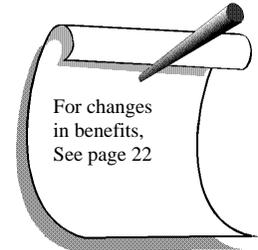


A Health Maintenance Organization



Serving: Philadelphia and seven adjacent counties in Southeastern Pennsylvania and New Jersey.
Enrollment in this plan is limited; see page 9 for requirements

Enrollment Code: 271 Self Only
272 Self and Family

Serving: Scranton Wilkes-Barre area

Enrollment Code: 2K1 Self Only
2K2 Self and Family

Visit the OPM website at <http://www.opm.gov/insure> or the Plan's website at <http://www.qualmed.com>.



United States
Office of
Personnel
Management



QualMed Plans for Health

QualMed Plans for Health, Inc., 11 Penn Center, 1835 Market Street, Philadelphia, PA 19103, has entered into a contract (CS 1743) 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 QualMed Plans for Health, Inc., or the Plan.

This brochure is based on text certified by OPM and is intended to be a complete statement of benefits available to FEHB members. A person enrolled in the Plan is entitled to the benefits stated in this brochure. However, if conflicts are discovered between the provisions of this brochure and the certified text of the brochure, the certified text will control. 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 22 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 800/736-2096 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
202/418-3300**

The Office of Personnel Management
Office of the Inspector General Fraud Hotline
1900 E Street, NW, 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 page 15.** 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 except as stated in any cosmetic surgery or dental benefits description in this brochure

General Information *continued*

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) option 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 member 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.

General Information *continued*

- 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. 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 non-group 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 non-payment of premium), they are entitled to another free 31-day extension of coverage when they may convert to non-group coverage.

General Information *continued*

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.

Notification and election requirements

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 non-payment of premium), you may be eligible to convert to an individual, non-group 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 Credible Coverage

Under Federal law, if you lose coverage under the FEHB Program, you should automatically receive a Certificate of Group Health Plan Coverage Certificate from the last FEHB Plan to cover you. This certificate, along with any certificates you receive from other FEHB Plans you may have been enrolled in, may reduce or eliminate the length of time a pre-existing 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 QualMed Plans for Health

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 the Plan providers except during a medical emergency. **Members are required to select a personal doctor from among participating Plan-contracted primary care doctors.** Services of a specialty care doctor can only be received by referral from the selected primary care doctor and approved by the plan. There are no claim forms when Plan-contracted doctors are used.

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 emphasizes 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 do not receive information about this plan, you can obtain it by calling the carrier at 1-800-998-2840. Or you may write the Plan.

- Disenrollment rates for 1998
- Compliance with state and Federal licensing or certification requirements and the dates met. If non-compliant, the reason for non-compliance
- Accreditations by recognized accrediting agencies and the dates received.
- Carrier's type of corporate form and dates received.
- Whether the carrier meets state, Federal, and accreditation requirements for fiscal solvency, confidentiality, and transfer of medical records

Who provides care to Plan members?

QualMed Plans for Health arranges for the provision of services through contracted doctors, nurse practitioners, physician assistants, and other skilled medical personnel at participating medical centers or offices. Your medical records will be maintained at the Plan medical office of your choice and your primary health care will be provided, by appointment, at that office. Except for emergencies, all care must be provided by or arranged for you through the primary care physician that you choose.

Role of a primary care doctor

The first and most important decision each member must make is the selection of a primary care doctor. The decision is important since 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-contracted providers and non-Plan-contracted providers are covered only when there has been a referral by the member's primary care doctor, and approved by the Plan, with the following exceptions: A woman may visit her participating gynecologist twice a year for routine gynecologic checkups.

