

Doctors Health Plan, Inc.

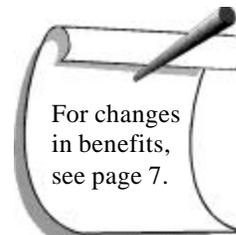
<http://www.dhphealth.com>



2001

A Health Maintenance Organization

Serving: The Greater Triangle, Charlotte, Upper and Lower Cape Fear areas



Enrollment in this Plan is limited; see page 5 for requirements.

Enrollment codes for this Plan:

6D1 Self Only
6D2 Self and Family

Authorized for distribution by the:



UNITED STATES
OFFICE OF PERSONNEL MANAGEMENT
RETIREMENT AND INSURANCE SERVICE
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Introduction

Doctors Health Plan, Inc.
3104 Croasdaile Drive
Suite 300
Durham, NC 27705

This brochure describes the benefits of Doctors Health Plan, Inc. under our contract (CS 2770) with the Office of Personnel Management (OPM), as authorized by the Federal Employees Health Benefits law. This brochure is the official statement of benefits. No oral statement can modify or otherwise affect the benefits, limitations, and exclusions of this brochure.

If you are enrolled in this Plan, you are entitled to the benefits described in this brochure. If you are enrolled for Self and Family coverage, each eligible family member is also entitled to these benefits. You do not have a right to benefits that were available before January 1, 2001, unless those benefits are also shown in this brochure.

OPM negotiates benefits and rates with each plan annually. Benefit changes are effective January 1, 2001, and are summarized on page 7. Rates are shown at the end of this brochure.

Plain Language

The President and Vice President are making the Government's communication more responsive, accessible, and understandable to the public by requiring agencies to use plain language. In response, a team of health plan representatives and OPM staff worked cooperatively to make this brochure clearer. Except for necessary technical terms, we use common words. "You" means the enrollee or family member; "we" means Doctors Health Plan, Inc..

The plain language team reorganized the brochure and the way we describe our benefits. When you compare this Plan with other FEHB plans, you will find that the brochures have the same format and similar information to make comparisons easier.

If you have comments or suggestions about how to improve this brochure, let us know. Visit OPM's "Rate Us" feedback area at www.opm.gov/insure or e-mail us at fehwebcomments@opm.gov or write to OPM at Insurance Planning and Evaluation Division, P.O. Box 436, Washington, DC 20044-0436.

Section 1. Facts about this HMO plan

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

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

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

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

How we pay providers

We contract with individual physicians, medical groups, and hospitals to provide the benefits in this brochure. These Plan providers accept a negotiated payment from us, and you will only be responsible for your copayments or coinsurance.

Who provides my health care

This Plan is an Individual Practice Prepayment (IPP) Plan that contracts with doctors and other healthcare providers operating out of their own private offices and facilities. When you require medical care, you will schedule an appointment with the primary care doctor you've selected. Care is rendered in the doctor's private office. For more extensive care, this Plan also contracts with local hospitals, specialist doctors and other health care providers. The primary care doctor coordinates all care.

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. Mental Health, Substance Abuse treatment, OB/GYN services, and routine vision services can be received without a referral from your primary care doctor.

The Plan's provider directory lists primary care doctors (family practitioners, general practitioners, pediatricians, and internists), with their locations and phone numbers, and notes whether or not the doctor is accepting new patients. Directories are updated quarterly and are available at the time of enrollment or upon request by calling the Member Services Department toll-free at 1-877-855-3034; 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.

Patient's Bill of Rights

OPM requires that all FEHB Plans comply with the Patients' Bill of Rights, recommended by the President's Advisory Commission on Consumer Protection and Quality in the Health Care Industry. You may get information about your health plan, its networks, providers, and facilities. OPM's FEHB website (www.opm.gov/insure) lists the specific types of information that we must make available to you. Some of the required information is listed below.

- Years in existence: 5
- Profit status: For-profit
- Methods of compensation, ownership or interest in health care facilities: The majority of our provider contracts include discounted fee schedules, case rates and inpatient per diems. Other contracted providers are reimbursed on a percent of billed charges basis.

If you want more information about us, call toll-free at 1-877-855-3034,

or write to: Doctors Health Plan, Inc.
3104 Croasdaile Drive, Suite 300
Durham, NC 27705

You may also contact us by fax at (919) 384-0749 or visit our website at www.dhphealth.com.

Service Area

To enroll with us, you must live or work in our service area. This is where our providers practice. Our service area is:

In North Carolina: Alexander, Bladen, Brunswick, Burke, Cabarrus, Catawba, Chatham, Cleveland, Cumberland, Durham, Edgecomb, Franklin, Gaston, Granville, Halifax, Harnett, Hoke, Iredell, Johnston, Lee, Lincoln, Mecklenberg, Montgomery, Moore, Nash, New Hanover, Orange, Pender, Person, Pitt, Sampson, Stanly, Union, Vance, Wake, Warren, Wayne and Wilson counties.

In South Carolina: York County

Ordinarily, you must get your care from providers who contract with us. If you receive care outside our service area, we will pay only for emergency care or urgent care service. We will not pay for any other health care services.

If you or a covered family member move outside of our service area, you can enroll in another plan. If your dependents live out of the area (for example, if your child goes to college in another state), you should consider enrolling in a fee-for-service plan or an HMO that has agreements with affiliates in other areas. If you or a family member move, you do not have to wait until Open Season to change plans. Contact your employing or retirement office.

Section 2. How we change for 2001

Program-wide changes

- The plain language team reorganized the brochure and the way we describe our benefits. We hope this will make it easier for you to compare plans.
- This year, the Federal Employees Health Benefits Program is implementing network mental health and substance abuse parity. This means that your coverage for mental health, substance abuse, medical, surgical, and hospital services from providers in our plan network will be the same with regard to deductibles, coinsurance, copays, and day and visit limitations when you follow a treatment plan that we approve. Previously, we had visit limitations on mental health and substance abuse services that we did not have on services to treat physical illness, injury, or disease.
- Many healthcare organizations have turned their attention this past year to improving healthcare quality and patient safety. OPM asked all FEHB plans to join them in this effort. You can find specific information on our patient safety activities by calling toll free 1-877-855-3034, or checking our website, www.dhphealth.com. You can find out more about patient safety on the OPM website, www.opm.gov/insure. To improve your healthcare, take these five steps:
 - Speak up if you have questions or concerns.
 - Keep a list of all the medicines you take.
 - Make sure you get the results of any test or procedure.
 - Talk with your doctor and health care team about your options if you need hospital care.
 - Make sure you understand what will happen if you need surgery.
- We clarified the language to show that anyone who needs a mastectomy may choose to have the procedure performed on an inpatient basis and remain in the hospital up to 48 hours after the procedure. Previously, the language referenced only women.

