is a comprehensive medical plan, sometimes called a health maintenance organization (HMO). When you enroll in an HMO, you are joining an organized system of health care that arranges in advance with specific doctors, hospitals and other providers to give care to members and pays them directly for their services. Benefits are available only from Plan providers except during a medical emergency. **Members are required to select a personal doctor from among participating Plan primary care doctors.** Services of a specialty care doctor can only be received by referral from a Plan primary care doctor. There are no claim forms when Plan doctors are used.

Your decision to join an HMO should be based on your preference for the Plan's benefits and delivery system, not because a particular provider is in the Plan's network. You cannot change plans because a provider leaves the HMO.

Because the Plan provides or arranges your care and pays the cost, it seeks efficient and effective delivery of health services. By controlling unnecessary or inappropriate care, it can afford to offer a comprehensive range of benefits. In addition to providing comprehensive health services and benefits for accidents, illness and injury, the Plan places great emphasis on preventive benefits such as office visits, physicals, immunizations and well-baby care. You are encouraged to get medical attention at the first sign of illness.

Information you have a right to know

All carriers in the FEHB Program must provide certain information to you. If you did not receive information about this Plan, you can obtain it by calling the Carrier at (972) 479-0332 or 1-800-324-8527 or you may write the Carrier at HMO Texas, L.C., Customer Service, 12720 Hillcrest Road, Suite 600, Dallas, Texas 75230. You may also contact the Carrier by fax at (972) 690-7087, at its website at http://www.sierrahealth.com

Information that must be made available to you includes:

- Disenrollment rates for 1997.
- Compliance with State and Federal licensing or certification requirements and the dates met. If noncompliant, the reason for noncompliance.
- Accreditations by recognized accrediting agencies and the dates received.
- Carrier's type of corporate form and years in existence.
- Whether the carrier meets State, Federal and accreditation requirements for fiscal solvency, confidentiality and transfer of medical records.

Who provides care to Plan members?

HMO Texas, L.C. offers comprehensive health care coverage on a pre-paid basis, at Plan facilities conveniently located throughout the Dallas/Ft. Worth metropolitan area and through referral specialists, hospitals and other providers in the community. All care should be received at these facilities and from these providers except in medical emergencies. The Plan contracts with The Medical Group of Texas, an independent multi-specialty group of physicians ("Plan doctors"), to provide or arrange all necessary physician care for plan members. Medical care is provided through doctors, nurse practitioners and other skilled medical personnel working as medical teams for consultation and treatment. These doctors are members of American Specialty Boards or are Board eligible. Other necessary medical services, such as physical therapy, laboratory and X-ray services, are also available at Plan facilities. Plan doctors also arrange any necessary specialty care. Hospital care is provided through the Plan at several local community hospitals.

Role of a primary care doctor

The first and most important decision each member must make is the selection of a primary care doctor. Primary care doctors include internists, family practitioners, gynecologists, and pediatricians. It is through this doctor that all other health services, particularly those of specialists, are obtained. It is the responsibility of your primary care doctor to obtain any necessary authorizations from the Plan before referring you to a specialist or making arrangements for hospitalization. Services of other Plan providers and of non-Plan providers are covered only when there has been a referral by your primary care doctor.

Choosing your doctor

The Plan's provider directory lists Plan facilities and the services available at each facility (generally family practice, pediatrics, gynecologists, internal medicine) with their locations and phone numbers, and notes whether or not the doctor is accepting new patients. Directories are updated on a regular basis and are available at the time of enrollment or upon request by calling the Customer Service Representative at 972/479-0332, (metro) 972/263-4830 or 1-800/324-8527; you can also find out if your doctor participates with this Plan by calling this number. If you are interested in receiving care from a specific provider who is listed in the directory, call the provider to verify that he or she still participates with the Plan and is accepting new patients. **Important note: When you enroll in this Plan, services (except for emergency benefits) are provided through the Plan's delivery system; the continued availability and/or participation of any one doctor, hospital, or other provider cannot be guaranteed.**

If you enroll, you will be asked to select a primary care doctor for you and each member of your family from the same Plan option and inform the Plan of your selection. You may see other Plan doctors if your primary care doctor is not available. Members may change their doctor selection by contacting Customer Service.

If you are receiving services from a doctor who terminates his or her association with the Plan, the Plan will provide payment for covered services until the Plan can make reasonable and medically appropriate provisions for the assumption of such services by another Plan doctor.

Referrals for specialty care

Except in a medical emergency, you must contact your primary care doctor for a referral before seeing any other doctor or obtaining special services. Referral to a participating specialist is given at the primary care doctor's discretion; if specialists or consultants are required beyond those participating in the Plan, the primary care doctor will make arrangements for appropriate referrals.

When you receive a referral from your primary care doctor, you must return to the primary care doctor after the consultation. All follow-up care must be provided or arranged by the primary care doctor. On referrals, the primary care doctor will give specific instructions to the consultant as to what services are authorized. If additional services or visits are suggested by the consultant, you must first check with your primary care doctor. Do not go to the specialist unless your primary care doctor has arranged for and the Plan has issued an authorization for the referral in advance.

If you have a chronic, complex, or serious medical condition that causes you to see a Plan specialist frequently, your primary care doctor will develop a treatment plan with you and your health plan that allows an adequate number of direct access visits with that specialist. The treatment plan will permit you to visit your specialist without the need to obtain further referrals.

Authorizations

The Plan will provide benefits for covered services only when the services are medically necessary to prevent, diagnose or treat your illness or condition. Your Plan doctor must obtain the Plan's determination of medical necessity before you may be hospitalized, referred for specialty care or obtain follow-up care from a specialist.

For new members

If you are already under the care of a specialist who is a Plan participant, you must still obtain a referral from a Plan primary care doctor for the care to be covered by the Plan. If you are selecting a new primary care doctor and want to continue with this specialist, you must schedule an appointment so that the primary care doctor can decide whether to treat the condition directly or refer you to a specialist.

Hospital care

If you require hospitalization, your primary care doctor or authorized specialist will make the necessary arrangements and continue to supervise your care.

Out-of-pocket maximum

Copayments are required for a few benefits. However, copayments will not be required for the remainder of the calendar year after your out-of-pocket expenses for services provided or arranged by the Plan reach $1,500 per Self Only enrollment or $4,500 per Self and Family enrollment. This copayment maximum does not include costs of prescription drugs, copayments for inpatient mental health benefits, copayments for dental services or copayments for durable medical equipment or orthopedic and prosthetic devices.