Choosing your doctor

The Plan's provider directory lists primary care doctors (family practitioners, pediatricians and internists) 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 Member Services Department at 1-800/736-2096. You can also find out if your doctor participates with this Plan, and is accepting new patients, by calling this number or by browsing the Plan's website at www.qualmed.com/pa. 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 you've selected for you and each member of your family by sending a selection form to the Plan. If you need help choosing a doctor, call the Plan. Members may change their doctor selection by notifying the Plan 30 days in advance.

In the event a member is 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 a participating doctor.

Facts about QualMed Plans for Health *continued*

Referrals for specialty care

Except in a medical emergency, or when a primary care doctor has designated another doctor to see his or her patients, you must receive a referral from your primary care doctor before seeing any other doctor or obtaining special services. Referral to a participating specialist is given at the primary care doctor's discretion and must be approved by the Plan; if non-Plan-contracted specialists or consultants are required, the Plan will make arrangements for appropriate referrals. For subsequent specialty care, the contracted specialist or consultant will obtain the necessary authorizations.

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

Authorizations

Your treating physician must obtain authorization from the Plan before you may be hospitalized or referred for specialty care. Follow-up care from a specialist must be approved by the Plan upon request of the specialist.

For new members

If you are already in 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 the doctor who originally referred you to this specialist prior to your joining this Plan is now your primary care doctor, you need only to call to explain that you are now Plan member and ask for a referral form to schedule an appointment with the specialist. If you are selecting a new primary care doctor, you must first schedule an appointment with this doctor so that he or she can decide whether to treat the condition directly or refer you to a specialist.

If you are selecting a new primary care doctor, you must schedule an appointment so the primary care doctor can decide whether to treat the condition directly or refer you back to the 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 \$500 per Self-Only enrollment or \$1,250 per Self and Family enrollment. This copayment maximum does not include charges for prescription drugs.

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.

Facts about QualMed Plans for Health *continued*

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

The following describes this Plan's criteria for determining when a medical treatment or procedure, or a drug, device, or biological product is experimental or investigational:

As determined by the PLAN a drug, device medical treatment or procedure is experimental or investigational: (i) if the drug or device cannot be lawfully marketed without the approval of the U.S. Food and Drug Administration and approval for marketing has not been given at the time the drug or device is furnished; or (ii) if the drug, device, medical treatment or procedure, or the patient informed consent document utilized with the drug, device, treatment or procedure, was reviewed and approved by the treating facility's Institutional Review Board or other body serving a similar function, or if federal law requires such review and approval; or (iii) if Reliable Evidence shows that the drug, device, medical treatment or procedure is the subject of on-going phase I and phase II clinical trials, is the research, experimental study or investigational arm of on-going phase III clinical trials, or is otherwise under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy compared with a standard means of treatment or diagnosis; or (iv) if Reliable Evidence shows that the prevailing opinion among experts regarding the drug, device, medical treatment or procedure is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis. As used here Reliable Evidence shall mean, only as determined by the PLAN, published reports and articles in the authoritative medical and scientific literature; the written protocol or protocols used by the treating facility or the protocols(s) of another facility studying substantially the same drug, device, medical treatment or procedure; or the written informed consent used by the treating facility or by another facility studying substantially the same drug, device, medical treatment or procedure.

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

Services from Plan are available only in the following areas: The *Pennsylvania* counties of Bucks, Chester, Delaware, Lackawanna, Luzerne, Montgomery and Philadelphia, and the *New Jersey* counties of Camden, Burlington and Gloucester. You must live or work in the service area to enroll in this plan. Benefits for care outside the service area are limited to emergency services, as described on page 14.

If you or a covered family member move outside the enrollment 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-contracted 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 the 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, Part B, or Parts A and B of Medicare, benefits will be coordinated with Medicare 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. You must tell your Plan that you or your family member is eligible for Medicare. Generally, this is all you 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 no-fault automobile insurance, including no-fault, the no-fault 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.

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 provider must authorize all care. See your CHAMPUS Health Benefits Advisor if you have questions about CHAMPUS coverage.