Changes to this Plan

- Your share of the non-Postal premium will increase by 0.6% for Self Only or decrease by 34.4% for Self and Family.
- Inpatient hospital admission copay is \$100 per admission instead of no copay per admission.
- Outpatient surgery copay is \$100 per procedure instead of no copay per procedure.
- The preventative dental reimbursement benefit has been dropped.
- Prescription drugs are covered per unit or refill. You pay \$10 for generic drugs, \$20 for brand name preferred drugs and \$30 for non-preferred drugs. Previously, the copays were \$5 for generic drugs and \$10 for brand name drugs.
- Cardiac rehabilitation following a heart transplant, bypass surgery or myocardial infarction is covered for 36 visits per occurrence. Previously, coverage was limited to 90 consecutive days per occurrence. The copay remains \$10 per office visit.

Section 3. How you get care

Identification cards

We will send you an identification (ID) card when you enroll. You should carry your ID card with you at all times. You must show it whenever you receive services from a Plan provider, or fill a prescription at a Plan pharmacy. Until you receive your ID card, use your copy of the Health Benefits Election Form, SF-2809, your health benefits enrollment confirmation (for annuitants), or your Employee Express confirmation letter.

If you do not receive your ID card within 30 days after the effective date of your enrollment, or if you need replacement cards, call us toll-free at 1-877-855-3034.

Where you get covered care

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

- Plan providers

Plan providers are physicians and other health care professionals in our service area that we contract with to provide covered services to our members. Each physician in our network undergoes a thorough credentialing process. This means we carefully screen providers who want to participate with us to ensure members have a choice of qualified physicians in the area.

- Plan facilities

Plan facilities are hospitals and other facilities in our service area that we contract with to provide covered services to our members. We list these in the provider directory, which we update periodically.

What you must do

It depends on the type of care you need. First, you and each family member must choose a primary care physician from the list of participating physicians in Doctors Health Plan’s provider directory. This decision is important since your primary care physician provides or arranges for most of your health care.

- Primary care

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

If you want to change primary care physicians or if your primary care physician leaves the Plan, call us. We will help you select a new one.

- Specialty care

Your primary care physician will refer you to a specialist for needed care. However, you may see an OB/GYN for female related services and mental health providers without a referral.

Here are other things you should know about specialty care:

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

- If you are seeing a specialist when you enroll in our Plan, talk to your primary care physician. Your primary care physician will decide what treatment you need. If he or she decides to refer you to a specialist, ask if you can see your current specialist. If your current specialist does not participate with us, you must receive treatment from a specialist who does. Generally, we will not pay for you to see a specialist who does not participate with our Plan.
- If you are seeing a specialist and your specialist leaves the Plan, call your primary care physician, who will arrange for you to see another specialist. You may receive services from your current specialist until we can make arrangements for you to see someone else.
- If you have a chronic or disabling condition and lose access to your specialist because we:
 - terminate our contract with your specialist for other than cause; or
 - drop out of the Federal Employees Health Benefits (FEHB) Program and you enroll in another FEHB Plan; or
 - reduce our service area and you enroll in another FEHB Plan,
 you may be able to continue seeing your specialist for up to 90 days after you receive notice of the change. Contact us, or if we drop out of the Program, contact your new plan.

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

- Hospital care

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

If you are in the hospital when your enrollment in our Plan begins, call our customer service department immediately at 1-877-855-3034 (toll free). If you are new to the FEHB Program, we will arrange for you to receive care.

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

- You are discharged, not merely moved to an alternative care center; or
- The day your benefits from your former plan run out; or
- The 92nd day after you become a member of this Plan, whichever happens first.

These provisions apply only to the benefits of the hospitalized person.

Circumstances beyond our control

Under certain extraordinary circumstances, such as natural disasters, we may have to delay your services or we may be unable to provide them.

In that case, we will make all reasonable efforts to provide you with the necessary care.

Services requiring our prior approval

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

We call this review and approval process preauthorization. Your physician must obtain preauthorization for services such as:

- Inpatient Hospitalization
- Specialty Care
- Diagnostic Testing
- Outpatient Surgery

Doctors Health Plan utilizes Doctors Health Plan medical policy statements, as well as Milliman & Robertson and InterQual guidelines in making decisions regarding the appropriateness of timing, place of service, and medical necessity for services. Whenever these criteria are not met, or if there are no applicable criteria, it is our policy to refer the case to the Medical Director for final determination. The Medical Director at that time may make a determination to approve the request, to not approve the request, or to request a peer review by an outside consultant prior to making a determination.

Providers are expected to call our Medical Management department to request authorization for services prior to delivery of the service. In the case of emergent provision of services, or if services are rendered outside of Doctors Health Plan operating hours, providers are expected to call within 48 hours to request authorization. If the request requires clinical information to be provided in order to determine benefit coverage, the caller will need to speak with a nurse or fax in clinical data to support their request. Doctors Health Plan requires 24-48 hours notification prior to provision of services in most cases in order for a determination to be made and communicated to the provider. Providers may request an expedited decision in special cases.

If requests are not called in a timely manner, coverage may be denied. If non-emergent services are to be provided by a non-participating provider, prior authorization must be given by Doctors Health Plan or payment for services will be denied. Extension of services may be requested by the provider within the dates of services originally authorized by Doctors Health Plan. In most cases, clinical status substantiating a need for extended services will be required verbally or in writing. If non-emergent services are provided in excess of the original authorization, or outside of the dates of service for the original authorization, payment may be denied. Your PCP will have to request additional services if the original dates of service have expired. You, or a provider on your behalf, may appeal any decision through the appropriate channels.

Section 4. Your costs for covered services

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

- Copayments

A copayment is a fixed amount of money you pay to the provider when you receive services.

Example: When you see your primary care physician you pay a copayment of \$10 per office visit and when you go in the hospital, you pay \$100 per admission.

- Deductible

We have no deductible.

NOTE: If you change plans during open season, you do not have to start a new deductible under your old plan between January 1 and the effective date of your new plan. If you change plans at another time during the year, you must begin a new deductible under your new plan.

And, if you change options in this Plan during the year, we will credit the amount of covered expenses already applied toward the deductible of your old option to any deductible of your new option.

- Coinsurance

We have no coinsurance.

Your out-of-pocket maximum for copayments

Your out-of-pocket expenses for benefits under this Plan are limited to the stated copayments required for a few benefits.

Section 5. Benefits – OVERVIEW

(See page 7 for how our benefits changed this year and page 53 for a benefits summary.)

NOTE: This benefits section is divided into subsections. Please read the important things you should keep in mind at the beginning of each subsection. Also read the General Exclusions in Section 6; they apply to the benefits in the following subsections. To obtain claims forms, claims filing advice, or more information about our benefits, contact Member Services toll-free at 1-877-855-3034 or at our website at www.dhphealth.com.

