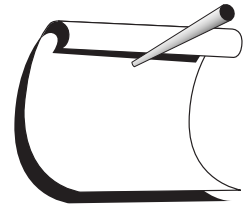


**A Health Maintenance Organization
with a
Point-of-Service product**



Serving: All of Arkansas

Enrollment in this Plan is limited; see page 12 for requirements.

Enrollment code:

8Q1 Self Only

8Q2 Self and Family

**Visit our website at
<http://www.opm.gov/insure>
and this Plan's website at
<http://www.qcark.com>
QCA Health Plan, Inc.**

Authorized for distribution by the:



**United States
Office of
Personnel
Management**



QCA Health Plan, Inc.

QCA Health Plan, Inc., 10800 Financial Centre Parkway, Suite 540, Little Rock, AR 72211, has entered into a contract (CS 2821) 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 QCA Health Plan, Inc., 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 28.

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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 800-235-7111 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, 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 SF2809 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 19 and 20, or when you self-refer for point of service, or POS, benefits as described on pages 24 and 25.** 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" section below.

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.

General Information *continued*

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 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 your 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 or POS 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.

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.

General Information *continued*

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.

General Information *continued*

Notification and election requirements

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.

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.

General Information *continued*

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 certificate you receive from other FEHB plans you may have been enrolled in, may reduce or eliminate the length of time 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 QCA Health Plan

[This Plan is a comprehensive medical plan, sometimes called a health maintenance organization (HMO) that offers a point of service, or POS, product. Whenever you need services, you may choose to obtain them from your personal doctor within the Plan's provider network or go outside the network for treatment. Within the Plan's network you are required to select a personal doctor who will provide or arrange for your care and you will pay minimal amounts for comprehensive benefits. There are no claim forms when Plan doctors are used. When you choose a non-Plan doctor or other non-Plan provider under the POS option, you will pay a substantial portion of the charges and the benefits available may be less comprehensive. See pages 24 and 25 for more information.]

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 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 did not receive information about this Plan, you can obtain it by calling the Carrier at 800/235-7111 or you may write the Carrier at QCA Health Plan, Inc, 10800 Financial Centre Parkway, Suite 540, Little Rock, AR, 72211. You may also contact the Carrier by fax at 501-228-0135 or at its website at <http://www.qcark.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?

This Plan is a Point-of-Service, or POS, Plan. Whenever you need services, you may choose to obtain them from your primary care doctor within the Plan's provider network or go outside the network for treatment. Within the Plan's network you are required to select a primary care doctor who will provide or arranged for your care and you will pay minimal amounts for comprehensive benefits. When you receive care from a non-Plan doctor or a non-Plan provider without a referral, you will pay a substantial portion of the charges and the benefits available may be less comprehensive. See pages 24 and 25 for more information.

Role of a primary care doctor

The first and most important decision each member must make is the selection of a network primary care doctor. This 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 network specialist or making arrangements for hospitalization. Services of other network providers are covered only **when** you have been referred by your primary care doctor [or when you use POS benefits]. Females age 16 years or older, must also select a network primary care obstetrician/gynecologist (OB/Gyn). Females may choose to use their family practitioner or general practitioner as their primary care OB/Gyn doctor as well. Women may see their

Facts about this Plan *continued*

primary care OB/Gyn at any time without a referral. Failure to select an OB/Gyn will result in all obstetrical and gynecological services being paid under the POS benefit if obtained without a referral.

Choosing your doctor

The Plan's provider directory lists primary care doctors (family practitioners, general practitioners, pediatricians, gynecologists, internists, obstetricians/gynecologists), with their locations and phone numbers, and notes whether or not the doctor is accepting new patients. Directories are updated twice a year and are available at the time of enrollment or upon request by calling the Customer Service Department at 1-800-235-7111; 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 or POS 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 and primary care OB/Gyn doctor (females age 16 years and older) for you and each of your family members by submitting the completed Selection Form to the Plan. Should you wish to change your primary care doctor you must notify the Plan. You may do this by indicating your selection of a new primary care physician and/or primary care OB/Gyn on a PCP Change Form and sending the form to the Plan. Changes received prior to the 25th of the month will become effective on the 1st of the next month. Changes received after the 25th of the month will become effective the following month.

If you are receiving services from a doctor who leaves the Plan, **the Plan will pay for covered services until the Plan can arrange with you for you to be seen by another participating doctor.**

If you are receiving services from a doctor who terminates a participation agreement, the Plan will provide the member with at least 30 days notice of the termination so the member will be able to select a new doctor to render their care.