You should maintain accurate records of the copayments made, as it is your responsibility to determine when the copayment maximum is reached. You are assured a predictable maximum in out-of-pocket costs for covered health and medical needs. Copayments are due when service is rendered, except for emergency care.

Deductible carryover

If you changed to this Plan during open season from a plan with a deductible and the effective date of the change was after January 1, any expenses that would have applied to that plan's deductible will be covered by your old plan if they are for care you got in January before the effective date of your coverage in this Plan. If you have already met the deductible in full, your old plan will reimburse these covered expenses. If you have not met it in full, your old plan will first apply your covered expenses to satisfy the rest of the deductible and then reimburse you for any additional covered expenses. The old plan will pay these covered expenses according to this year's benefits; benefit changes are effective January 1.

Submit claims promptly

When you are required to submit a claim to this Plan for covered expenses, submit your claim promptly. The Plan will not pay benefits for claims submitted later than December 31 of the calendar year following the year in which the expense was incurred unless timely filing was prevented by administrative operations of Government or legal incapacity, provided the claim was submitted as soon as reasonably possible.

Experimental/ Investigational determinations

A service is experimental or investigational if it is: (1) not approved by the FDA; (2) the subject of a new drug or new device application on file with FDA; or (3) part of a Phase I or Phase II clinical trial, as the experimental or research arm of a Phase III clinical trial; or is intended to evaluate the safety, toxicity, or efficacy of the service; or (4) provided pursuant to a written protocol that evaluates the service's safety, toxicity, or efficacy; or (5) subject to the approval or review of an Institutional Review Board; or (6) provided pursuant to informed consent documents that describe the service as experimental or investigational. The Plan and its Medical Group carefully evaluate if a particular therapy is either proven to be safe and effective or offers a degree of promise with respect to improving health outcomes. The primary source of evidence about health outcomes of any intervention is peer-reviewed medical literature.

Other considerations

Plan providers will follow generally accepted medical practice in prescribing any course of treatment. Before you enroll in this Plan, you should determine whether you will be able to accept treatment or procedures that may be recommended by Plan providers.

The Plan's service areas

The service area for this Plan, where Plan providers and facilities are located, is described below. You must live in the service area to enroll in this Plan.

The service area for this Plan includes the following areas:

The counties of Dallas, Tarrant, and Rockwall, and portions of nine other counties as shown below:

Collin County	Kaufman County	Parker County	Johnson County
75002	75114	76008	76009
75009	75118	76082	76028
75013	75126	76086-88	76031
75023-26	75142		76033
75026	75157	Denton County	76044
75034-35	75158	75007	76058-59
75069-70	75160-61	75010	76061
75074-75		75022	76084
75078	Ellis County	75027	76087
75086	75119	75029	76097
75093-94	75120	75034-35	
75098	75125	75056-57	Hood County
75121	75152	75065	76035
75164	75154	75067-68	
75166	75165	75077	Hunt County
75173	75168	75287	75135
75189	75167	76201-08	75474
75287	76064	76226-27	
75407		76247	Wise County
75409		76249	76023
75442		76259	76071
75454		76262	76078

Benefits for care outside the service area are limited to emergency services, as described on pages 17-18.

If you or a covered family member travels frequently or lives away from home part of the year, you should be aware that benefits for care outside the service area are restricted to emergency care and care received at contracting providers in other areas of the continental United States. Contact the Plan for further details on services available from providers that have a contractual arrangement with HMO Texas, L.C. or an affiliate organization. The service area is the area within which the Plan's providers are most accessible. For this Plan, the service area is the same as the enrollment area listed on the front cover of this brochure (the area in which you must live to enroll in this Plan).

If you or a covered family member move outside the service area, you may enroll in another approved plan. It is not necessary to wait until you move or for the open season to make such a change; contact your employing office or retirement system for information if you are anticipating a move.

General Limitations

Important notice

Although a specific service may be listed as a benefit, it will be covered for you only if, in the judgment of your Plan doctor, it is medically necessary for the prevention, diagnosis, or treatment of your illness or condition. **No oral statement of any person shall modify or otherwise affect the benefits, limitations and exclusions of this brochure, convey or void any coverage, increase or reduce any benefits under this Plan or be used in the prosecution or defense of a claim under this Plan.** This brochure is based **official statement of benefits on which you can rely.**

Circumstances beyond Plan control

In the event of major disaster, epidemic, war, riot, civil insurrection, disability of a significant number of Plan providers, complete or partial destruction of facilities, or other circumstances beyond the Plan's control, the Plan will make a good faith effort to provide or arrange for covered services. However, the Plan will not be responsible for any delay or failure in providing service due to lack of available facilities or personnel.

Other sources of benefits

This section applies when you or your family members are entitled to benefits from a source other than this Plan. You must disclose information about other sources of benefits to the Plan and complete all necessary documents and authorizations requested by the Plan.

Medicare

If you or a covered family member is enrolled in this Plan and Part A and/or Part B, the Plan will coordinate benefits according to Medicare's determination of which coverage is primary. However, this Plan will not cover services, except those for emergencies, unless you use Plan providers. Generally, that is all you will need to do, unless your Plan tells you that you need to file a Medicare claim.

Group Health insurance and automobile insurance

This coordination of benefits (double coverage) provision applies when a person covered by this Plan also has, or is entitled to benefits from, any other group health coverage, or is entitled to the payment of medical and hospital costs under no-fault or other automobile insurance that pays benefits without regard to fault. Information about the other coverage must be disclosed to this Plan.

When there is double coverage for covered benefits, other than emergency services from non-Plan providers, this Plan will continue to provide its benefits in full, but is entitled to receive payment for the services and supplies provided, to the extent that they are covered by the other coverage, no-fault or other automobile insurance or any other primary plan.

One plan normally pays its benefits in full as the primary payer, and the other plan pays a reduced benefit as the secondary payer. When this Plan is the secondary payer, it will pay the lesser of (1) its benefits in full or (2) a reduced amount which, when added to the benefits payable by the other coverage, will not exceed reasonable charges. The determination of which health coverage is primary (pays its benefits first) is made according to guidelines provided by the National Association of Insurance Commissioners. When benefits are payable under automobile insurance, including no-fault, the automobile insurer is primary (pays its benefits first) if it is legally obligated to provide benefits for health care expenses without regard to other health benefits coverage the enrollee may have. This provision applies whether or not a claim is filed under the other coverage. When applicable, authorization must be given this Plan to obtain information about benefits or services available from the other coverage, or to recover overpayments from other coverages.