(a) Medical services and supplies provided by physicians and other health care professionals	13-20
•Diagnostic and treatment services	•Hearing services (testing, treatment, and supplies)
•Lab, X-ray, and other diagnostic tests	•Vision services (testing, treatment, and supplies)
•Preventive care, adult	•Foot care
•Preventive care, children	•Orthopedic and prosthetic devices
•Maternity care	•Durable medical equipment (DME)
•Family planning	•Home health services
•Infertility services	•Alternative treatments
•Allergy care	•Educational classes and programs
•Treatment therapies	
•Rehabilitative therapies	
(b) Surgical and anesthesia services provided by physicians and other health care professionals	21-24
•Surgical procedures	•Oral and maxillofacial surgery
•Reconstructive surgery	•Organ/tissue transplants
	•Anesthesia
(c) Services provided by a hospital or other facility, and ambulance services	25-27
•Inpatient hospital	•Extended care benefits/skilled nursing care facility benefits
•Outpatient hospital or ambulatory surgical center	•Hospice care
	•Ambulance
(d) Emergency services/accidents	28-29
•Medical emergency	
(e) Mental health and substance abuse benefits	30-31
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Section 5 (a) Medical services and supplies provided by physicians and other health care professionals

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

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

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Benefit Description	You pay
Diagnostic and treatment services	
Professional services of physicians <ul style="list-style-type: none"> • In physician's office • Specialty Care and OB-GYN • Pediatric Care including Well-baby Care 	\$10 per office visit
Professional services of physicians <ul style="list-style-type: none"> • In an urgent care center • During a hospital stay • In a skilled nursing facility • Initial examination of a newborn child covered under a family enrollment • Office medical consultations • Second surgical opinion 	\$10 per office visit \$25 per office visit Nothing Nothing Nothing \$10 per office visit \$10 per office visit
At home	Nothing

Lab, X-ray and other diagnostic tests	You pay
Tests, such as: <ul style="list-style-type: none"> • Blood tests • Urinalysis • Non-routine pap tests • Pathology • X-rays • Non-routine Mammograms • Cat Scans/MRI • Ultrasound • Electrocardiogram and EEG 	Nothing for diagnostic test \$10 per doctor visit
Preventive care, adult	
Routine screenings, such as: <ul style="list-style-type: none"> • Blood lead level – One annually • Total Blood Cholesterol – once every three years, ages 19 through 64 • Colorectal Cancer Screening, including <ul style="list-style-type: none"> ••Fecal occult blood test 	\$10 per doctor visit Nothing for routine screening
<ul style="list-style-type: none"> ••Sigmoidoscopy, screening – every five years starting at age 50 	\$10 for doctor visit Nothing for test
Prostate Specific Antigen (PSA test) – one annually for men age 40 and older	\$10 for doctor visit Nothing for test
Routine pap test Note: The office visit is covered if pap test is received on the same day; see <i>Diagnosis and Treatment</i> , above.	\$10 for doctor visit Nothing for test
Routine mammogram –covered for women age 35 and older, as follows: <ul style="list-style-type: none"> • From age 35 through 39, one during this five year period • From age 40 through 64, one every calendar year • At age 65 and older, one every two consecutive calendar years 	Nothing
<i>Not covered: Physical exams required for obtaining or continuing employment or insurance, attending schools or camp, or travel.</i>	<i>All charges</i>
Routine Immunizations, limited to: <ul style="list-style-type: none"> • Tetanus-diphtheria (Td) booster – once every 10 years, ages 19 and over (except as provided for under Childhood immunizations) • Influenza/Pneumococcal vaccines, annually, age 65 and over 	\$10 per office visit Nothing for immunization

Preventive care, children	You pay
<ul style="list-style-type: none"> • Childhood immunizations recommended by the American Academy of Pediatrics 	\$10 per office visit
<ul style="list-style-type: none"> • Examinations, such as: <ul style="list-style-type: none"> ••Eye exams through age 17 to determine the need for vision correction ••Ear exams through age 17 to determine the need for hearing correction ••examinations done on the day of immunizations (through age 22) ••Well-child care charges for routine examinations, immunizations, and care (through age 22) 	\$10 per office visit
Maternity care	
<p>Complete maternity (obstetrical) care, such as:</p> <ul style="list-style-type: none"> • Prenatal care • Delivery • Postnatal care <p>Note: Here are some things to keep in mind:</p> <ul style="list-style-type: none"> • You do not need to precertify your normal delivery; see page 9 for other circumstances, such as extended days for you or your baby. • You may remain in the hospital up to 48 hours after a regular delivery and 96 hours after a cesarean delivery. We will extend your inpatient stay if medically necessary. • We cover routine nursery care of the newborn child during the covered portion of the mother’s maternity stay. We will cover other care of an infant who requires non-routine treatment only if we cover the infant under a Self and Family enrollment. • We pay hospitalization and surgeon services (delivery) the same as for illness and injury. See Hospital benefits (Section 5c) and Surgery benefits (Section 5b). 	<p>\$10 per pregnancy</p> <p>Nothing</p> <p>Nothing</p>
<p><i>Not covered: Routine sonograms to determine fetal age, size or sex</i></p>	<p><i>All charges</i></p>
Family planning	
<ul style="list-style-type: none"> • Voluntary sterilization • Surgically implanted contraceptives • Injectable contraceptive drugs • Intrauterine devices (IUDs) 	<p>\$10 per office visit</p> <p>\$250 per device</p> <p>\$30 per injection</p> <p>\$10 per office visit</p>
<p><i>Not covered: reversal of voluntary surgical sterilization, genetic counseling,</i></p>	<p><i>All charges</i></p>

Infertility services	You pay
Diagnosis and treatment of infertility, such as: <ul style="list-style-type: none"> • Artificial insemination: <ul style="list-style-type: none"> •• <i>intravaginal insemination (IVI)</i> 	\$10 per office visit
<i>Not covered:</i> <ul style="list-style-type: none"> • <i>Assisted reproductive technology (ART) procedures, such as:</i> <ul style="list-style-type: none"> •• <i>in vitro fertilization</i> •• <i>embryo transfer and GIFT</i> • <i>Services and supplies related to excluded ART procedures</i> • <i>Cost of donor sperm</i> • <i>Fertility drugs</i> 	<i>All charges</i>
Allergy care	
Testing and treatment Allergy injection	\$10 per office visit Nothing
Allergy serum	Nothing
<i>Not covered: provocative food testing and sublingual allergy desensitization</i>	<i>All charges</i>
Treatment therapies	
<ul style="list-style-type: none"> • Chemotherapy and radiation therapy <p>Note: High dose chemotherapy in association with autologous bone marrow transplants are limited to those transplants listed under Organ/Tissue Transplants on page 23.</p> <ul style="list-style-type: none"> • Respiratory and inhalation therapy • Dialysis – Hemodialysis and peritoneal dialysis • Intravenous (IV)/Infusion Therapy – Home IV and antibiotic therapy • Growth hormone therapy (GHT) <p>Note: – We will only cover GHT when we preauthorize the treatment. Call toll-free at 1-877-855-3034 for preauthorization. We will ask you to submit information that establishes that the GHT is medically necessary. Ask us to authorize GHT before you begin treatment; otherwise, we will only cover GHT services from the date you submit the information. If you do not ask or if we determine GHT is not medically necessary, we will not cover the GHT or related services and supplies. See <i>Services requiring our prior approval</i> in Section 3.</p>	Nothing