General Limitations *continued*

Medicaid

If both this Plan and Medicaid cover you, 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.

General Exclusions

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.

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 abortions except when the life of the mother would be endangered if the fetus were carried to term or when the pregnancy is the result of an act of rape or incest.

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

A \$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 judgement of the Plan doctor, such care is necessary and appropriate.

You pay

A \$0 copay for a house call by a doctor and \$0 for home visits by nurses and health aides. Plan doctors also provide all necessary medical or surgical care in a hospital or extended care facility, at no additional cost to you.

The following services are included and are subject to the office visit copay unless stated otherwise:

- Preventive care, including well-baby care and periodic check-ups
- Routine immunizations and boosters (except for travel and conditions of employment)
- Consultations by specialists
- Diagnostic procedures, such as laboratory tests and X-rays
- Complete obstetrical (maternity) care for all covered females, including prenatal, delivery and postnatal care by a Plan doctor or nurse midwife. 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 an infant who requires definitive treatment will be covered only if the infant is covered under a Self and Family enrollment.
- Voluntary sterilization (**you pay** a \$100 copayment for sterilization) and family planning services
- Diagnosis and treatment of diseases of the eye
- Surgical treatment of morbid obesity
- Allergy testing and treatment, including test and treatment materials (such as allergy serum)
- The insertion of internal prosthetic devices, such as pacemakers and artificial joints, including the cost of the device; implantable drugs. Dental implants are not covered.
- Cornea, heart, kidney, kidney/pancreas, and liver transplants; allogenic (donor) bone marrow transplants; autologous bone marrow transplants as medically indicated. Transplants are covered when approved by the Plan Medical Director. Related medical and hospital expenses of the donor are covered when the recipient is covered by the Plan.
- Dialysis
- Chemotherapy and radiation therapy and inhalation therapy
- Home health services of nurses and home health aides, including intravenous fluids and medications, when in lieu of hospitalization and 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.

CARE MUST BE RECEIVED FROM OR ARRANGED BY PLAN CONTRACTED DOCTORS.

Medical and Surgical Benefit *continued*

Limited benefits

Oral and maxillofacial surgery is provided for non-dental 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. All other procedures, except the extraction of bony impacted wisdom teeth, involving the teeth or areas surrounding the teeth are not covered. Procedures for cosmetic purposes including shortening of the mandible or maxillae, correction of malocclusion, and any dental care involved in treatment of temporomandibular joint (TMJ) pain dysfunction syndrome are not covered.

Reconstructive surgery will be provided to correct serious disfigurement or deformity resulting from illness or injury sustained by a member while enrolled in the Plan; or the medically necessary care and treatment of medically necessary diagnosed congenital defects and birth abnormalities. Reconstructive surgery must be prior-authorized by the Plan

Short-term rehabilitative therapy (physical, speech and occupational) is provided on an inpatient or outpatient basis for up to two months per condition if significant improvement can be expected within two months; **you pay** nothing. Inpatient services require prior-authorization. Speech therapy is limited to treatment of certain speech impairments of organic origin but not developmental in nature. 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.

Diagnosis and treatment of infertility is covered; **you pay** nothing for the initial evaluation and 50% of professional and facility costs as contracted by the Plan after the initial evaluation. Artificial insemination is covered; **you pay** 50% of the cost limited to six cycles. Cost of donor sperm is not covered. Fertility drugs are not covered. Other assisted reproductive technology (ART) procedures, such as in vitro fertilization and embryo transfer, are not covered.

For external prosthetic devices, such as artificial limbs, **you pay** a \$100 deductible per calendar year.

Durable medical equipment, **you pay** a \$100 deductible per calendar year (subject to \$25,000 lifetime maximum).