General Limitations *continued*

CHAMPUS

If you are covered by both this Plan and the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS), this Plan will pay benefits first. As a member of a prepaid plan, special limitations on your CHAMPUS coverage apply; your primary care provider must authorize all care. See your CHAMPUS Health Benefits Advisor if you have questions about CHAMPUS coverage.

Medicaid

If you are covered by both this Plan and Medicaid, this Plan will pay benefits first.

Workers' compensation

The Plan will not pay for services required as the result of occupational disease or injury for which any medical benefits are determined by the Office of Workers Compensation Programs (OWCP) to be payable under workers' compensation (under section 8103 of title 5, U.S.C.) or by a similar agency under another Federal or State law. This provision also applies when a third party injury settlement or other similar proceeding provides medical benefits in regard to a claim under workers' compensation or similar laws. If medical benefits provided under such laws are exhausted, this Plan will be financially responsible for services or supplies that are otherwise covered by this Plan. The Plan is entitled to be reimbursed by OWCP (or the similar agency) for services it provided that were later found to be payable by OWCP (or the agency).

DVA facilities, DoD facilities, and Indian Health Service

Facilities of the Department of Veterans Affairs, the Department of Defense, and the Indian Health Service are entitled to seek reimbursement from the Plan for certain services and supplies provided to you or a family member to the extent that reimbursement is required under the Federal statutes governing such facilities.

Other Government agencies

The Plan will not provide benefits for services and supplies paid for directly or indirectly by any other local, State, or Federal Government agency.

Liability insurance and third party actions

If a covered person is sick or injured as a result of the act or omission of another person or party, the Plan requires that it be reimbursed for the benefits provided in an amount not to exceed the amount of the recovery, or that it be subrogated to the person's rights to the extent of the benefits received under this Plan, including the right to bring suit in the person's name. If you need more information about subrogation, the Plan will provide you with its subrogation procedures.

General Exclusions

All benefits are subject to the limitations and exclusions in this brochure. **Although a specific service may be listed as a benefit, it will not be covered for you unless your Plan doctor determines it is medically necessary to prevent, diagnose or treat your illness or condition.** The following are excluded:

- Care by non-Plan doctors or hospitals except for authorized referrals or emergencies (see Emergency Benefits);
- Expenses incurred while not covered by this Plan;
- Services furnished or billed by a provider or facility barred from the FEHB Program;
- Services not required according to accepted standards of medical, dental, or psychiatric practice;
- Procedures, treatments, drugs or devices that are experimental or investigational;
- Procedures, services, drugs and supplies related to sex transformations; and
- Procedures, services, drugs and supplies related to abortion 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.

Medical and Surgical Benefits

What is covered

A comprehensive range of preventive, diagnostic and treatment services is provided by Plan doctors and other Plan providers. This includes all necessary office visits; **you pay** $5 office visit copay, but no additional copay for laboratory tests and X-rays. Within the Service Area, house calls will be provided if in the judgment of the Plan doctor such care is necessary and appropriate; **you pay** nothing for a doctor's house call and nothing for home visits by nurses and health aides.

The following services are included:

- Preventive care, including well-baby care.
- Mammograms are covered as follows: for women age 35 through 39, one mammogram during these five years; for women age 40 through 49, one mammogram every one or two years; for women age 50 through 64, one mammogram every year; and for women age 65 and above, one mammogram every two years. **You pay** nothing. In addition to routine screening, mammograms are covered when prescribed by the doctor as medically necessary to diagnose or treat your illness.
- Routine immunizations and boosters
- Visits to primary care doctors, non-physician providers and consultations with specialists
- Diagnostic procedures, such as laboratory tests and X-rays. **You pay** nothing.
- Complete obstetrical (maternity) care for all covered females, including prenatal, delivery and postnatal care by a Plan doctor. **You pay** nothing for office visits to Plan doctors for prenatal and postnatal care. Complete obstetrical (maternity) care for covered females, including all prenatal, delivery and postnatal care by a Plan doctor. The mother, at her option, may remain in the hospital up to 48 hours after a regular delivery and 96 hours after a caesarean delivery. Inpatient stays will be extended if medically necessary. If enrollment in the Plan is terminated during pregnancy, benefits will not be provided after coverage under the Plan has ended. Ordinary nursery care of the newborn child during the covered portion of the mother's hospital confinement for maternity will be covered under either a Self Only or Self and Family enrollment; other care of a newborn who requires definitive treatment will be covered only if the infant is covered under a Self and Family enrollment.
- Voluntary sterilization and family planning services. **You pay** $75 for a vasectomy and $200 for a tubal ligation
- Diagnosis and treatment of diseases of the eye
- Allergy testing and treatment (including materials)
- Insertion of internal prosthetic devices, such as pacemakers and artificial joints. **You pay** nothing.
- Cornea, heart, kidney, liver, lung (single or double), heart/lung and kidney/pancreas transplants; allogeneic (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. Related medical and hospital expenses of the donor are covered.
- Women who undergo mastectomies may, at their option, have this procedure performed on an inpatient basis and remain in the hospital up to 48 hours after the procedure.
- Dialysis at no charge
- Chemotherapy, radiation therapy, and respiratory therapy
- Surgical treatment of morbid obesity
- For homebound members residing in the service area, home health services of doctors, nurses and health aides, including intravenous fluids and medications, when prescribed by your Plan doctor, who will periodically review the program for continuing appropriateness and need
- All necessary medical or surgical care in a hospital or extended care facility from Plan doctors and other Plan providers, at no additional cost to you, except where noted

What is covered
continued

- Blood and blood products not replaced by the member. **You pay** 20% of charges. **You pay** nothing for the administration of blood and blood products, including blood processing.
- Medical management of mental health conditions, including drug therapy evaluation and maintenance
- Visits for childhood immunizations for children, from birth to the date the child is six years old. Immunizations covered under this benefit include immunizations against diphtheria, haemophilus influenza type b, hepatitis B, measles, mumps, pertussis, polio, rubella, tetanus, varicella and any other immunization that is required by law for the child; **you pay** nothing

If you do not pay any of the charges required for services at the time you receive the services, you will be billed for those charges. You will also be required to pay an administrative charge of $10 for each service for which a bill is sent.