Rehabilitative therapies	You pay
<p>Physical therapy, occupational therapy and speech therapy --</p> <ul style="list-style-type: none"> • Up to two months of coverage per condition, illness, or injury if significant improvement can be expected within two months. <ul style="list-style-type: none"> ••qualified physical therapists; ••speech therapists; and ••occupational therapists. <p>Note: We only cover therapy to restore bodily function or speech when there has been a total or partial loss of bodily function or functional speech due to illness or injury.</p> <ul style="list-style-type: none"> • Cardiac rehabilitation following a heart transplant, bypass surgery or a myocardial infarction, is provided for up to 36 visits per occurrence. 	\$10 per office visit
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>long-term rehabilitative therapy</i> • <i>exercise programs</i> 	<i>All charges</i>
Hearing services (testing, treatment, and supplies)	
<ul style="list-style-type: none"> • Hearing screening for children (see <i>Preventive care, children</i>) 	\$10 per office visit
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>all other hearing testing</i> • <i>hearing aids, testing and examinations for them</i> 	<i>All charges</i>
Vision services (testing, treatment, and supplies)	
<ul style="list-style-type: none"> • Prescription lenses, frames and contacts are covered every two years 	All charges over \$125 once every 2 years
<ul style="list-style-type: none"> • One pair of eyeglasses or contact lenses to correct an impairment directly caused by accidental ocular injury or intraocular surgery (such as for cataracts) 	\$10 per office visit
<ul style="list-style-type: none"> • Eye exam to determine the need for vision correction for children through age 17 (see preventive care) • Annual eye refractions 	\$10 per office visit
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Eye exercises and orthoptics</i> • <i>Radial keratotomy and other refractive surgery</i> 	<i>All charges</i>

Foot care	You pay
<p>Routine foot care when you are under active treatment for a metabolic or peripheral vascular disease, such as diabetes.</p> <p>See orthopedic and prosthetic devices for information on podiatric shoe inserts.</p>	<p>\$10 per office visit</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Cutting, trimming or removal of corns, calluses, or the free edge of toenails, and similar routine treatment of conditions of the foot, except as stated above</i> • <i>Treatment of weak, strained or flat feet or bunions or spurs; and of any instability, imbalance or subluxation of the foot (unless the treatment is by open cutting surgery)</i> 	<p><i>All charges</i></p>
Orthopedic and prosthetic devices	
<ul style="list-style-type: none"> • Artificial limbs and eyes; stump hose • Externally worn breast prostheses and surgical bras, including necessary replacements, following a mastectomy • Internal prosthetic devices, such as artificial joints, pacemakers, cochlear implants, and surgically implanted breast implant following mastectomy. Note: See 5(b) for coverage of the surgery to insert the device. • Corrective prosthetic appliances for non-dental treatment of temporomandibular joint (TMJ) pain dysfunction syndrome. 	<p>\$10 per office visit</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>orthopedic and corrective shoes</i> • <i>arch supports</i> • <i>foot orthotics</i> • <i>heel pads and heel cups</i> • <i>lumbosacral supports</i> • <i>corsets, trusses, elastic stockings, support hose, and other supportive devices</i> • <i>prosthetic replacements except as determined medically necessary</i> 	<p><i>All charges</i></p>

Durable medical equipment (DME)	You pay
<p>Rental or purchase, at our option, including repair and adjustment, of durable medical equipment prescribed by your Plan physician, such as oxygen and dialysis equipment. Under this benefit, we also cover:</p> <ul style="list-style-type: none"> • hospital beds; • wheelchairs; • crutches; • walkers; • blood glucose monitors; and • insulin pumps. <p>Note: Call us at 1-877-855-3034 as soon as your Plan physician prescribes this equipment. We will arrange with a health care provider to rent or sell you durable medical equipment at discounted rates and will tell you more about this service when you call.</p>	Nothing
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Motorized wheel chairs</i> • <i>Convenience items for wheelchairs</i> • <i>Electrical hospital beds unless Medically Necessary</i> 	<i>All charges</i>
Home health services	
<ul style="list-style-type: none"> • Home health care ordered by a Plan physician and provided by a registered nurse (R.N.), licensed practical nurse (L.P.N.), licensed vocational nurse (L.V.N.), or home health aide. • Services include oxygen therapy, intravenous therapy and medications. 	Nothing
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>nursing care requested by, or for the convenience of, the patient or patient's family;</i> • <i>nursing care primarily for hygiene, feeding, exercising, moving the patient, homemaking, companionship or giving oral medication.</i> 	<i>All charges</i>
Alternative treatments	
<ul style="list-style-type: none"> • Muskulo-skeletal Treatment, up to 20 visits per calendar year • Biofeedback, for the treatment of pain management, up to 20 visits per calendar year 	\$10 per office visit

Alternative treatments (<i>Continued</i>)	You pay
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Naturopathic services</i> • <i>hypnotherapy</i> • <i>acupuncture</i> 	<p><i>All charges</i></p>
Educational classes and programs	
<p>Coverage is limited to:</p> <ul style="list-style-type: none"> • Smoking Cessation – Up to \$100 for one smoking cessation program per member per lifetime, including all related expenses such as drugs. • Healthy ReturnssmDisease Management Program • Baby Benefitssm Maternity Program 	<p>All charges over \$100</p> <p>Nothing</p> <p>Nothing</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>nursing care requested by, or for the convenience of, the patient or the patient's family;</i> • <i>nursing care primarily for hygiene, feeding, exercising, moving the patient, homemaking, companionship or giving oral medication.</i> 	<p><i>All charges</i></p>

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

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

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

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Benefit Description	You pay
Surgical procedures	
<ul style="list-style-type: none"> • Treatment of fractures, including casting • Normal pre- and post-operative care by the surgeon • Correction of amblyopia and strabismus • Endoscopy procedure • Biopsy procedure • Removal of tumors and cysts • Correction of congenital anomalies (see reconstructive surgery) • Surgical treatment of morbid obesity -- a condition in which an individual weighs 100% over his or her normal weight according to current underwriting standards or has a Body Mass Index (BMI) of greater than 40 kg/m²; or is 50% over his or her normal weight or 100 lbs overweight, whichever is greater, and has severe co-morbidity; or whose weight exceeds the ideal weight in the above range for at least five years; or who has a documented history within the past three years of at least one non-surgical attempt to lose weight in a physician-supervised weight loss program of at least three months duration. The individual must have achieved full growth and have undergone psychiatric or behavioral health evaluation within the last year to rule out an eating disorder. • Insertion of internal prosthetic devices. See 5(a) – Orthopedic braces and prosthetic devices for device coverage information. 	<p>\$10 per office visit, if performed in doctor’s office</p> <p>Nothing when performed in hospital</p>