Referrals for specialty care

To obtain the most comprehensive benefits, you must receive a referral from your primary care doctor before seeing any network provider or obtaining special services, except in a medical emergency, or when a primary care doctor has designated a backup doctor to see his or her patients. If you choose to receive treatment from a provider other than your primary care doctor or without a referral, benefits that are medically necessary will be paid under the POS benefits as described on pages 24 and 25.

When you receive a referral from your primary care doctor, you must return to the primary care doctor after the consultation unless your doctor authorizes additional visits. All follow-up care must be provided or authorized by the primary care doctor. Your primary care doctor will provide you with a copy of the completed Network Referral Form which will indicate the services you are to obtain. Do not go to the specialist for a second visit unless your primary care doctor has arranged for, and the Plan has issued an authorization for, the referral in advance.

If you have 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

Facts about this Plan *continued*

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 network 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 the doctor who originally referred you to this specialist is now your Plan primary care doctor, you need only call to explain that you are now a Plan member and ask that you be referred for your next appointment.

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 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

Your out-of-pocket expenses for benefits under this Plan are limited to the stated copayments required for a few benefits. There is a \$5,000 out-of-pocket maximum for the charges you pay when you use POS benefits. This is in addition to deductibles and any charges above the Maximum Allowable Payment, and does not include costs of prescription drugs.

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/Investigative determinations

The Plan considers as experimental/investigative any medication, procedure, test or equipment that has not been accepted by mainstream medicine or that is part of an ongoing experimental protocol. This determination is made by referring to the Hayes directory, calling physicians at the UAMS Medical Center, and querying the National Library of Medicine database.

Facts about this Plan *continued*

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 area

The service area for this Plan, where Plan providers and facilities are located, is described below. [You must live or work in the service area to enroll in this Plan.] [You may enroll in this Plan if you live or work inside the service area or live in the geographic area described below.

The service area for this Plan includes all 75 counties throughout Arkansas: Arkansas, Ashley, Baxter, Benton, Boone, Bradley, Calhoun, Carroll, Chicot, Clark, Clay, Cleburne, Cleveland, Columbia, Conway, Craighead, Crawford, Crittenden, Cross, Dallas, Desha, Drew, Faulkner, Franklin, Fulton, Garland, Grant, Greene, Hempstead, Hot Spring, Howard, Independence, Izard, Jackson, Jefferson, Johnson, Lafayette, Lawrence, Lee, Lincoln, Little River, Logan, Lonoke, Madison, Marion, Miller, Mississippi, Monroe, Montgomery, Nevada, Newton, Ouachita, Perry, Phillips, Pike, Poinsett, Polk, Pope, Prairie, Pulaski, Randolph, Saint Francis, Saline, Scott, Searcy, Sebastian, Sevier, Sharp, Stone, Union, Van Buren, Washington, White, Woodruff and Yell.

Benefits for care outside the service area are limited to emergency services, as described on pages 19 and 20, and to services covered under Point of Service Benefits, as described on pages 24 and 25.

If you or a covered family member move outside the service area, or farther away from 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.

Service Area: Services from Plan providers are available only in the area described above.

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 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 Medicare 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 or the services are covered under this Plan's POS benefits. You must tell your Plan that you or your family member is eligible for Medicare. 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 **unless you use a non-Plan provider for POS benefits as described on pages 24 and 25**. 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 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 as discussed under Authorizations on page 11.** The following are excluded:

- Care by non-Plan doctors or hospitals except for authorized referrals or emergencies (see Emergency Benefits) or eligible self-referred services obtained under Point of Service 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 \$10 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** a \$10 copay for a doctor's house call and pay nothing for home visits by nurses and health aides.

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
- Mammograms are covered as follows: for women age 35 through age 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. 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
- 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. Copays are waived for maternity care. 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 an infant 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
- Diagnosis and treatment of diseases of the eye
- Allergy testing and treatment, including testing and treatment materials (such as allergy serum)
- The insertion of internal prosthetic devices, such as pacemakers and artificial joints
- Cornea, heart, kidney and liver 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. Pre-authorization is required for transplant evaluations, procedures and services. Transplants are covered when approved by the Medical Director. Related medical and hospital expenses of the donor are covered when the recipient is covered by this Plan.
- Women who undergo mastectomies may, at their option, have this procedure basis and remain in the hospital up to 48 hours after the procedure.
- Dialysis
- Chemotherapy, radiation therapy, and inhalation therapy
- Surgical treatment of morbid obesity
- Orthopedic devices, such as braces; foot orthotics
- Prosthetic devices, such as artificial limbs and lenses following cataract removal

Medical and Surgical Benefits *continued*

- Home health services of 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

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. All other procedures involving the teeth or intra-oral areas surrounding the teeth are not covered, including any dental care involved in the treatment of temporomandibular joint (TMJ) pain dysfunction syndrome.