Limited benefits

Oral and maxillofacial surgery is provided for nondental surgical and hospitalization procedures for congenital defects, such as cleft lip and cleft palate, and for medical or surgical procedures occurring within or adjacent to the oral cavity or sinuses including, but not limited to, treatment of fractures and excision of tumors and cysts. Coverage includes the treatment of TMJ disorders to cover medically necessary diagnostic or surgical treatment of conditions affecting the TM joint regardless of whether the condition results from an accident, a trauma, an inherited defect, a developmental defect or a disease. All other procedures involving the teeth or intra-oral areas surrounding the teeth are not covered, including shortening of the mandible or maxillae for cosmetic purposes, and any dental care involved in treatment of temporomandibular joint (TMJ) pain dysfunction syndrome, except as defined on page 21.

Reconstructive surgery will be provided to correct a condition resulting from a functional defect or from an injury or surgery that has produced a major effect on the member's appearance and if the condition can reasonably be expected to be corrected by such surgery.

Short-term rehabilitative therapy (physical, speech and occupational and chronic pain management) is provided on an inpatient or outpatient basis for up to two months or 30 visits, whichever is greater, per medical episode if significant improvement can be expected within two months. For physical therapy, **you pay** $5 per outpatient session and nothing per inpatient session. For speech therapy and chronic pain management therapy, **you pay** 20% of charges per inpatient or outpatient session. 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.

Medically necessary physical therapy, occupational therapy and speech therapy services will not be denied, limited or terminated and will continue to be covered provided your condition improves and you continue to meet or exceed treatment goals. If at any point in treatment, a Plan doctor determines that treatment goals will not be met, the rehabilitative services will no longer be covered and will be subject to the benefit maximums stated above. Treatment goals include recovery, restoration in function or improvement in the medical condition. Treatment goals for a physically disabled person may include maintenance of functioning or prevention of or slowing of further deterioration. For purposes of this benefit "physically disabled" means a person who is entitled to Social Security disability benefits.

Diagnosis and treatment of infertility is covered. **You pay** 50% of charges. The following types of artificial insemination are covered: intravaginal insemination (IVI), intracervical insemination (ICI), and intrauterine insemination (IUI)). **You pay** 50% of charges. Cost of donor sperm and donor eggs is not covered. Other assisted reproductive technology (ART) procedures, such as in vitro fertilization, gamete and zygote intrafallopian transfers are not covered. Infertility services are not available when either member of the family has been voluntarily surgically sterilized. Drugs related to non-covered infertility services are not covered. Drugs used for covered infertility treatments are provided under the Prescription Drug Benefit at 50% of the charge to members who do not have a prescription drug benefit.

Cardiac rehabilitation following a heart transplant; bypass surgery or a myocardial infarction is covered for up to 36 sessions per incident. Y**ou pay** $5 per session.

Limited benefits
continued

Durable medical equipment (DME), when prescribed by a Plan doctor and intended to be used repeatedly and in the home is covered. Coverage is limited to the standard item of DME in accord with the Plan's formulary guidelines, that adequately meets the medical needs of the member. **You pay** 20% of charges. **You pay** nothing for the rental or purchase of phototherapy equipment for pediatric jaundice. The following items are not covered: comfort and convenience equipment; exercise and hygiene equipment; disposable supplies, (except diabetic supplies covered under the prescription drug benefit); electronic monitors of the function of the heart or lungs (except apnea monitors for newborns), and devices to perform medical tests on blood or other bodily substances or excretions (except blood glucose monitors for diabetics); dental appliances; experimental or research equipment; devices not medical in nature such as sauna baths and elevators; modifications to the home or auto; and chiropractic appliances. The decision to rent or purchase equipment is made by the Plan.

One pair of eyeglasses or contact lenses following surgery in which the natural lens of the eye has been removed, when prescribed by a Plan doctor or other Plan provider to replace the natural lens of the eye. **You pay** 20% of charges.

Orthopedic and prosthetic devices (such as braces; artificial limbs and the first set of lenses following cataract removal where an intraocular lens was not implanted) are provided when prescribed by a Plan doctor. **You pay** 20% of the charges. Coverage is limited to rigid or semi-rigid devices that are affixed to the body externally and are required to replace a missing body organ or extremity, to support a defect in form or function, or to restrict motion of a diseased or injured body part.

Rehabilitation is provided on an inpatient or outpatient basis as part of a specialized multidisciplinary therapy program in a specialized facility for up to two months per medical episode, when in the judgment of the Plan doctor significant improvement in function is achievable within a period of two months. **You pay** nothing for inpatient care and $5 per outpatient session.

What is not covered

- Physical examinations that are not necessary for medical reasons, such as those required for obtaining or continuing employment or insurance or governmental licensing, attending school or camp, or travel
- Reversal of voluntary, surgically-induced sterility
- Surgery primarily for cosmetic purposes
- External and internally implanted hearing aids
- Foot orthotics
- Homemaker services
- Long-term rehabilitative therapy
- Chiropractic services
- Transplants not listed as covered
- Any eye surgery solely for the purpose of correcting refractive defects of the eye, such as nearsightedness (myopia), farsightedness (hyperopia) and astigmatism
- Devices, equipment, supplies and prosthetics related to the treatment of sexual dysfunction

Hospital/Extended Care Benefits

What is covered

Hospital care

The Plan provides a comprehensive range of benefits with no dollar or day limit when you are hospitalized under the care of a Plan doctor. **You pay** nothing. All necessary services are covered, including:

- Semiprivate room accommodations; when a Plan doctor determines it is medically necessary, the doctor may prescribe private accommodations or private duty nursing care
- Specialized care units, such as intensive care or cardiac care units

Extended care

The Plan provides a comprehensive range of benefits for up to 100 days per calendar year when full-time skilled nursing care is necessary and confinement in a skilled nursing facility is medically appropriate as determined by a Plan doctor. **You pay** nothing. All necessary services are covered, including:

- Bed, board and general nursing care
- Prescribed drugs and their administration, biologicals, supplies, and equipment ordinarily provided or arranged by the skilled nursing facility when prescribed by a Plan doctor.

Hospice care

Supportive and palliative care for a terminally ill member is covered in the home. **You pay** nothing. Services include outpatient care and family counseling. These services are provided under the direction of a Plan doctor who certifies that the patient is in the terminal stages of illness, with a life expectancy of approximately six months or less.

Ambulance service

Benefits are provided for ambulance transportation ordered or authorized by a Plan doctor. **You pay** $50 per ambulance trip.

