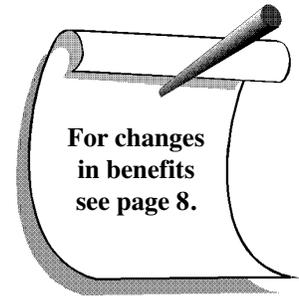

A Health Maintenance Organization

Serving: Washington, DC, Maryland, Northern Virginia,
Roanoke, Richmond and Tidewater areas

**Enrollment in this Plan is limited;
see pages 6 and 7 for requirements.**



*This Plan has excellent accreditation
from the NCQA. See the 2001 Guide
for more information on NCQA.*

Enrollment codes for this Plan:

**JP1 Self Only
JP2 Self and Family**

Authorized for distribution by the:



**United States
Office of Personnel Management**

Retirement and Insurance Service
<http://www.opm.gov/insure>



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Introduction

MD-Individual Practice Association, Inc. (MD-IPA)
4 Taft Court
Rockville, MD 20850

This brochure describes the benefits of MD-IPA under our contract (CS 1935) 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, 2002, unless those benefits are also shown in this brochure.

OPM negotiates benefits and rates with each plan annually. Benefit changes are effective January 1, 2002, and changes are summarized on page 8. Rates are shown at the end of this brochure.

Plain Language

Teams of Government and health plans' staff worked on all FEHB brochures to make them responsive, accessible, and understandable to the public. For instance,

- Except for necessary technical terms, we use common words. For instance, "you" means the enrollee or family member; "we" means MD-IPA.
- We limit acronyms to ones you know. FEHB is the Federal Employees Health Benefits Program. OPM is the Office of Personnel Management. If we use others, we tell you what they mean first.
- Our brochure and other FEHB plans' brochures have the same format and similar descriptions to help you compare plans.

If you have comments or suggestions about how to improve the structure of this brochure, let OPM know. Visit OPM's "Rate Us" feedback area at www.opm.gov/insure or e-mail OPM at fehwebcomments@opm.gov- You may also write to OPM at the Office of Personnel Management, Office of Insurance Planning and Evaluation Division, 1900 E Street, NW Washington, DC 20415-3650

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 at 301/360-8080, or 800-251-0956 and explain the situation.
- If we do not resolve the issue, call

THE HEALTH CARE FRAUD HOTLINE

202/418-3300

or write:

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.

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 and coinsurance 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.

Your Rights

OPM requires that all FEHB Plans to provide certain information to their FEHB members. You may get information about us, our 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.

If you want more information about us, call MD-IPA's Member Services Office at 301/360-8080 or at 1-800/251-0956 (TTY: 301/360-8111 or 1-800/553-7109), or write to P.O. Box 933, Frederick, and Maryland 21705. You may also contact us by fax at 301/360-8907 or visit our website at www.mamsi.com.

Service Area

To enroll in this Plan, you must live in or work in our Service Area. This is where our providers practice.

Our service area is:

Washington, D.C.;

Maryland (the entire state)

Virginia

Cities of:

Alexandria, Charlottesville, Chesapeake, Clifton Forge, Colonial Heights, Covington, Emporia, Fairfax, Falls Church, Franklin, Fredericksburg, Hampton, Hopewell, Manassas, Manassas Park, Newport News, Norfolk, Petersburg, Poquoson, Portsmouth, Radford, Richmond, Roanoke, Salem, Staunton, Suffolk, Virginia Beach, Waynesboro and Williamsburg

Counties of:

Accomack, Albemarle, Alleghany, Amelia, Arlington, Augusta, Bath, Bedford, Bland, Botetourt, Buchanan, Buckingham, Caroline, Charles City, Chesterfield, Clarke, Craig, Cumberland, Dinwiddie, Fairfax, Fauquier, Floyd, Franklin, Giles, Goochland, Gloucester, Greensville, Hanover, Henrico, Isle of Wight, James City, King George, King William, King and Queen, Loudoun, Louisa, Mathews, Middlesex, Montgomery, Nelson, New Kent, Northampton, Nottoway, Orange, Page, Patrick, Powhatan, Prince George, Prince William, Pulaski, Rappahannock, Roanoke, Russell, Southampton, Spotsylvania, Stafford, Surry, Sussex, Tazewell, Westmoreland, Wythe, and York.

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 benefits. We will not pay for any other health care services out of our service area unless the services have prior plan approval.

If you or a covered family member moves 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 moves, you do not have to wait until Open Season to change plans. Contact your employing or retirement office.