Surgical procedures (Continued)	You pay
<ul style="list-style-type: none"> • Voluntary sterilization • Norplant (a surgically implanted contraceptive) and intrauterine devices (IUDs) Note: Devices are covered under 5(a). • Treatment of burns <p>Note: Generally, we pay for internal prostheses (devices) according to where the procedure is done. For example, we pay Hospital benefits for a pacemaker and Surgery benefits for insertion of the pacemaker.</p>	\$10 per office visit; nothing if performed in a hospital
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Reversal of voluntary sterilization</i> • <i>Routine treatment of conditions of the foot; see Foot care.</i> 	<i>All charges</i>
Reconstructive surgery	
<ul style="list-style-type: none"> • Surgery to correct a functional defect • Surgery to correct a condition caused by injury or illness if: <ul style="list-style-type: none"> ••the condition produced a major effect on the member's appearance and ••the condition can reasonably be expected to be corrected by such surgery • Surgery to correct a condition that existed at or from birth and is a significant deviation from the common form or norm. Examples of congenital anomalies are: protruding ear deformities; cleft lip; cleft palate; birth marks; webbed fingers; and webbed toes. • All stages of breast reconstruction surgery following a mastectomy, such as: <ul style="list-style-type: none"> •• surgery to produce a symmetrical appearance on the other breast; •• treatment of any physical complications, such as lymphedemas; •• breast prostheses and surgical bras and replacements (see Prosthetic devices) <p>Note: If you need a mastectomy, you may choose to have the procedure performed on an inpatient basis and remain in the hospital up to 48 hours after the procedure.</p>	\$10 per office visit; nothing if performed in a hospital
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Cosmetic surgery – any surgical procedure (or any portion of a procedure) performed primarily to improve physical appearance through change in bodily form, except repair of accidental injury</i> • <i>Surgeries related to sex transformation</i> 	<i>All charges</i>

Oral and maxillofacial surgery	You pay
<p>Oral surgical procedures, limited to:</p> <ul style="list-style-type: none"> • Reduction of fractures of the jaws or facial bones; • Surgical correction of cleft lip, cleft palate or severe functional malocclusion; • Removal of stones from salivary ducts; • Excision of leukoplakia or malignancies; • Excision of cysts and incision of abscesses when done as independent procedures; and • Other surgical procedures that do not involve the teeth or their supporting structures. 	<p>\$10 per office visit; nothing if performed in a hospital</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Oral implants and transplants</i> • <i>Procedures that involve the teeth or their supporting structures (such as the periodontal membrane, gingiva, and alveolar bone)</i> 	<p><i>All charges</i></p>
Organ/tissue transplants	
<p>Limited to:</p> <ul style="list-style-type: none"> • Cornea • Heart • Heart/lung • Kidney • Kidney/Pancreas • Liver • Lung: Single –Double • Pancreas <ul style="list-style-type: none"> • Allogeneic (donor) transplants • Autologous bone marrow transplants (autologous stem cell and peripheral stem cell support) for the following conditions: acute lymphocytic or non-lymphocytic leukemia; advanced Hodgkins’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. Transplants are covered when approved by Medical Director. Note: We cover related medical and hospital expenses of the donor when we cover the recipient. • National Transplant Program (NTP) - <i>The United Resource Networks Transplant Network</i> 	<p>Nothing</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Donor screening tests and donor search expenses, except those performed for the actual donor</i> • <i>Implants of artificial organs</i> • <i>Transplants not listed as covered</i> 	<p><i>All charges</i></p>

Anesthesia	You pay
Professional services provided in – <ul style="list-style-type: none"> • Hospital (inpatient) 	Nothing
Professional services provided in – <ul style="list-style-type: none"> • Hospital outpatient department • Skilled nursing facility • Ambulatory surgical center • Office 	Nothing

Inpatient hospital (Continued)	You pay
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • Custodial care • Non-covered facilities, such as nursing homes, extended care facilities, schools • Personal comfort items, such as telephone, television, barber services, guest meals and beds • Private nursing care • Blood and blood derivatives not replaced by the member 	<p><i>All charges</i></p>
Outpatient hospital or ambulatory surgical center	
<ul style="list-style-type: none"> • Operating, recovery, and other treatment rooms • Prescribed drugs and medicines • Diagnostic laboratory tests, X-rays, and pathology services • Administration of blood, blood plasma, and other biologicals • Blood and blood plasma, if donated or replaced • Pre-surgical testing • Dressings, casts, and sterile tray services • Medical supplies, including oxygen • Anesthetics and anesthesia service <p>NOTE: – We cover hospital services and supplies related to dental procedures when necessitated by a non-dental physical impairment. We do not cover the dental procedures.</p>	<p>\$100 per surgery</p>
<p><i>Not covered: blood and blood derivatives not replaced by the member</i></p>	<p><i>All charges</i></p>
Extended care benefits/skilled nursing care facility benefits	
<p>Covered for up to 100 days per calendar year when full time skilled nursing care is necessary and confinement in a Skilled Nursing Facility (SNF) is medically appropriate as determined by a Plan doctor and approved by the Plan.</p>	<p>Nothing</p>
<p><i>Not covered: custodial care</i></p>	<p><i>All charges</i></p>
Hospice care	
<p>Services include:</p> <ul style="list-style-type: none"> • Inpatient care • Outpatient care • Family counseling <p>NOTE: – Supportive and palliative care for a terminally ill member is covered in the home or a hospice facility. 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.</p>	<p>Nothing</p>
<p><i>Not covered: Independent nursing, homemaker services</i></p>	<p><i>All charges</i></p>

Ambulance	You pay
<ul style="list-style-type: none">Local professional ambulance service when medically appropriate	Nothing

Section 5 (d). Emergency services/accidents

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

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

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What is a medical emergency?

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

What to do in case of emergency:

Emergencies within our service area: If you are in an emergency situation, please call your primary care physician (PCP). 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 must notify the Plan as soon as it is reasonably possible to do so. It is your responsibility to ensure that the Plan has been notified in a timely manner.

If you need to be hospitalized, please notify the Plan or your PCP to inform them of your condition and the services you are receiving as soon as reasonably possible upon stabilization of your condition. 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.

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

Emergencies outside our 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 as soon as reasonably possible following your admission. 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 services to the extent the services would have been covered if received from Plan providers.

Benefit Description	You pay
Emergency within our service area	
<ul style="list-style-type: none"> • Emergency care at a doctor's office • Emergency care at an urgent care center • Emergency care as an outpatient or inpatient at a hospital, including doctors' services 	<p>\$10 per office visit</p> <p>\$25 per office visit</p> <p>\$50 per emergency room visit; waived if admitted to a hospital.</p>
<i>Not covered: Elective care or non-emergency care</i>	<i>All charges</i>
Emergency outside our service area	
<ul style="list-style-type: none"> • Emergency care at a doctor's office • Emergency care at an urgent care center • Emergency care as an outpatient or inpatient at a hospital, including doctors' services 	<p>\$10 per office visit</p> <p>\$25 per office visit</p> <p>\$50 per emergency room visit; waived if admitted to a hospital.</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Elective care or non-emergency care</i> • <i>Emergency care provided outside the service area if the need for care could have been foreseen before leaving the service area</i> • <i>Medical and hospital costs resulting from a normal full-term delivery of a baby outside the service area</i> 	<i>All charges</i>
Ambulance	
<p>Professional ambulance service when medically appropriate.</p> <p>See 5(c) for non-emergency service.</p>	Nothing

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

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Parity

Beginning in 2001, all FEHB plans' mental health and substance abuse benefits will achieve "parity" with other benefits. This means that we will provide mental health and substance abuse benefits differently than in the past.