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) is provided on an inpatient or outpatient basis for up to two consecutive months per condition if significant improvement can be expected within two months; **you pay** \$10 per outpatient session. Speech therapy is limited to treatment of certain speech impairments of organic origin. 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** 50% of the cost. The following types of artificial insemination **are** covered: intravaginal insemination (IVI); intracervical insemination (ICI) and intrauterine insemination (IUI). Cost of donor sperm is not covered. Fertility drugs are covered under the Prescription Drug Benefit. **Other assisted reproductive technology (ART) procedures, such as in vitro fertilization and embryo transfer, are not covered.**

Durable medical equipment, such as wheelchairs and hospital beds; limited to a Plan payment of up to \$2,000 per year.

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
- Reversal of voluntary, surgically-induced sterility
- Surgery primarily for cosmetic purposes
- Homemaker services
- Hearing aids
- Transplants not listed as covered
- Long-term rehabilitative therapy
- Chiropractic services
- Blood and blood derivatives not replaced by the member

Medical and Surgical Benefits *continued*

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 30 days per calendar year when full-time skilled nursing care is necessary and confinement in a skilled nursing facility is medically appropriate as determined by a Plan doctor and approved by the Plan. **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 a 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 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 nothing.**

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 21 for nonmedical substance abuse benefits.

What is not covered

- Personal comfort items, such as telephone and television
- Blood and blood derivatives not replaced by the member
- Custodial care, rest cures, domiciliary or convalescent care

Medical and Surgical Benefits *continued*

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 care. Some problems are emergencies because, if not treated promptly, they might become more serious; examples include deep cuts and broken bones. Others are emergencies because they are potentially life-threatening, such as heart attacks, strokes, poisonings, gunshot wounds, or sudden inability to breathe. There are many other acute conditions that the Plan may determine are medical emergencies — what they all have in common is the need for quick action.

Emergencies within the service area

On-Call 24 hour Line — Members will be able to call a medical advice hotline 24 hours a day, 7 days a week with questions about their health and if they are experiencing a sudden illness or injury. By calling 1-800-722-7179 the member could reduce their ER copay by 50%.

If you are in an emergency situation, please call your primary care doctor. In extreme 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 [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 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.

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.

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 except as covered under POS benefits.

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 \$25 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 copay is waived.

Medical and Surgical Benefits *continued*

Emergency Benefits (continued)

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 except as covered under POS benefits.

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 \$25 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 copay is waived.

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

What is not covered

- Elective care or nonemergency care except as covered under POS Benefits
- Emergency care provided outside the service area if the need for care could have been foreseen before leaving the service area except as covered under POS Benefits
- Medical and hospital costs resulting from a normal full-term delivery of a baby outside the service area except as covered under POS Benefits

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 27.

Medical and Surgical Benefits *continued*

Mental Conditions/Substance Abuse Benefits

Mental conditions

The medical management of 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 40 outpatient Mental Conditions visit limit.

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 40 outpatient visits to Plan doctors or other psychiatric personnel each calendar year; **you pay** a \$25 copay for each covered visit.

Inpatient care

Up to 30 days of hospitalization each calendar year; **you pay** nothing per day for the first 30 days.

What is not covered

- Care for psychiatric conditions that in the professional judgment of Plan psychiatric designees 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 Plan psychiatric designees to be necessary and appropriate.
- Psychological testing that is not medically necessary to determine the appropriate treatment of a short-term psychiatric condition.

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.

Services for the psychiatric aspects are provided in conjunction with the mental conditions benefit shown above. Outpatient visits to Plan mental health providers for follow-up care and counseling are covered, as well as inpatient services necessary for diagnosis and treatment. The mental conditions visit/day limitations and copays apply.

What is not covered

- Treatment that is not authorized by a Plan doctor

Medical and Surgical Benefits *continued*

Prescription Drug Benefits

What is covered

Prescription drugs prescribed by a plan or referral doctor and obtained at a Plan pharmacy will be dispensed for up to a 34-day supply. **You pay** a \$7 copay for generic drugs and a \$15 copay for brand name drugs.

- Drugs for which a prescription is required by Federal law
- Oral contraceptives
- Insulin
- Diabetic supplies, including insulin syringes, needles, glucose test tablets and test tape, Benedict's solution or equivalent, glucose monitor and acetone test tablets.
- Disposable needles and syringes needed to inject covered prescribed medication.