Limited benefits

Inpatient dental procedures

Hospitalization for certain dental procedures is covered when a Plan doctor determines there is a need for hospitalization for reasons totally unrelated to the dental procedure; the Plan will cover the hospitalization, but not the cost of the professional dental services. Conditions for which hospitalization would be covered include hemophilia and heart disease; the need for anesthesia, by itself, is not such a condition.

Acute inpatient detoxification

Hospitalization for medical treatment of substance abuse is limited to emergency care, diagnosis, treatment of medical conditions, and medical management of withdrawal symptoms (acute detoxification) if the Plan doctor determines that outpatient management is not medically appropriate. See page 19 for nonmedical substance abuse benefits.

What is not covered

- Personal comfort items, such as telephone and television
- Custodial care or care in an intermediate care facility

Emergency Benefits

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 attention. 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 the Plan may determine are medical emergencies – what they all have in common is the need for quick action.

Emergencies within the service area

If you are in an emergency situation, please call the Plan's Medical Advice phone number: 972/680-9913 in Dallas or (metro) 972/263-3131 in Fort Worth.

In extreme emergencies, if you are unable to contact your Plan facility, contact the local emergency system (e.g., the 911 telephone system) or go to the nearest hospital emergency room. Be sure to tell the emergency room personnel that you are a Plan member so they can notify the Plan. 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.

If you need to be hospitalized in a non-Plan facility, the Plan must be notified within 48 hours or on the first working day following your admission, unless it was not reasonably possible to notify the Plan within that time. If you are hospitalized in non-Plan facilities and Plan doctors believe care can be better provided in a Plan hospital, you will be transferred when medically feasible with any ambulance charges covered in full.

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

To be covered by this Plan, any follow-up care recommended by non-Plan providers must be approved by the Plan or provided by Plan providers.

Plan pays…

Reasonable charges for emergency services to the extent the services would have been covered if received from Plan providers.

You pay...

$50 per hospital emergency room visit or urgent care center visit for emergency services that are covered benefits of this Plan (waived if the emergency care services include admission to a hospital), plus any copayments (other than office visit copayments) which would have been required if the care had been rendered by the Plan.

Emergencies outside the service area

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

If you need to be hospitalized, the Plan must be notified within 48 hours or on the first working day following your admission, unless it was not reasonably possible to notify the Plan within that time. If a Plan doctor believes care can be better provided in a Plan hospital, you will be transferred when medically feasible with any ambulance charges covered in full.

To be covered by this Plan, any follow-up care recommended by non-Plan providers must be approved by the Plan or provided by Plan providers.

Plan pays…

Reasonable charges for emergency services to the extent the services would have been covered if received from Plan providers.

You pay...

$50 per hospital emergency room visit or urgent care center visit for emergency services that are covered benefits of this Plan (waived if the emergency care services include admission to a hospital), plus any copaymentss (other than office visit copayments) which would have been required if the care had been rendered by the Plan.

Emergency Benefits *continued*

What is covered

- Emergency care at a doctor's office or an urgent care center
- Emergency care as an outpatient or inpatient at a hospital, including doctors' services
- Ambulance service approved by the Plan; **You pay** $50 per ambulance trip

What is not covered

- Elective care or nonemergency 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

Filing claims for non-Plan providers

With your authorization, the Plan will pay benefits directly to the providers of your emergency care upon receipt of their claims. Physician claims should be submitted on the HCFA 1500 claim form. Submit claims to HMO Texas, L.C., Claims Department, P.O. Box 741508, Dallas, Texas 75374-1508. If you are required to pay for the services, submit itemized bills and your receipts to the Plan along with an explanation of the services and the identification information from your ID card.

Payment will be sent to you (or the provider if you did not pay the bill), unless the claim is denied. If it is denied, you will receive notice of the decision, including the reasons for the denial and the provisions of the contract on which denial was based. If you disagree with the Plan's decision, you may request reconsideration in accordance with the disputed claims procedure described on page 23.

Mental Conditions/Substance Abuse Benefits

Mental Conditions

What is covered

To the extent shown below, the Plan provides the following services necessary for the diagnosis and treatment of acute psychiatric conditions, including the treatment of mental illness or disorders:

- Diagnostic evaluation
- Psychiatric treatment (including individual and group therapy)
- Medical management visits, including drug evaluation and maintenance. **You pay $5** per visit. (These visits are not charged as mental health outpatient visits.)
- Hospitalization (including inpatient professional services)

Outpatient care

Up to 30 outpatient visits to Plan doctors, consultants, or other psychiatric personnel each calendar year. **You pay** $5 for each covered visit—all charges thereafter.

Inpatient care

Up to 30 days of hospitalization each calendar year (less 1 day for each 2 sessions of day or night care). **You pay** $25 per covered day of hospitalization—all charges thereafter.

Day and night care

If, in the professional judgement of a Plan doctor, a member would benefit from day care or night care services, up to 60 sessions of such prescribed care are provided each calendar year. You pay $25 per session. However, the number of such sessions is reduced by two for each day of hospitalization for inpatient Mental Conditions services received during the calendar year. Day and night care sessions, of no less than four and no more than 12 hour duration, are provided in a hospital-based or residential program. Such care includes all services of Plan doctors and mental health professionals. In addition, the following services and supplies prescribed by a Plan doctor are covered: room and board, psychiatric nursing care, group therapy, drugs and medical supplies.

If you do not pay any of the charges required for services at the time you receive the services, you will be billed for those charges. You will also be required to pay an administrative charge of $10 for each service for which a bill is sent.

Mental Conditions/Substance Abuse Benefits *continued*

What is not covered

- Care for psychiatric conditions which in the professional judgment of Plan doctors are not subject to significant improvement through relatively short-term treatment
- Psychiatric evaluation or therapy on court order or as a condition of parole or probation, unless determined by a Plan doctor to be necessary and appropriate
- Psychological testing, except when needed as part of a medical evaluation

Serious mental illness

Coverage is provided for the medically necessary care, diagnosis, and treatment of serious mental illnesses. "Serious mental illness" means the following psychiatric illnesses as defined by the American Psychiatric Association in the Diagnostic and Statistical Manual (DSM):

- schizophrenia;
- paranoid and other psychotic disorders;
- bipolar disorders (hypomanic, manic, depressive, and mixed);
- major depressive disorders (single episode or recurrent);
- schizo-affective disorders (bipolar or depressive);
- pervasive developmental disorders; and
- obsessive-compulsive disorders; and
- depression in childhood and adolescence.