Section 2. How we change for 2002

Do not rely on these change descriptions; this page is not an official statement of benefits. For that, go to Section 5 Benefits. Also, we edited and clarified language throughout the brochure; any language change not shown here is a clarification that does not change benefits.

Program-wide changes

- We now cover certain intestinal transplants. (Section 5(b))

Changes to this Plan

- Your share of the non-Postal premium will be increase by 10.7% for Self Only coverage, or by 10.3% for Self and Family coverage.
- You pay a \$20 specialist copayment per office visit.
- You pay a \$25 urgent care center copayment or \$50 a hospital copayment for emergency care.
- You pay a \$50 outpatient copayment for products, services, and/or test at hospital outpatient departments or ambulatory surgical centers.
- You pay \$15 for brand name drugs in our formulary or \$30 for non-formulary drugs.
- Hearing aids for children under 19 years old are covered with a 50% copayment up to \$1,400 per ear every 36 months.
- We clarified *Chiropractic services* to show coverage is up to a maximum of \$500.
- We changed the speech therapy benefit to combine both rehabilitative and habilitative services. Habilitative speech therapy no longer has an age limit. All speech therapy is limited to two months or sixty (60) days, whichever is greater. (Section 5 (a))
- We have changed the age at which members can get routine vaccines for influenza from age 65 to age 50.

Section 3. How you get care

Identification cards

We will send you an identification (ID) card. 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 at 301/360-8080 or 1-800/251-0956.

Where you get covered care

You get care from “Plan providers” and “Plan facilities.” You will only pay copayments and/or coinsurance 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.

All of our physicians are credentialed in accordance with the standards set by the National Committee for Quality Assurance (NCQA). For further information on our credentialing procedures, please contact our Member Services Department 301/360-8080 or 1-800/251-0956.

We list Plan providers in the provider directory, which we update periodically. The list is also on our website, www.mamsi.com. Information in the directory is subject to change. For this reason, we recommend that you access our website to look up the most up-to-date information.

- **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. The list is also on our website, www.mamsi.com. Information in the directory is subject to change. For this reason, we recommend that you access our website to look up the most up-to-date information.

What you must do to get covered care

It depends on the type of care you need. First, you and each family member must choose a primary care physician. This decision is important since your primary care physician provides or arranges for most of your health care. To choose a Primary Care Physician, select the PCP of your choice either from the provider directory, or from our website. You may call the Member Services Department at 301/360-8080 or 1-800/251-0956 and we will make the change for you over the phone. Or, if you wish, you may complete the “Federal Information Form” included in your open season information packet and mail it to us at P.O. Box 943, Frederick, Maryland 21705.

- **Primary care**

Your primary care physician can be an internist, an obstetrician/gynecologist for a woman, a pediatrician for a child, or a general/family practitioner for any member of the family. 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. When you receive a referral from your primary care physician, you must return to the primary care physician after the consultation, unless your primary care physician authorized a certain number of visits without additional referrals. The primary care physician must provide or authorize all follow-up care. Do not go to the specialist for return visits unless your primary care physician gives you a referral. However, female members may see a participating obstetrician or gynecologist, or a participating Certified Nurse Midwife, for obstetrical and gynecological care without a referral. Obstetrical and gynecological services include routine care and follow-up services, as well as medically necessary services. Eye refractions and dental care are also available from Plan 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 Member Services Department immediately at 301/360-8080 or 1-800/251-0956. 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 precertification. Your physician must obtain precertification for some services such as, but not limited to the following:

- Acupuncture
- Biofeedback
- Breast Reconstruction/Breast Reduction
- Reconstructive surgery
- Growth Hormone Therapy (GHT)
- Infertility Services
- Morbid Obesity Surgery
- Rhinoplasty
- Therapies (Physical Therapy, Occupational Therapy and Speech Therapy) for members under the age of ten (10)
- Temporomandibular Joint (TMJ) Pain Dysfunction and/or related
- Myofascial Pain Dysfunction (MPD) treatment
- Transplants
- Uvulopalatopharyngoplasty
- Most Durable Medical Equipment, Orthopedic and Prosthetic Devices

In addition, your admitting physician and facility must also preauthorize any elective inpatient stays.

It is your **primary care physician or specialist's responsibility** to obtain precertification for the procedures listed above before performing them. If the PCP/specialist does not do this, you will not be liable for the cost of covered services.

We will decide whether or not to precertify a procedure within two working days of the receipt of the information we need to make a decision.