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

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

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

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Benefit Description	You pay
Mental health and substance abuse benefits	
<p>All diagnostic and treatment services recommended by a Plan provider and contained in a treatment plan that we approve. The treatment plan may include services, drugs, and supplies described elsewhere in this brochure.</p> <p>Note: Plan benefits are payable only when we determine the care is clinically appropriate to treat your condition and only when you receive the care as part of a treatment plan that we approve.</p>	<p>Your cost sharing responsibilities are no greater than for other illness or conditions.</p>
<ul style="list-style-type: none"> • Professional services, including individual or group therapy by providers such as psychiatrists, psychologists, or clinical social workers • Medication management 	<p>\$10 per office visit</p>
<ul style="list-style-type: none"> • Diagnostic tests 	<p>Nothing</p>
<ul style="list-style-type: none"> • Services provided by a hospital or other facility • Services in approved alternative care settings such as partial hospitalization, half-way house, residential treatment, full-day hospitalization, facility based intensive outpatient treatment 	<p>\$100 per admission</p>

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

Preauthorization

A primary care doctor referral is not required for members to access mental conditions/substance abuse benefits. To make arrangements to receive these services, you must call Magellan Behavioral Health at 1-800-359-2422.

Special transitional benefit

If a mental health or substance abuse professional provider is treating you under our plan as of January 1, 2001, you will be eligible for continued coverage with your provider for up to 90 days under the following conditions:

- If your mental health or substance abuse professional provider with whom you are currently in treatment leaves the plan at our request for other than cause.

If this condition applies to you, we will allow you reasonable time to transfer your care to a Plan mental health or substance abuse professional provider. During the transitional period, you may continue to see your treating provider and will not pay any more out-of-pocket than you did in the year 2000 for services. This transitional period will begin with our notice to you of the change in coverage and will end 90 days after you receive our notice. If we write to you before October 1, 2000, the 90-day period ends before January 1 and this transitional benefit does not apply.

Section 5 (f). Prescription drug benefits

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

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

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

- **Who can write your prescription.**

A licensed Plan or referral doctor must write the prescription.

- **Where you can obtain them:**

You must fill the prescription at a Plan pharmacy except for Emergency or Urgent Care prescriptions. You can choose to have up to a three month supply of certain maintenance medications filled at a Plan pharmacy or by mail. Maintenance medications are prescription drugs that are designated as such in the prescription drug formulary, and are prescribed for use in a chronic disease state or in the treatment of a disease or illness the course of which is expected to continue for more than 102 days, and must be taken on a regular basis.

- **We use an open formulary.**

An open formulary provides coverage for the full range of FDA-approved drugs, prescriptions, and devices for birth control. You pay a \$10 copayment per prescription unit or refill for generic drugs, a \$20 copayment for brand name drugs listed as Preferred on our formulary, and a \$30 copayment for brand name drugs listed as Non-Preferred on our formulary.

“Preferred” drugs are brand name prescription drugs designated by Doctors Health Plan, Inc. as Preferred, and include drugs which have been proven clinically effective when compared to other therapies. “Non-Preferred” drugs are all brand name drugs not listed as Preferred. These include new FDA-approved drugs where comparison with established treatment is difficult; brand name prescription drugs which have a generic equivalent; prescription drugs which offer no significant therapeutic advantage over drugs classified as Generic or Preferred Brand; or prescription drugs not usually used as a first-line treatment choice.

Certain drugs associated with non-covered services are not covered.

- **These are the dispensing limitations:**

Prescription drugs will be dispensed for up to a 30-day supply. Member may purchase up to a three-month supply of drugs on the maintenance list for two copayments.

Listings of Preferred brand name drugs, Non-Preferred brand name drugs and Maintenance list drugs, and/or prescription drugs with dispensing limits will be supplied to Members upon request by calling Doctors Health Plan, Inc. at 1-877-855-3034.

- **When you have to file a claim.**

Contact Doctors Health Plan to receive a drug reimbursement claim form. Submit the form with applicable receipts to the address on the form.

Benefit Description	You pay
Covered medications and supplies	
<p>We cover the following medications and supplies prescribed by a Plan physician and obtained from a Plan pharmacy or through our mail order program:</p> <ul style="list-style-type: none"> • Drugs for which a prescription is required by law • Full range of FDA-approved drugs, prescription, and devices for birth control • Insulin; a copay charge applies to each vial • Disposable needles and syringes needed to inject covered prescribed medication • Diabetic supplies, including insulin syringes, needles, glucose test tablets and test tape, Benedict’s solution or equivalent, glucose monitors and acetone test tablets • Drugs to treat sexual dysfunction are limited. Contact the Plan for dose limits. • Intravenous fluids and medication for home use, implantable drugs, such as Norplant, and some injectable drugs are covered under <i>Medical and Surgical Benefits</i>. <p>We have an open formulary. If your physician believes a name brand product is necessary or there is no generic available, your physician may prescribe a name brand drug from a formulary list. This list of name brand drugs is a preferred list of drugs that we selected to meet patient needs at a lower cost. To order a prescription drug brochure, call 1-877-855-3034.</p>	<p>\$10 copay for generic drugs</p> <p>\$20 copay for Preferred brand name drugs and Preferred brand name glucose test strips</p> <p>\$30 copay for Non-Preferred brand name drugs and Non-Preferred brand name glucose test strips</p> <p>NOTE: If there is no generic equivalent available, you will still have to pay the brand name copay.</p>

Covered medications and supplies	You pay
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Drugs and supplies for cosmetic purposes</i> • <i>Vitamins, nutrients and food supplements even if a physician prescribes or administers them except for prenatal vitamins</i> • <i>Nonprescription medicines</i> • <i>Fertility drugs</i> • <i>Athletic performance drugs</i> • <i>Medical supplies</i> 	<p><i>All Charges</i></p>

Section 5 (g). Special Features

Feature	Description
<p>Centers of excellence for transplants/heart surgery/etc.</p>	<p>Patients requiring transplant services have access to the United Resource Networks Transplant Network, a national transplant network. Each facility undergoes an extensive credentialing to gauge the quality of each transplant program, and programs undergo annual review for ongoing participation in the network. Doctors Health Plan has a dedicated Transplant Case Manager who follows the transplant candidate from initial referral, facility selection, initial evaluation, pre-transplant services, transplantation, and post-transplant care.</p>
<p>Quarterly Newsletters</p>	<p>You receive <i>Healthy Elements</i>, a quarterly newsletter. The newsletter provides updates, changes and/or important news about Doctors Health Plan. It promotes health and wellness as well as Doctors Health Plan's disease management programs.</p>
<p>Healthy Returnssm Disease Management Program</p>	<p>Conditions: Asthma, Diabetes, Coronary Artery Disease, and Congestive Heart Failure. Educational information, integrated member care, behavior modification assistance, case management, and assistance to you and your family in managing chronic disease states.</p>
<p>Baby Benefitssm Maternity Program</p>	<p>Doctors Health maternity program Baby provides educational materials for mothers before and after delivery date, identifies signs of pre-term labor and high risk pregnancies, and manages risk cases.</p>
<p>Healthy Returnssm 24-hour Nurse Line</p>	<p>Provides access to a Registered Nurse 24 hours a day, triage to the appropriate level of care, patient education and information, an audiotape library with over 400 topics, and access to an interactive Web site.</p>

Section 5 (h). Dental benefits

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

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

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Accidental injury benefit

We cover 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

\$10 per office visit; \$25 per urgent center care visit; \$50 per emergency room visit (emergency room copay waived if you are admitted to hospital).