Outpatient care

Up to 60 outpatient visits to Plan doctors, consultants or other psychiatric personnel each calendar year. **You pay** $5 for each covered visit - all charges thereafter. An outpatient visit for the purpose of medication management does not count toward this 60 visit limit. **You pay** $5 for each covered visit for medication management.

Inpatient care

Up to 45 days of inpatient treatment each calendar year. **You pay** nothing.

Substance abuse

What is covered

This Plan provides medical and hospital services such as acute detoxification services for the medical, non-psychiatric aspects of substance abuse, including alcoholism and drug addiction, the same as for any other illness or condition. In addition, the Plan provides all necessary inpatient and outpatient rehabilitation and counseling services for the treatment of substance abuse, including treatment in an approved chemical dependency treatment center. **You pay** $5 per outpatient visit and nothing for inpatient care.

If you do not pay any of the charges required for services at the time you receive the services, you will be billed for those charges. You will also be required to pay an administrative charge of $10 for each service for which a bill is sent.

What is not covered

- Treatment which is not authorized by a Plan doctor
- All charges if the member does not complete the substance abuse treatment program
- Substance abuse treatment on court order or as a condition of parole or probation, unless determined by a Plan doctor to be necessary and appropriate

Prescription Drug Benefits

What is covered

Prescription drugs prescribed by your Plan doctors or dentist and obtained at a Plan pharmacy will be dispensed for up to a 30-day supply. Outpatient maintenance prescription drugs prescribed by your Plan doctor or dentist and obtained through Plan prescription mail order services will be dispensed for up to a 60-day supply. **You pay** $5 per prescription unit or refill. It may be possible for you to receive refills by mail at no extra charge. Delivery may be made available at an additional charge. Ask for details at a Plan pharmacy.

The Plan uses a formulary to determine which prescribed drugs will be provided to members. If the doctor or dentist specifically prescribes a non-formulary drug, and does not prescribe a substitution, the nonformulary drug will be covered. If you request the nonformulary drug when your doctor or dentist has prescribed a substitution, the nonformulary drug is not covered. However, you may purchase the nonformulary drug from a Plan pharmacy at prices charged to members for non-covered drugs.

The following drugs are provided at the $5 charge (unless another charge is specifically identified):

- Drugs for which a prescription is required by law, except that non prescriptive oral agents for controlling blood sugar are covered.
- Oral contraceptive drugs
- Implanted time-release drugs. For Norplant, **you pay** a one-time charge of $200. For other internally-implanted time-release drugs, **you pay** a one-time payment equal to $5 per prescription times the expected number of months the drug will be effective, not to exceed $200. There will be no refund of any portion of these payments if the drug is removed before the end of its expected life.
- Injectable contraceptive drugs (in the doctor's office or hospital). **You pay** a one-time payment equal to the $5 per prescription times the expected number of months the medication will be effective, not to exceed $200.
- Contraceptive diaphragms and intrauterine devices. **You pay** 50% of the charges per device.
- Insulin and insulin analogs
- Diabetic supplies, limited to disposable insulin syringes and needles, glucose monitoring test strips, lancets and lancet devices, injection aids, glucagon emergency kits
- Disposable needles and syringes needed for injecting covered prescribed medications
- Amino acid modified products used in the treatment of inborn errors of amino acid metabolism (PKU)
- Intravenous fluids and medication for home use, some implantable drugs, and some injectable drugs are covered under Medical and Surgical Benefits.

Limited Benefits

Drugs to treat sexual dysfunction have dispensing limitations. Contact the Plan for details. You pay 50% of charges.

If you do not pay any of the charges required for services at the time you receive the services, you will be billed for those charges. You will also be required to pay an administrative charge of $10 for each service for which a bill is sent.

What is not covered

- Drugs available without a prescription or for which there is a nonprescription equivalent available
- Drugs obtained at a non-designated pharmacy except for out-of-Plan emergencies
- Vitamins and nutritional substances which can be purchased without a prescription
- Medical supplies such as dressings and antiseptics
- Contraceptive devices (except diaphragms and intrauterine devices)
- Drugs for cosmetic purposes
- Drugs to enhance athletic performance
- Smoking cessation drugs and medication
- Drugs for non-covered services

Special Benefits for Medicare Eligible Enrollees

If you are enrolled in this Plan through FEHBP, have Medicare Part A coverage and have purchased Part B coverage, you may also enroll in the HMO Texas, L.C. Golden Choice program.

The Golden Choice plan provides all Medicare covered Part A and Part B benefits to the Medicare beneficiary, as well as some benefits not covered by Medicare. It is an arrangement between Medicare and this Plan in which Medicare pays a specific amount to this plan for each Medicare beneficiary who enrolls in the Plan.

Like your FEHBP enrollment in this Plan, you are required to obtain your services from this Plan's doctors and providers, except for emergencies and out-of-area urgent care. The rules regarding enrollment in Golden Choice are fully explained in the Plan's Evidence of Coverage. For a copy of these rules, please contact Customer Service at 972/479-0332, (metro) 972/263-4830 or 1-800/324-8527.

Following your enrollment in Golden Choice, you will be entitled to receive an enhanced benefits package that combines your FEHBP coverage with your Golden Choice benefits.

If you choose to enroll in Golden Choice, you will be responsible for paying the Part B premium. You must make an affirmative enrollment in Golden Choice. Information regarding enrollment and disenrollment rules may be found in the Evidence of Coverage for Golden Choice Federal Members. You will also continue to pay the employee share of the FEHBP premium.

Other Benefits

Dental Care

What is covered

The following dental services are covered when provided by participating Plan dentists. You are limited to two visits per calendar year for any combination of the five preventive and diagnostic services listed below. **You pay** $5 per visit, except where noted:

- Oral examinations; **you pay** an additional $15 per emergency oral examination
- Dental prophylaxis (cleaning). **You pay** an additional $5 per visit.
- Topical application of fluoride
- Bitewing X-rays (no more than one set every six months)
- Full mouth series X-ray as reasonable and necessary for dental diagnosis and treatment
- Emergency dental services received outside of the service area. **You pay** an additional $25 per emergency visit

In addition, you receive a 15% discount on the dental services that are listed on the schedule of dental benefits, which can be obtained from the Plan.

What is not covered

- Cosmetic dental services
- Replacement of lost or stolen dentures; appliances or bridgework
- Nonemergency care received from non-Plan dentists or nonemergency care received outside of the service area

Vision Care

What is covered

In addition to the medical and surgical benefits provided for diagnosis and treatment of diseases of the eye, annual eye refractions (to provide a written lens prescription for eyeglasses) may be obtained from Plan providers. **You pay** $5 per visit.