What is not covered

- Physical examinations that are not necessary for medical reasons, such as those required for obtaining or continuing employment or insurance, attending school or camp, or travel
- Orthopedic devices, such as permanent braces and foot orthotics except to correct for missing portions
- Reversal of voluntary, surgically-induced sterility
- Plastic surgery primarily for cosmetic purposes
- Hearing aids
- Chiropractic services
- Homemaker services
- Long-term rehabilitative therapy
- Organ transplants not specified as covered
- Cardiac rehabilitation
- Corrective eyeglasses, frames and contact lenses, including the fitting of contact lenses, except as necessary for the first pair of corrective lenses following cataract surgery.
- Blood and blood derivatives not replaced by the member.

CARE MUST BE RECEIVED FROM OR ARRANGED BY PLAN CONTRACTED DOCTORS.

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 the Plan 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 120 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 the Plan. **You pay nothing. All necessary services are covered,** including:

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

Hospice Care

Supportive and palliative care for a terminally ill member is covered in the home, or hospice facility. Services include inpatient and outpatient care, and family counseling; these services are provided under the direction of a Plan doctor who certifies that the patient is in terminal stages of illness, with a life expectancy of approximately six months or less.

Ambulance service

Benefits are provided for medically necessary ambulance transportation ordered or authorized by a Plan doctor.

Limited Benefits

Inpatient Dental Procedures

Hospitalization for certain dental procedures is covered when the Plan determines there is need for hospitalization for reasons totally unrelated to the dental procedure in order to safeguard the medical condition of the patient. The Plan will cover the hospitalization, but not the cost of the professional services from doctors, dentists or other medical professionals nor any hospital charges, such as anesthesia, directly related to dental care. 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 15 for non-medical substance abuse benefits.

What is not covered

- Personal comfort items, such as telephone and television
- Custodial care, rest cures, domiciliary or convalescent care

CARE MUST BE RECEIVED FROM OR ARRANGED BY PLAN CONTRACTED DOCTORS.

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 a serious injury or disability and requires immediate medical or surgical care. Some problems are emergencies because, if not treated promptly, they might become more serious; examples include deep cuts and broken bones. Others are emergencies because they are potentially life threatening, such as heart attacks, strokes, poisonings, gunshot wounds, or sudden inability to breathe.

Emergencies in the service area

If you are in a non-threatening emergency situation, please call your primary care doctor. In life-threatening emergencies, if you are unable to contact your doctor, 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 should notify the Plan within 48 hours. It is your responsibility to ensure that the plan has been timely notified.

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 you are hospitalized in non-Plan facilities and Plan doctors believe care can be better provided in a Plan hospital, you may be transferred when medically stable 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 provider would result in death, disability or significant jeopardy to your condition.

Plan pays...

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

You pay...

\$25 per hospital emergency room visit or urgent care center visit for emergency services which are covered benefits of this Plan. If the emergency results in admission to hospital, the emergency care copay is waived.

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.

Plan pays...

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

You pay...

\$25 per hospital emergency room visit or per urgent care center visit for emergency services that are covered benefits of this Plan. If the emergency results in admission to a hospital, the emergency care copay is waived.

CARE MUST BE RECEIVED FROM OR ARRANGED BY PLAN CONTRACTED DOCTORS.

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 determined by the Plan to be medically necessary

What is not covered

- Elective care or non-emergency care
- Emergency care provided outside the service area if the need for care could have been foreseen before leaving the service area
- Medical and hospital costs resulting from a normal full-term delivery of a baby outside the service area (Travel restrictions apply after 36-weeks of gestation).

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. 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 19.

Medical 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
- Psychological testing
- Psychiatric treatment (including individual and group therapy)
- Hospitalization (including inpatient professional services)

Outpatient care

Up to 20 outpatient visits to Plan doctors or other psychiatric personnel each calendar year; **you pay** nothing for the first 6 visits per year; \$10 copayment per visit for visits 7-15; a \$25 copayment per visit for visits 16-20 -- all charges thereafter.

Inpatient care

Up to 30 days of hospitalization each calendar year; **you pay** nothing for the first 30 days--all charges thereafter.