Dental benefits

We have no other dental benefits.

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

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

Complementary Health Care Access Program

As a member of Doctors Health Plan, Inc. you are eligible for:

Complementary Health Care Providers - Access to an extensive network of Complementary Health Care Providers, including chiropractors, acupuncturists and massage therapists. These providers have met strict credentialing criteria and have agreed to accept special member fees for services they provide to you. This program allows you to access high quality providers at a 25% discount off of charges.

Fitness Clubs - Access to various fitness clubs, through a partnership with the International Fitness Club Network (IFCN). The IFCN participating clubs offer the lowest membership rates for the type of membership you select.

Healthyroads.com - Access to healthyroads.com on-line or toll-free by phone. This website and mail order catalog offers hundreds of high quality health products such as vitamins, herbal supplements, books, tapes and other products. Prices are guaranteed to be the same or lower than amazon.com, drugstore.com and barnesandnoble.com.

A member kit will be sent to you that includes the provider directory and brochures.

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

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

We do not cover the following:

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

Section 7. Filing a claim for covered services

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

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

Medical and hospital benefits

In most cases, providers and facilities file claims for you. Physicians must file on the form HCFA-1500, Health Insurance Claim Form. Facilities will file on the UB-92 form. For claims questions and assistance, call us toll-free at 1-877-855-3034.

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

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

**Submit your claims to: Doctors Health Plan, Inc.
3104 Croasdaile Drive, Suite 300
Durham, NC 27705**

Prescription drugs

Call Member Services at 1-877-855-3034 to receive a claim form, and attach your receipt.

**Submit your claims to: ATTN: DMR's
PharmaCare
695 George Washington Hwy
Lincoln, RI 02865**

Deadline for filing your claim

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

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

Section 8. The disputed claims process

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

Step	Description
------	-------------

- | | |
|----------|---|
| 1 | <p>Ask us in writing to reconsider our initial decision. Write to us at: 3104 Croasdaile Drive, Suite 300, Durham, NC 27705. You must:</p> <ol style="list-style-type: none">Write to us within 6 months from the date of our decision; andSend your request to us at: Doctors Health Plan, Inc., 3104 Croasdaile Drive, Suite 300, Durham, NC 27705; andInclude a statement about why you believe our initial decision was wrong, based on specific benefit provisions in this brochure; andInclude copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms. |
|----------|---|

- | | |
|----------|---|
| 2 | <p>We have 30 days from the date we receive your request to:</p> <ol style="list-style-type: none">Pay the claim, (or if applicable, arrange for the health care provider to give you the care); orWrite to you and maintain our denial -- go to step 4; orAsk you or your provider for more information. If we ask your provider, we will send you a copy of our request—go to step 3. |
|----------|---|

- | | |
|----------|---|
| 3 | <p>You or your provider must send the information so that we receive it within 60 days of our request. We will then decide within 30 more days.</p> <p>If we do not receive the information within 60 days, we will decide within 30 days of the date the information was due. We will base our decision on the information we already have.</p> <p>We will write to you with our decision.</p> |
|----------|---|

- | | |
|----------|---|
| 4 | <p>If you do not agree with our decision, you may ask OPM to review it.</p> <p>You must write to OPM within:</p> <ul style="list-style-type: none">90 days after the date of our letter upholding our initial decision; or120 days after you first wrote to us -- if we did not answer that request in some way within 30 days; or120 days after we asked for additional information. |
|----------|---|

Write to OPM at: Office of Personnel Management, Office of Insurance Programs, Contracts Division III, P.O. Box 436, Washington, D.C. 20044-0436.

Send OPM the following information:

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

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

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

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

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

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

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

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

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

- (a) We haven't responded yet to your initial request for care or preauthorization/prior approval, then call us toll-free at 1-877-855-3034 and we will expedite our review; or
- (b) We denied your initial request for care or preauthorization/prior approval, then:
 - If we expedite our review and maintain our denial, we will inform OPM so that they can give your claim expedited treatment too, or
 - You can call OPM's Health Benefits Contracts Division III at 202/606-0737 between 8 a.m. and 5 p.m. eastern time.

Section 9. Coordinating benefits with other coverage

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

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

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

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

- What is Medicare?

Medicare is a Health Insurance Program for:

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

Medicare has two parts:

- Part A (Hospital Insurance). Most people do not have to pay for Part A.
- Part B (Medical Insurance). Most people pay monthly for Part B.

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

- The Original Medicare Plan

The Original Medicare Plan is available everywhere in the United States. It is the way most people get their Medicare Part A and Part B benefits. You may go to any doctor, specialist, or hospital that accepts Medicare. Medicare pays its share and you pay your share. Some things are not covered under Original Medicare, like prescription drugs.

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

We will not waive any of our copayments.

(Primary payer chart begins on next page.)

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

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

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

Claims process -- You may have to file a claim form when you have both our Plan and Medicare if your plan physician does not participate with Medicare.

- When we are the primary payer, we process the claim first.
- When Original Medicare is the primary payer, Medicare processes your claim first. In most cases, your claims will be coordinated automatically and we will pay the balance of covered charges. You will not need to do anything. To find out if you need to do something about filing your claims, call us 1-877-855-3034.
- **We waive some costs when you have Medicare --** When Medicare is the primary payer, we will waive some out-of-pocket costs, as follows:
 - Medical services and supplies provided by physicians and other health care professionals.
 - Your hospital admission copayment.

- Medicare managed care plan

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

This Plan and another Plan's Medicare managed care plan: You may enroll in another plan's Medicare managed care plan and also remain enrolled in our FEHB plan. We will still provide benefits when your Medicare managed care plan is primary, even out of the managed care plan's network and/or service area (if you use our Plan providers), but we will not waive any of our copayments.

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

- Enrollment in Medicare Part B

Note: If you choose not to enroll in Medicare Part B, you can still be covered under the FEHB Program. We cannot require you to enroll in Medicare.

TRICARE

TRICARE is the health care program for eligible dependents of military persons and retirees of the military. TRICARE includes the CHAMPUS program. If both TRICARE and this Plan cover you, we pay first. See

your TRICARE Health Benefits Advisor if you have questions about TRICARE coverage.

Workers' Compensation

We do not cover services that:

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

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

Medicaid

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

When other Government agencies are responsible for your care

We do not cover services and supplies when a local, State, or Federal Government agency directly or indirectly pays for them.