What is not covered

- Examinations for fitting of or prescriptions for contact lenses
- Corrective eyeglasses and frames or contact lenses, except as provided on page 15 under Limited Benefits
- Eye exercises, except for patients for whom amblyopia or strabismus is a concurrent diagnosis

Non-FEHB Benefits Available to Plan Members

The benefits described on this page are neither offered nor guaranteed under the contract with the FEHB Program, but are available to all enrollees and family members who are members of this Plan. The cost of the benefits described on this page is not included in the FEHB premium and any charges for these services do not count toward any FEHB deductibles, or out-of-pocket maximum. These benefits are not subject to the FEHB disputed claims procedures.

Vision Care Service

Optical Fee Schedule

Contact Lenses (materials only) . . . . . .20% Discount
(excludes disposable/programmed replacement lenses, fit and follow-up, professional services and prepaid service agreements)

Real Value (featuring everyday low package prices) . . . . . .10% Discount

- Complete pair of glasses (frames and lenses)
- Choose from selection of over 350 frames

Single vision . . . . . .starting at $59.00
Bifocal (FT 28) . . . . . .starting at $89.00
Trifocal (7 x 28) . . . . . .starting at $119.00

Frames, Lenses and Lens Options * . . . . . .33% Discount

- Choose from over 2,000 frames, including the latest in designer brands.
- Choose from the latest technology in lenses including thinner and lighter Hi-index lenses and anti-reflective coatings.

* Excludes package priced collection.

Knockabouts & *No Rules* Collection . . . . . .15% Discount

- Eye Care Centers of America policy is to provide eyewear for all school age children and young adults that only include impact-resistant polycarbonate lenses for maximum eye protection. Therefore, all *Knockabout* frames are priced to include vision polycarbonate lenses.
- All *Knockabout* glasses have built-in ultra violet protection, scratch resistant coating and are guaranteed for one year against scratches and breakage.
- Choose from a selection of over 175 frames. Featuring everyday low package prices starting at $87.00

Non-Rx Sunglasses & Accessories . . . . . .20% Discount

Additional Items Not Listed Above . . . . . .20% Discount

You must receive services from participating EyeMasters optical facilities listed in your provider directory. There is no premium charge for this benefit.

How to Obtain Benefits

Questions

If you have a question concerning Plan benefits or how to arrange for care, contact the Plan's Customer Service Department at 972/479-0332, (metro) 972/263-4830, 1-800/324-8527, or 972/263-1732 TDD or you may write to them at 12720 Hillcrest Road, Suite 600, Dallas, Texas 75230.

Disputed claims review

Plan reconsideration

If a claim for payment or services is denied by the Plan, you must ask the Plan, in writing and within six months of the date of the denial, to reconsider its denial before you request a review by OPM. (This time limit may be extended if you show you were prevented by circumstances beyond your control from making your request within the time limit.) OPM will not review your request unless you demonstrate that you gave the Plan an opportunity to reconsider your claim. Your written request to the Plan must state why, based on specific benefit provisions in this brochure, you believe the denied claim for payment or service should have been paid or provided.

Within 30 days after receipt of your request for reconsideration, the Plan must affirm the denial in writing to you, pay the claim, provide the service, or request additional information reasonably necessary to make a determination. If the Plan asks a provider for information it will send you a copy of this request at the same time. The Plan has 30 days after receiving the information to give its decision. If this information is not supplied within 60 days, the Plan will base its decision on the information it has on hand.

OPM review

If the Plan affirms its denial, you have the right to request a review by OPM to determine whether the Plan's actions are in accordance with the terms of its contract. You must request the review within 90 days after the date of the Plan's letter affirming its initial denial.

You may also ask OPM for a review if the Plan fails to respond within 30 days of your written request for reconsideration or 30 days after you have supplied additional information to the Plan. In this case, OPM must receive a request for review within 120 days of your request to the Plan for reconsideration or of the date you were notified that the Plan needed additional information, either from you or from your doctor or hospital.

This right is available only to you or the executor of a deceased claimant's estate. Providers, legal counsel, and other interested parties may act as your representative only with your specific written consent to pursue payment of the disputed claim. OPM must receive a copy of your written consent with their request for review.

Your written request for an OPM review must state why, based on specific benefit provisions in this brochure, you believe the denied claim for payment or service should have been paid or provided. If the Plan has reconsidered and denied more than one unrelated claim, clearly identify the documents for each claim.

Your request must include the following information or it will be returned by OPM:

• A copy of your letter to the Plan requesting reconsideration;

• A copy of the Plan's reconsideration decision (if the Plan failed to respond, provide instead (a) the date of your request to the Plan or (b) the dates the Plan requested and you provided additional information to the Plan);

• Copies of documents that support your claim, such as doctors' letters, operative reports, bills, medical records, and explanation of benefit (EOB) forms; and

• Your daytime phone number.

Medical documentation received from you or the Plan during the review process becomes a permanent part of the disputed claim file, subject to the provisions of the Freedom of Information Act and the Privacy Act.

Send your request for review to: Office of Personnel Management, Office of Insurance Programs, Contracts Division III, P.O. Box 436, Washington, DC 20044.

OPM review continued

You (or a person acting on your behalf) may not bring a lawsuit to recover benefits on a claim for treatment, services, supplies or drugs covered by this Plan until you have exhausted the OPM review procedure, established at section 890.105, title 5, Code of Federal Regulations (CFR). If OPM upholds the Plan's decision on your claim, and you decide to bring a lawsuit based on the denial, the lawsuit must be brought no later than December 31 of the third year after the year in which the services or supplies upon which the claim is predicated were provided. Pursuant to section 890.107, title 5, CFR, such a lawsuit must be brought against the Office of Personnel Management in Federal court.

Federal law exclusively governs all claims for relief in a lawsuit that relates to this Plan's benefits or coverage or payments with respect to those benefits. Judicial action on such claims is limited to the record that was before OPM when it rendered its decision affirming the Plan's denial of the benefit. The recovery in such a suit is limited to the amount of benefits in dispute.

Privacy Act statement – If you ask OPM to review a denial of a claim for payment or service, OPM is authorized by chapter 89 of title 5, U.S.C., to use the information collected from you and the Plan to determine if the Plan has acted properly in denying you the payment or service, and the information so collected may be disclosed to you and/or the Plan in support of OPM's decision on the disputed claim.