What is not covered

- Care for psychiatric conditions that 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 for initial testing to formulate a diagnosis
- Neuropsychological testing except prior to epilepsy surgery

CARE MUST BE RECEIVED FROM OR ARRANGED BY PLAN CONTRACTED DOCTORS

Medical Conditions / Substance Abuse Benefits *continued*

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, and, to the extent shown below, the services necessary for diagnosis and treatment.
Outpatient care	Up to 20 outpatient visits or equivalent partial visits per member per year to a licensed treatment facility that is a participating provider. The Plan, at its discretion, may exchange 30 outpatient visits on a two-for-one basis for up to 15 additional non-hospital residential days. The services are limited to a lifetime maximum of 120 full outpatient visits or an equivalent number of partial visits. You pay nothing for the covered visits.
Inpatient care	Up to 30 days per member per year for residential substance abuse treatment services in a licensed treatment facility that is a participating provider. You pay nothing for the first 30 days each calendar year -- all charges thereafter. The benefit the Plan provides is also subject to a lifetime maximum of 90 days -- you pay all charges thereafter.
What is not covered	<ul style="list-style-type: none">• Treatment that is not authorized by a Plan doctor.• All charges if the member does not complete the treatment program

Prescription Drug Benefits

What is covered	<p>Prescription drugs prescribed by a Plan contracted or referral doctor and obtained at a Plan contracted pharmacy will be dispensed in accordance with the Plan's drug formulary, for up to a 34 day supply. You pay a \$4 copay per prescription unit or refill. Up to a 90-day supply of drugs classified as maintenance by QualMed may be purchased through the Plan's mail order drug program with an \$8 copay per prescription unit or refill. Drugs will be dispensed in accordance with the Plan's drug formulary.</p> <p>QualMed Plans for Health has implemented a Select Drug Formulary which has been effective since May 15, 1995. The Select Formulary is a list of commonly prescribed covered medications that have been chosen by the Pharmacy and Therapeutics Committee based on a drug's effectiveness and cost. There are over 700 drugs on the Select Formulary. This list covers over 98% of all prescriptions written for QualMed members. If a drug does not appear on the formulary, it is because there is another drug listed that works as well or better. All non-formulary drugs are not covered unless prior authorization is granted. <u>Only physicians may call to receive authorization for a non-formulary drug.</u></p> <p>The Select Formulary is NOT a reduction in a member's pharmacy benefit. In fact, it is a better tool for physicians to prescribe the most effective drugs for QualMed members.</p> <p>Covered medications and accessories include:</p> <ul style="list-style-type: none">• Drugs for which a prescription is required by Federal law• Oral contraceptive drugs• Insulin, with a copay charge applied to each vial• Diabetic supplies, including disposable insulin syringes, needles, glucose test tablets and test tape, Benedict's solution or equivalent and acetone test tablets• Intravenous fluids and medication for home use, implantable drugs, and some injectable drugs are covered under Medical and Surgical Benefits (covered under Medical and Surgical Benefits as a home health service, see page 11.)• Disposable needles and syringes needed for injecting covered prescribed medication
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CARE MUST BE RECEIVED FROM OR ARRANGED BY PLAN CONTRACTED DOCTORS

Prescription Drug Benefits *continued*

Limited Benefits

- Drugs to treat sexual dysfunction are limited. Contact the Plan for dose limits. You pay a \$4 copay for up to the dose limit and all charges above that.

What is not covered

- Drugs available without a prescription or for which there is a nonprescription equivalent available
- Drugs prescribed by non-contracted doctors except for out-of-area urgent/emergent care
- Drugs obtained at a non-Plan contracted pharmacy except for out-of-area urgent/emergent care
- Medical supplies such as dressings and antiseptics
- Vitamins and nutritional substances which can be purchased without a prescription
- Drugs for cosmetic purposes
- Drugs to enhance athletic performance
- Smoking cessation drugs and medication, including nicotine patches
- Contraceptive devices, including diaphragms; Depo Provera; Norplant
- Implanted time-release medications

Other Benefits

Dental care

Accidental injury benefit

Restorative services and supplies necessary to promptly repair (but not replace) sound natural teeth. The need for these services must result from an accidental injury; **you pay** nothing.