When others are responsible for injuries

When you receive money to compensate you for medical or hospital care for injuries or illness caused by another person, you must reimburse us for any expenses we paid. However, we will cover the cost of treatment that exceeds the amount you received in the settlement.

If you do not seek damages you must agree to let us try. This is called subrogation. If you need more information, contact us for our subrogation procedures.

Section 10. Definitions of terms we use in this brochure

Calendar year	January 1 through December 31 of the same year. For new enrollees, the calendar year begins on the effective date of their enrollment and ends on December 31 of the same year.
Copayment	A copayment is a fixed amount of money you pay when you receive covered services. See page 11.
Covered services	Care we provide benefits for, as described in this brochure.
Custodial care	Care that provides a level of routine maintenance for the purpose of meeting personal needs. Custodial care can be provided by a layperson who does not have professional qualifications, skills or training.
Experimental or investigational services	<p>A drug, treatment, device or procedure that meets any of the following conditions:</p> <ul style="list-style-type: none">A. It requires federal or other governmental agency approval, and such approval has not been granted at the time of use or proposed use. Examples include drugs and devices that do not have unrestricted market approval from the Food and Drug Administration (FDA) or final approval from any other governmental regulatory body for use in treatment of a specified condition. Any approval that is granted as an interim step in the regulatory process is not a substitute for final or unrestricted market approval;B. It is being provided pursuant to a Phase I or Phase II clinical trial;C. There is insufficient or inconclusive:<ul style="list-style-type: none">• published authoritative medical and scientific literature to establish the efficacy of the treatment, drug, device or procedure;• evidence that the service or supply has a beneficial effect on health outcomes;• scientific evidence that, when utilized in a non-investigational setting, the service or supply has a beneficial effect on health outcomes and is as beneficial as any established alternatives.D. It is not as beneficial as any established alternatives;E. Its delivery or provision is directly attributable to, or a result of, an Experimental and Investigational procedure;F. It is otherwise reasonably determined by Doctors Health Plan, Inc. to be Experimental and Investigational in nature.
Group health coverage	Any Group health plan that is offered by the Group and covers the Subscriber or Family Members as part of the Group.
Medical necessity	<p>For the purpose of payment, a covered activity, service or supply that is:</p> <ol style="list-style-type: none">1. Provided for the diagnosis, treatment, cure or relief of a Medical Condition, illness, injury or disease;2. Not for experimental, investigational or cosmetic purposes;3. Necessary for and appropriate to the diagnosis, treatment, cure or relief of a health condition, illness, injury, disease or its symptoms;4. Within generally accepted standards of medical care in the community;5. Not solely for the convenience of the insured, the insured's family or the provider.

For Medically Necessary services, Doctors Health Plan, Inc. will compare the cost-effectiveness of alternative services and supplies when interpreting which of these services will be covered.

Us/We

Us and we refer to Doctors Health Plan, Inc.

You

You refers to the enrollee and each covered family member.

Section 11. FEHB facts

No pre-existing condition limitation

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

Where you can get information about enrolling in the FEHB Program

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

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

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

Types of coverage available for you and your family

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

If you have a Self Only enrollment, you may change to a Self and Family enrollment if you marry, give birth, or add a child to your family. You may change your enrollment 31 days before to 60 days after that event. The Self and Family enrollment begins on the first day of the pay period in which the child is born or becomes an eligible family member. When you change to Self and Family because you marry, the change is effective on the first day of the pay period that begins after your employing office receives your enrollment form; benefits will not be available to your spouse until you marry.

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

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

When benefits and premiums start

The benefits in this brochure are effective on January 1. If you are new to this Plan, your coverage and premiums begin on the first day of your first pay period that starts on or after January 1. Annuitants' premiums begin on January 1.

Your medical and claims records are confidential

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

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

When you retire

When you retire, you can usually stay in the FEHB Program. Generally, you must have been enrolled in the FEHB Program for the last five years of your Federal service. If you do not meet this requirement, you may be eligible for other forms of coverage, such as Temporary Continuation of Coverage (TCC).

When you lose benefits

- When FEHB coverage ends

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

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

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

- Spouse equity coverage

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

- TCC

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

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

Get the RI 79-27, which describes TCC, and the RI 70-5, *the Guide to Federal Employees Health Benefits Plans for Temporary Continuation of*

Coverage and Former Spouse Enrollees, from your employing or retirement office or from www.opm.gov/insure.

- Converting to individual coverage

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

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

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

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

Getting a Certificate of Group Health Plan Coverage

If you leave the FEHB Program, we will give you a Certificate of Group Health Plan Coverage that indicates how long you have been enrolled with us. You can use this certificate when getting health insurance or other health care coverage. Your new plan must reduce or eliminate waiting periods, limitations, or exclusions for health related conditions based on the information in the certificate, as long as you enroll within 63 days of losing coverage under this Plan.

If you have been enrolled with us for less than 12 months, but were previously enrolled in other FEHB plans, you may also request a certificate from those plans.

Inspector General Advisory

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

- Call the provider and ask for an explanation. There may be an error.
- If the provider does not resolve the matter, call us toll-free at 1-877-855-3034 and explain the situation.
- If we do not resolve the issue, call **THE HEALTH CARE FRAUD HOTLINE--202/418-3300** or write to: The United States Office of Personnel Management, Office of the Inspector General Fraud Hotline, 1900 E Street, NW, Room 6400, Washington, DC 20415.

Penalties for Fraud

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

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Do not rely on this page; it is for your convenience and does not explain your benefit coverage.

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Summary of benefits for Doctors Health Plan - 2001

- **Do not rely on this chart alone.** All benefits are provided in full unless indicated and are subject to the definitions, limitations, and exclusions in this brochure. On this page we summarize specific expenses we cover; for more detail, look inside.
- If you want to enroll or change your enrollment in this Plan, be sure to put the correct enrollment code from the cover on your enrollment form.
- We only cover services provided or arranged by Plan physicians, except in emergencies.

Benefits	You Pay	Page
Medical services provided by physicians: • Diagnostic and treatment services provided in the office	Office visit copay: \$10 primary care; \$10 specialist	13
Services provided by a hospital: • Inpatient.....	\$100 per admission copay	25
• Outpatient.....	\$100 per surgery	26
Emergency benefits: • In-area or out-of-area.....	\$10 physician's office visit \$25 urgent care facility \$50 emergency room visit	28
Mental health and substance abuse treatment	Regular cost sharing.	30
Prescription drugs	\$10 generic \$20 preferred brand \$30 non-preferred brand	33
Dental Care (Accidental Dental Only).....	\$10 physician's office visit \$25 urgent care facility \$50 emergency room visit	36
Vision Care.....	\$10 per office visit All charges over \$125 once every two years for prescription lenses, frames and contacts	17
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NOTES:

2001 Rate Information for Doctors Health Plan, Inc.

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

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

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

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

The Greater Triangle, Charlotte, Upper and Lower Cape Fear areas

Self Only	6D1	\$74.28	\$24.76	\$160.94	\$53.65	\$87.90	\$11.14
Self and Family	6D2	\$176.74	\$58.91	\$382.94	\$127.64	\$209.14	\$26.51