If we deny the request or if you wish to extend the number of authorized visits, your primary care physician or specialist may ask us to reevaluate our decision or extend the number of authorized visits at any time. A decision will be made within one working day of receiving all of the information we need to make the decision.

If you are not satisfied with our decision, you, or your primary care physician or specialist on your behalf, may appeal the decision.

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, facility, pharmacy, etc. 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 nothing per admission.
- **Deductible** We do not have a deductible.
- **Coinsurance** Coinsurance is the percentage of our negotiated fee that you must pay for your care.
Example: In our Plan, you pay 50% of our allowance for infertility services and durable medical equipment.

Your catastrophic protection out-of-pocket maximum for coinsurance and copayments

After your copayments and/or coinsurance total \$1,800 per person or \$4,800 per family enrollment in any calendar year, you do not have to pay any more for covered services. However, copayments and coinsurance for the following services do not count toward your out-of-pocket maximum, and you must continue to pay copayments and coinsurance for these services:

- Prescription drugs
- Dental Services
- Eyeglasses or contact lenses
- In-vitro fertilization

Be sure to keep accurate records of your copayments and coinsurance since you are responsible for informing us when you reach the maximum.

Section 5. Benefits – OVERVIEW

(See page 8 for how our benefits changed this year and page 56 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 subsections. To obtain claims forms, claims filing advice, or more information about our benefits, contact us at 301/ 360-8080 or 1-800/251-0956 or at our website at www.mamsi.com.

1. Medical services and supplies provided by physicians and other health care professionals.....	15-24
• Diagnostic and treatment services	• Speech therapy
• Lab, X-ray, and other diagnostic tests	• Habilitative therapies
• Preventive care, adult	• Hearing services (testing, treatment, and supplies)
• Preventive care, children	• Vision services (testing, treatment, and supplies)
• Maternity care	• Foot care
• Family planning	• Orthopedic and prosthetic devices
• Infertility services	• Durable medical equipment (DME)
• Allergy care	• Home health services
• Treatment therapies	• Chiropractic
• Physical, cardiac and occupational therapies	• Alternative treatments
	• Educational classes and programs
2. Surgical and anesthesia services provided by physicians and other health care professionals.....	25-27
• Surgical procedures	• Oral and maxillofacial surgery
• Reconstruction surgery	• Organ/tissue transplants
	• Anesthesia
3. Services provided by a hospital or other facility, and ambulance services.....	28-30
• Inpatient hospital	• Extended care benefits/skilled nursing care facility benefits
• Outpatient hospital or ambulatory surgical center	• Hospice care
	• Ambulance
4. Emergency services/accidents.....	31-32
• Medical emergency	• Ambulance
5. Mental health and substance abuse benefits.....	33-34
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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 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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Benefit Description	You pay
Diagnostic and treatment services	
Professional services of physicians <ul style="list-style-type: none"> • In physician's office • Office medical consultations • Second surgical opinion 	\$10 per office visit to your primary care physician \$20 per office visit to a specialist
Professional services of physicians <ul style="list-style-type: none"> • In an urgent care center • During a hospital stay • In a skilled nursing facility 	Nothing
At home	\$10 per visit from your primary care physician \$20 per visit from a specialist
Lab, X-ray and other diagnostic tests	
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 if you receive these services during your office visit; otherwise, \$20 per office visit to a specialist \$50 per outpatient hospital visit

Preventive care, adult	You pay
Routine screenings, such as: <ul style="list-style-type: none"> • Total Blood Cholesterol • Colorectal Cancer Screening, including: <ul style="list-style-type: none"> - Fecal occult blood test - Sigmoidoscopy screening – every five years starting at age 50 	\$10 per office visit to your primary care physician \$20 per office visit to a specialist
Prostate Specific Antigen (PSA test) – one annually for men age 40 and older	\$10 per office visit to your primary care physician \$20 per office visit to a specialist
Routine pap test Note: The office visit is covered if pap test is received on the same day; see <i>Diagnostic and Treatment services</i> , above.	\$10 per office visit to your primary care physician \$20 per office visit to a specialist Nothing per visit to a Certified Nurse Midwife
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 	\$10 per office visit to your primary care physician \$20 per office visit to a specialist \$50 per outpatient hospital visit
<i>Not covered: Physical exams and immunizations 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 vaccine, annually, age 50 and over • Pneumococcal vaccine, once after age 65 or older 	\$10 per office visit to your primary care physician \$20 per office visit to a specialist
Preventive care, children	
<ul style="list-style-type: none"> • Childhood immunizations recommended by the American Academy of Pediatrics (AAP), American Academy of Family Physicians (AAFP), and the Advisory Committee on Immunization Practices (ACIP) 	\$10 per office visit to your primary care physician \$20 per office visit to a specialist
<ul style="list-style-type: none"> • Examinations, such as: <ul style="list-style-type: none"> - Ear exams to determine the need for hearing correction - Examinations done on the day of immunizations (up to age 22) • Well-child care for routine examinations, immunizations and care (up to age 22) 	\$10 per office visit to your primary care physician \$20 per office visit to a specialist
<ul style="list-style-type: none"> • Eye exams to determine the need for vision correction 	\$25 per office visit to a specialist