What is not covered

- Other dental services not shown as covered

Vision Care

What is covered

In addition to the medical and surgical benefits provided for diagnosis and treatment of diseases of the eye, routine eye examinations (including refractions) once every calendar year for members seventeen (17) years of age and under, and once every two (2) calendar years for members eighteen (18) years of age and older. Members may self refer for routine eye examinations and must obtain services from Plan contracted providers only. **You pay** a \$5 copay per visit.

What is not covered

- Corrective eyeglasses and frames or contact lenses (including the fitting of the lenses)
- Eye exercises

CARE MUST BE RECEIVED FROM OR ARRANGED BY PLAN CONTRACTED DOCTORS

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 made 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; any charges for these services do not count toward the FEHB deductibles, out of pocket maximum copay charges, etc. These benefits are not subject to the FEHB disputed claims procedures.

Health Care Information and Assistance

QualMed HealthLine	Through QualMed's toll-free HealthLine, registered nurses are available to provide health care answers for members, 24 hours a day, every day of the year. These skilled professionals use their years of clinical experience and the extensive computerized medical resources at their fingertips to assist members and direct them to the appropriate care.
Health Newline and Resource Guide	Members can call a toll-free number listen to more than 150 pre-recorded health care topics. The Resource Guide also includes toll-free numbers for organizations that can provide even more information.
Being Well Magazine	Subscriber households receive <i>Being Well</i> , QualMed's exclusive, award winning magazine.
Self-Care Book	As our special thanks, each new QualMed subscriber receives a coupon to redeem for a free, 330-page self-care book.

Wellness Incentives

Fitness Reimbursement	QualMed members receive up to \$300 annual reimbursement for participation in cardiovascular programs at the fitness club of their choice. QualMed has also arranged for fitness club discounts at over 150 area fitness clubs. Members can combine the discounted membership and reimbursement for even greater savings.
Weight Management Reimbursement	QualMed members receive up to \$200 annual reimbursement when they achieve and maintain their goal weight by participating in a network hospital or other approved weight management program.
Smoking Cessation Reimbursement	QualMed Members can receive up to \$200 annual reimbursement for participation in QualMed's Committed Quitters Stop Smoking program which combines a nicotine replacement product with a personalized stop smoking plan. Reimbursement is also available for smoking cessation programs at participating hospitals.

Women's Health Programs

Preventive Care	QualMed members may go for routine gynecological exams without a PCP referral two times a year. Members also receive mammography reminders on a regular basis.
New Mom 's Program	QualMed offers members a free, comprehensive maternity services program that includes valuable information concerning prenatal health, health during pregnancy, member benefits, money saving coupons, and a free gift for the new mom and baby.
Childbirth Class Reimbursement	QualMed reimburses up to \$85 when members attend and complete childbirth classes at participating hospitals.

Safety Programs

Bike Safety Program with Free Helmet	QualMed offers free helmets to kids and teen members, aged 4-18, who attend our free class on bike safety basics with a parent or guardian.
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Questions

If you have a question concerning Plan benefits or how to arrange for care, contact the Plan's Customer Service Department at:

11 Penn Center; 9th Floor
1835 Market St.
Philadelphia, PA 19103
1-800-736-2096
TDD 215-209-6469

or

Suite 100
60 Public Square
Wilkes-Barre, PA 18701
1-888-513-0461

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.

Disputed claims review *continued*

Send your request for review to: Office of Personnel Management, Office of Insurance Programs, Contracts Division 4, P.O. Box 436, Washington, DC 20044.