Limitations

- Prescriptions for Ritalin are limited to a three month supply
- Refills and oral contraceptives are limited to 100 day supply with a copayment for each 34 day supply
- Imitrex will be limited to a maximum of 12 vials and/or 36 tablets in a rolling 30 period, with a maximum dosage of 4 vials or 18 tablets per prescription.

Drugs to treat sexual dysfunction is limited. Contact the Plan for dose limits. Intravenous fluids and medication for home use, implantable drugs, such as Norplant, and some injectable drugs, such as Depo Provera, are covered under Medical and Surgical Benefits.

What is not covered

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

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** the corresponding copay as listed below according to how service is rendered:

- \$10 copay for office visit through your PCP.
- \$50 copay for an emergency room visit.

What is not covered

Other dental services not shown as covered

Point of Service (POS) Benefits

Facts about their Plan's POS Benefits

Services from any doctor without a referral, are available under the POS benefits. Covered services under these benefits include all those available from Plan doctors except for those listed below. All hospital admissions and some surgery must be pre-authorized by the Plan for maximum benefits to be paid.

Maximum Plan payment

All benefits under the POS benefits are limited to a total maximum payment by the Plan of \$1,000,000.

Pre-authorization

The purpose of pre-authorization is to ensure that benefits are provided only for medically necessary care. When you seek care through your Plan primary doctor, he/she will obtain the necessary pre-authorizations for you. When you seek care under POS benefits, you are responsible for assuring that pre-authorization is obtained.

This pre-authorization process must be completed to receive full POS benefits for covered hospital and outpatient expenses. **All POS hospital admissions and outpatient services must be pre-authorized.** To qualify for maximum benefits, QCA Health Plan must be notified. The number to call for prior authorization is specified on the insurer's identification card. If you do not obtain pre-authorization from the Plan for inpatient hospital admissions or outpatient services, benefits will be reduced by \$500.

What is covered

- Doctor office visit
- Well-baby office visit
- Diagnostic laboratory and x-ray tests
- Surgical procedures
- Home health care (limited to 40 days)
- Durable medical equipment (\$2,000 per calendar year)
- Physical, speech or occupational therapy (covered at 50%)
- Prescription drugs (\$7 copay for generic/ \$15 copay for brand name)

What is not covered

- Physical exams
- Routine gynecologic visits
- Immunizations
- Mental Health/Substance Abuse
- Temporomandibular joint (TMJ)
- Organ Transplant
- Infertility testing and treatment

Deductible

The calendar year deductible is \$300 per individual.

Coinsurance

Coinsurance is a fixed percentage of charges **you must pay** after you have met your deductible. You are required to pay 20% of the Plan's Maximum Allowable Payment for the covered services provided to you. The network provider may bill you directly for the amount of coinsurance (but may not bill you the amount of the difference between his or her customary charge for such covered service and the Plan's Maximum Allowable Payment for such covered service.) An out-of-network provider may bill you directly for the amount of the coinsurance and may bill you for the difference between the Maximum Allowable Payment and the billed charges.

Point of Service (POS) Benefits *continued*

Hospital/extended care

When you are admitted to a network or out-of-network hospital without a referral from your Plan doctor, you will be responsible for the deductible and coinsurance amounts applicable to the POS benefits. The hospital charge, sometimes called facility charge, does not cover any charges for doctors' services.

Emergency benefits

True emergency care is always payable as an Plan benefit. If you are hospitalized in a non-Plan facility and a Plan doctor believes care can be better provided in a Plan hospital, you will be transferred by ambulance when medically feasible without any charge. If you elect to remain in the non-Plan facility, benefits will be considered as POS from the date that transfer was recommended.

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 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, POS maximum benefits, or out-of-pocket maximums. These benefits are not subject to the FEHB disputed claims procedure.

Vision care

Routine eye exam (1 visit every 24 months) - \$10 copay

Optional Dental Coverage

The Optional Dental Coverage plan being offered to the Federal Employees who elect QCA Health Plan as their health insurer for the 1999 FEHBP contract period are eligible to purchase dental benefits provided through Delta Dental Plan of Arkansas, Inc. You as the Federal Employee are responsible for paying the premium through payroll deduction for this dental coverage and the premiums are as follows:

- Individual - \$9.00 (bi weekly)
- Individual and Family - \$25.00 (bi weekly)

Delta Dental Plan of Arkansas has more than 900 dentists in the state as participating members. Over 90% of the dentists in Arkansas participate. No other dental program administrator has this large a network to service the people enrolled in its programs.