Maternity Care	You pay
<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"> • Office visit copays for routine obstetrical care are waived after the first maternity care visit. • Routine care includes office visits, one office sonogram (as part of prenatal care) and lab work. • You do not have to obtain a referral to see a participating obstetrician or gynecologist, or a participating Certified Nurse Midwife, for obstetrical and gynecological care. Obstetrical and gynecological services include routine care and follow-up services, as well as medically necessary services. A participating obstetrician/gynecologist may issue referrals for pregnancy-related illnesses through the postpartum period. • 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. • Circumcisions are covered 100% during newborn stay. • 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 office visit to your primary care physician</p> <p>\$20 per office visit to a specialist</p> <p>Nothing per visit to a Certified Nurse Midwife</p>
Family planning	
<p>A broad range of voluntary family planning services, limited to:</p> <ul style="list-style-type: none"> • Voluntary sterilization • Surgically implanted contraceptives (such as Norplant) • Injectable contraceptive drugs (such as Depo provera) • Intrauterine devices (IUDs) • Diaphragms <p>NOTE: We cover oral contraceptives under the prescription drug benefit.</p>	<p>\$10 per office visit to your primary care physician</p> <p>\$20 per office visit to a specialist</p> <p>\$50 per outpatient hospital visit</p>
<p><i>Not covered: reversal of voluntary surgical sterilization</i></p>	<p><i>All charges</i></p>

Infertility services	You pay
<p>Diagnosis and treatment of infertility, such as:</p> <ul style="list-style-type: none"> • Artificial insemination: <ul style="list-style-type: none"> - intravaginal insemination (IVI) - intracervical insemination (ICI) - intrauterine insemination (IUI) • In-vitro fertilization when the following criteria is met: <ul style="list-style-type: none"> - your oocytes are fertilized with your spouse's sperm - you and your spouse have a history of infertility of at least 2 years, or - your infertility is associated with endometriosis, or exposure in-utero to diethylstilbestrol (DES), or blockage of, or surgical removal of one or both fallopian tubes, or abnormal male factors, including oligospermia, contributing to the infertility - you have been unable to attain a successful pregnancy through a less costly treatment that is covered by the Plan <p>In-vitro fertilization is limited to three (3) in-vitro attempts per live birth and a maximum lifetime benefit of \$100,000, except drugs.</p> <p>Note: We cover injectables and oral fertility drugs for in-vitro fertilization, and Clomid (clomiphene) for artificial insemination under the prescription drug benefit.</p> 	<p>\$10 per office visit to your primary care physician</p> <p>50% per office visit to other plan providers</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Assisted reproductive technology (ART) procedures, such as:</i> <ul style="list-style-type: none"> - <i>embryo transplant, gamete intrafallopian transfer (GIFT), zygote intrafallopian transfer (ZIFT), sex selection, surrogacy, gene therapy, and cryopreservation</i> • <i>Other services and supplies related to ART procedures</i> • <i>Cost of donor sperm, donor eggs, and related costs</i> • <i>Infertility services after reversal of voluntary sterilization</i> 	<p><i>All charges</i></p>
Allergy care	
<p>Testing and treatment</p> <p>Allergy injections</p>	<p>\$10 per office visit to your primary care physician</p> <p>\$20 per office visit to a specialist</p>
<p>Allergy serum</p>	<p>Nothing</p>
<p><i>Not covered: provocative food testing and sublingual allergy desensitization.</i></p>	<p><i>All charges</i></p>