How HMO Texas, L.C. Changes January 1999

Do not rely on this page; it is not an official statement of benefits.

Program-wide changes

Several changes have been made to comply with the President's mandate to implement the recommendations of the Patient Bill of Rights.

Women may see their Plan gynecologist for their annual routine examination without a referral from their primary care doctor. See page 8.

If you have a chronic, complex, or serious medical condition that causes you to frequently see a Plan specialist, your primary care doctor will develop a treatment plan with you and your health plan that allows an adequate number of direct access visits with that specialist, without the need to obtain further referrals. See page 8 for details.

A medical emergency is defined as 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. See page 17.

The medical management of certain mental conditions will be covered under this Plan's Medical and Surgical Benefits provisions. Related drug costs will be covered under this Plan's Prescription Drug Benefits, and any costs for psychological testing or psychotherapy will be covered under this Plan's Mental Conditions Benefits. Office visits for the medical aspects of treatment do not count toward the outpatient Mental Conditions visit limit.

Changes to this Plan

If you do not pay any of the charges required for services at the time you receive the services, you will be billed for those charges. You will also be required to pay an administrative charge of $10 for each service for which a bill is sent.

There is no office visit charge for certain immunizations for children from birth to the date the child is six years old. See page 14.

The per visit charge for chronic pain management therapy is now 20% of charges. Previously, the per visit charge was $5. See page 14.

Devices, equipment, supplies and prosthetics related to the treatment of sexual dysfunction are not covered. See page 15.

Coverage of oral and maxillofacial surgery has been expanded to include treatment of conditions affecting the temporomandibular joint, including medically necessary diagnostic or surgical treatment of conditions affecting th TM joint regardless of whether the condition results from an accident, a trauma, an inherited defect, a developmental defect or a disease. See page 14.

Coverage limitations for treatment of short-term rehabilitative therapy, specifically physical therapy, speech therapy and occupational therapy, have been modified to two months or 30 visits, whichever is greater, per medical episode and to allow for continued coverage if your condition improves and you continue to meet or exceed treatment goals. See page 14.

Prescription drug benefits now include coverage for additional drugs and supplies for diabetic care, such as nonprescriptive oral agents for controlling blood sugar, lancets and lancet devices, injection aids and glucagon emergency kits. See page 20.

Drugs to treat sexual dysfunction are covered under the Prescription Drug Benefit. See page 20.

Federal annuitants with Part A and B of Medicare may enroll in this Plan's Golden Choice Program. See page 21.

Summary of Benefits for HMO Texas, L.C. - 1999

Do not rely on this chart alone. All benefits are provided in full unless otherwise indicated subject to the limitations and exclusions set forth in the brochure. This chart merely summarizes certain important expenses covered by the Plan. If you wish to enroll or change your enrollment in this Plan, be sure to indicate the correct enrollment code on your enrollment form (codes appear on the cover of this brochure). **ALL SERVICES COVERED UNDER THIS PLAN, WITH THE EXCEPTION OF EMERGENCY CARE, ARE COVERED ONLY WHEN PROVIDED OR ARRANGED BY PLAN DOCTORS.**

	Benefits	Plan pays/provides	Page
Inpatient care	**Hospital**	Comprehensive range of medical and surgical services without dollar or day limit. Includes in-hospital doctor care, room and board, general nursing care, private room and private nursing care if medically necessary, diagnostic tests, drugs and medical supplies, use of operating room, intensive care and complete maternity care. **You pay** nothing	16
	Extended Care	All necessary services, up to 100 days each calendar year. **You pay** nothing	16
	Mental Conditions	Diagnosis and treatment of acute psychiatric conditions for up to 30 days of inpatient care per year. **You pay** $25 per day	18
	Serious Mental illness	Treatment for serious mental illnesses is provided for up to 45 days of inpatient care per calendar year. **You pay** nothing	19
	Substance Abuse	Treatment for substance abuse in a chemical dependency treatment center. Treatment for medical aspects and detoxification provided under hospital benefits. No dollar or day limit. **You pay** nothing	19
Outpatient care		Comprehensive range of services such as diagnosis and treatment of illness or injury, including specialist's care; preventive care, including well-baby care, periodic check-ups and routine immunizations; laboratory tests and X-rays; complete maternity care. **You pay** $5 per office visit. **You pay** nothing for laboratory and X-rays, childhood immunizations, prenatal and postnatal office visits and nothing per house call by a doctor	13,14
	Home Health Care	All necessary visits by nurses and health aides. **You pay** nothing	16
	Mental Conditions	Up to 30 outpatient visits per year. **You pay** $5 per visit	18
	Serious Mental Illness	Treatment for serious mental illnesses is provided for up to 60 outpatient visits per calendar year. **You pay** $5 per visit	19
	Substance Abuse	All necessary outpatient visits for treatment of substance abuse including treatment in a chemical dependency treatment center. **You pay** $5 per visit	19
Emergency care		Reasonable charges for services and supplies required because of a medical emergency. **You pay** $50 (waived if admitted to a hospital) for each emergency visit to a non-Plan provider, any copays (other than office visit copays) which would have been paid to the Plan and any charges for services that are not covered benefits of this Plan	17,18
Prescription drugs		Drugs prescribed by a Plan doctor or participating or participating dentist and obtained at a Plan pharmacy or through mail order services. **You pay $5** per prescription unit or refill.	20
Dental care		Preventive and diagnostic services. **You pay** copays for these services	21
Vision care		One refraction annually, including eyeglass lens prescription. **You pay** $5 per visit	21
Out-of-pocket limit		Copayments are required for a few benefits; however, after your out-of-pocket expenses reach a maximum of $1,500 per Self Only or $4,500 per Self and Family enrollment per calendar year, covered benefits will be provided at 100%. This copay maximum does not include prescription drugs, inpatient mental conditions benefits, dental services, durable medical equipment benefits, or orthopedic and prosthetic device benefits	9

Notes

1999 Rate Information for HMO Texas, L.C.

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 most career U.S. Postal Service employees, but do not apply to non-career Postal employees, Postal retirees, certain special Postal employment categories or associate members of any Postal employee organization. If you are in a special Postal employment category, refer to the FEHB Guide for that category.

		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
Self Only	UK1	$60.77	$20.25	$131.66	$43.88	$71.91	$9.11
Self and Family	UK2	$150.08	$50.03	$325.18	$108.39	$177.60	$22.51