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 QualMed Plans for Health, Inc. Changes January 1999

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

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

Program-wide

- Women may see their Plan gynecologist for their annual routine examinations without a referral from their primary care doctor. See page 6.
- 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 17 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 14).
- 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 Condition's Benefit. Office visits for the medical aspects of treatments do not count towards the 20 outpatient Mental Conditions visit limit.
- Coverage for drugs for sexual dysfunction is shown under the prescription drug benefit (see page 17).

Changes to this Plan

- Kidney/pancreas transplant is now covered.
- Women aged 40 to 49 years are now covered for one mammogram annually.

Summary of Benefits for QualMed Plans for Health, Inc. - 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 CONTRACTED 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	13
	Extended care	All necessary services up to 120 days per calendar year. You pay nothing	13
	Mental conditions	Diagnosis and treatment of acute psychiatric conditions for 30 days of inpatient care per year. You pay nothing	15
	Substance abuse	Up to 30 day per member per year for residential substance abuse treatment services in a licensed participating facility up to a lifetime maximum of 90 days. You pay nothing during the benefit period -- all charges thereafter.....	15
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 a \$5 copay per office visit; \$5 copay for house call by a doctor.....	11, 12
	Home health care	All necessary visits by nurses and health aides. You pay nothing	11
	Mental conditions	Up to 20 outpatient visits per year. You pay nothing for the first 6 visits per year; a \$10 copayment per visit for visits 7-15; a \$25 copayment per visit for visits 16-20 -- all charges thereafter.....	15
	Substance abuse	Up to 60 outpatient visits per member per calendar year to a participating facility for the treatment of substance abuse up to a lifetime maximum of 120 day. You pay nothing during the benefit period -- all charges thereafter.....	15
Emergency care		Reasonable charges for services and supplies required because of a medical emergency. You pay a \$25 copay to the hospital for each emergency room visit and any charges for services that are not covered by this Plan.....	14
Prescription drugs		Drugs prescribed by a Plan doctor and obtained at a Plan pharmacy. You pay a \$4 copay up to a 34 day supply with a maximum of five (5) refills. A 90-day supply of maintenance drugs may be purchased through the Plan's mail order Drug program. You pay a \$8.00 copay per prescription unit or refill.....	16
Dental care		Accidental injury benefit. You pay nothing	17
Vision care		Routine eye examinations (including refractions) once every calendar year for members seventeen (17) years of age and under, and once every two(2) calendar years for members eighteen (18) years of age and older. Members may self refer for routine eye examinations and must obtain services from Plan providers only. You pay \$5	17
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 \$500 per member. This copayment maximum does not include costs of prescription drugs.....	7

Notes

Notes

1999 Rate Information for QualMed Plans for Health

FEHB Benefits of this Plan are described in brochure 73-40

The 1999 rates for this Plan follow. Non-Postal rates apply to most non-Postal enrollees. If you are in a special enrollment category, refer to an FEHB Guide or contact the agency that maintains your health benefits enrollment. Postal rates apply to all USPS career employees and do not apply to non-career Postal employees, Postal retirees or associate members of any Postal employees organization.

Type of Enrollment	Code	<u>Non-Postal Premium</u>				<u>Postal Premium</u>	
		<u>Biweekly</u>		<u>Monthly</u>		<u>Biweekly</u>	
		Gov't Share	Your Share	Gov't Share	Your Share	USPS Share	Your Share

Southern Pennsylvania/New Jersey

Self Only	271	\$72.06	\$33.93	\$156.13	\$73.52	\$84.98	\$21.01
Self and Family	272	\$160.39	\$86.05	\$347.51	\$186.44	\$183.29	\$63.15

Scranton/Wilkes-Barre

Self Only	2K1	\$63.60	\$21.20	\$137.80	\$45.93	\$75.26	\$9.54
Self and Family	2K2	\$154.43	\$51.47	\$334.59	\$111.53	\$182.74	\$23.16