A Delta Dental Plan of Arkansas participating dentist agrees to accept payment based on his or her submitted fee or Delta Dental's customary fee, whichever is less. If Delta Dental's customary fee payment for a particular service is lower than the submitted fee, the dentist agrees not to charge the difference to the enrollee.

Optional Voluntary Restorative Services

Benefits are subject to the Limitations and Exclusions and Other Terms and Conditions of the Certificate, dental services set forth on this page will be provided when rendered by a participating dentist.

Coverage A - Diagnostic and Preventive Services Copayment: 100% - Exams, cleanings, X-rays and fluoride.

Coverage B - Basic Restorative Services Copayment: 80% - Amalgam and composite fillings, simple and surgical extractions, non-surgical periodontics, oral surgery, endodontics, sealants, space maintainers and stainless steel crowns for children.

Coverage C - Major Restorative Services Copayment: 50% - Bridges, partial and full dentures, precious metal restoration, crowns and jackets, surgical periodontics.

Coverage D - Orthodontic Services Copayment: 50% - Orthodontic care is treatment for the correction of malposed teeth of an eligible child to age 19.

Maximums - \$1,500 maximum benefit for service for each covered person per benefit period (12 months) beginning on the membership service date. Lifetime maximum benefit for orthodontics is \$1,000 per eligible dependent child to age 19 for orthodontic services being on or after the membership service date.

Deductible - \$50 for benefits received with a maximum of \$150 per family, per benefit period (12 months) beginning on the membership service date. Deductible waived on diagnostic and preventive services (Coverage A).

Dependent Children - Covered to 19th birthday or to 22nd birthday if a full-time student.

Delta Dental Plan of Arkansas, Inc. is a separate company from QCA Health Plan, Inc. QCA members will receive a separate ID card for dental in addition to their QCA Health Plan ID card. Please call Delta Dental for further details on the dental plan at 501-835-3400 or 800-462-5410, ext. 420.

This brochure is intended to highlight the features of the benefits of the dental plan. A more complete description of the benefits can be found in the Certificate which will be issued to each covered member. All benefits are subject to the provisions of the Certificate.

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 **1-800-235-7111** or you may write to the Plan at 10800 Financial Centre Parkway, Suite 540, Little Rock, AR 72211. You may also contact the Plan by fax at 501-228-0135 or at its website at <http://www.qcark.com>.

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);

How to Obtain Benefits *continued*

- 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 2 3 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 QCA Health Plan, Inc changes January 1999

Program-wide changes

Do not rely on this page, it is not the official statement of benefits

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

If you have 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.

A medical emergency is defined as the sudden and unexpected onset of a condition or an injury that you believe endangers your life could result in serious injury or disability, and requires immediate medical or surgical care (see page 19). The medical management of mental conditions will be covered under this Plan's Medical and Surgical benefits provision. 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 aspect of treatment do not count toward the 40 outpatient Mental Conditions visit limit.

Summary of Benefits for QCA Health Plan - 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 AND SERVICES AVAILABLE AS POS BENEFITS, 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 18
	Extended care	All necessary services, no dollar or day limit. You pay nothing 18
	Mental conditions	Diagnosis and treatment of acute psychiatric conditions for up to 30 days of inpatient care per year. You pay nothing 21
	Substance abuse	Covered under Mental Conditions 21
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 \$10 copay per office visit; copays are waived for maternity care; You pay a \$10 copay per house call by a doctor 18
	Home health care	All necessary visits by nurses and health aides. You pay nothing 18
	Mental conditions	Up to 40 outpatient visits per year. You pay a \$25 copay per visit 21
	Substance abuse	Covered under Mental Conditions 21
Emergency care		Reasonable charges for services and supplies required because of a medical emergency. You pay a \$50 copay to the hospital for each emergency room visit and any charges for services that are not covered by this Plan 19
Prescription drugs		Drugs prescribed by a Plan doctor and obtained at a Plan pharmacy You pay a \$7 copay for generic; a \$15 copay for brand name and \$25 for non-preferred brand name drugs per prescription unit or refill 22
Dental care		Accidental injury benefit; you pay applicable copay. Preventive dental - No current benefit 23
Point of Service Benefits		Services of non-Plan doctors and hospitals. Not all benefits are covered You pay deductibles and coinsurance and a maximum benefit applies 24
Out-of-pocket maximum		Your out-of-pocket expenses for benefits under this Plan are limited to the stated copayments required for few benefits. There is a \$5,000 out-of-pocket maximum for the charges you pay when you use POS benefits. This is in addition to deductible any charges above the Maximum Allowable Payment, and does not include costs of prescription drugs 11