Treatment therapies	You pay
<ul style="list-style-type: none"> Chemotherapy and radiation therapy <p>Note: High dose chemotherapy in association with autologous bone marrow transplants is limited to those transplants listed under Organ/Tissue Transplants on page 26.</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>Notes: Growth hormone is covered under the prescription drug benefit. We will only cover GHT when we precertify the treatment. See <i>Services requiring our prior approval</i> in Section 3.</p>	<p>\$10 per office visit to your primary care physician</p> <p>\$20 per office visit to a specialist</p> <p>\$50 per outpatient hospital visit</p>
Physical, cardiac and occupational therapies	
<ul style="list-style-type: none"> Up to two months or 60 visits (whichever is more) per condition, for the services of the following: <ul style="list-style-type: none"> qualified physical therapists and occupational therapists. <p>Note: We only cover therapy to restore bodily function when there has been a total or partial loss of bodily function due to illness or injury.</p> Cardiac rehabilitation following a heart transplant, bypass surgery or a myocardial infarction, is provided for up to two months or 60 visits (whichever is more) per condition. 	<p>\$20 per office visit to a specialist</p> <p>\$50 per outpatient hospital visit</p> <p>Nothing per visit during covered inpatient admission</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <i>long-term rehabilitative therapy</i> <i>exercise programs, gym or pool memberships</i> 	<p><i>All charges</i></p>
Speech therapy	
<ul style="list-style-type: none"> Up to two months or 60 visits (whichever is more) per condition 	<p>\$20 per office visit to a specialist</p> <p>\$50 per outpatient hospital visit</p> <p>Nothing per visit during covered inpatient admission</p>
Habilitative Therapies	
<p>Habilitative services for children under age 19 with congenital or genetic birth defects. Treatment is provided to enhance the child’s ability to function. Services include:</p> <ul style="list-style-type: none"> Occupational therapy, and Physical therapy; <p>Notes: No day or visit limits apply to these services. A congenital disorder means a significant structural or functional abnormality that was present from birth.</p>	<p>\$20 per office visit to a specialist</p> <p>\$50 per outpatient hospital visit</p>

Hearing services (testing, treatment, and supplies)	You Pay
<ul style="list-style-type: none"> Hearing testing Hearing aid examinations for children under 19; hearing aids covered under <i>Durable Medical Equipment</i>. 	\$10 per office visit to your primary care physician \$20 per office visit to a specialist
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <i>Hearing aids, except as covered for children under age 19 under Durable Medical Equipment in this section</i> 	<i>All charges</i>
Vision services (testing, treatment, and supplies)	
<ul style="list-style-type: none"> Diagnosis and treatment of diseases of the eye 	\$10 per office visit to your primary care physician \$20 per office visit to a specialist
<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) 	50% of charges
<ul style="list-style-type: none"> Annual eye refractions to provide a written lens prescription <p>You do not have to obtain a referral from your Primary Care Physician for this service</p>	\$25 per office visit to a specialist
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <i>Eyeglasses or contact lenses</i> <i>Eye exercises and orthoptics</i> <i>Radial keratotomy and other refractive surgery</i> 	<i>All charges</i>
Foot Care	
<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>	\$10 per office visit to your primary care physician \$20 per office visit to a specialist \$50 per outpatient hospital visit
<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>All charges</i>

Orthopedic and prosthetic devices	
<p>Orthopedic devices, such as:</p> <ul style="list-style-type: none"> • Artificial limbs and eyes; stump hose • External lenses following cataract removal • Externally worn breast prostheses and surgical bras, including necessary replacements, following a mastectomy • Enteral equipment and supplies for covered tube feedings • Ostomy supplies except deodorants, filters, lubricants, tape, appliance cleaners, adhesive and adhesive removers • Orthotic braces and splints not available over-the-counter • Surgical dressings not available over-the-counter; (see <i>Durable Medical Equipment</i>) • A hair prosthesis for hair loss resulting from chemotherapy or radiation treatment for cancer. There is a limit of one hair prosthesis per lifetime, with a maximum cost of \$350. • Corrective orthopedic appliances for non-dental treatment of temporomandibular joint (TMJ) pain dysfunction syndrome. • Internal prosthetic devices, such as artificial joints, pacemakers, cochlear implants, and surgically implanted breast implants following mastectomy. <p>Note: We pay internal prosthetic devices as hospital benefits; see Section 5(c) for payment information. See 5(b) for coverage of the surgery to insert the device.</p>	50% of charges
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>orthopedic and corrective shoes</i> • <i>shoes and foot orthotics, including heel pads, heel cups and arch supports</i> • <i>lumbosacral supports</i> • <i>corsets trusses, elastic stockings, support hose, and other supportive devices</i> • <i>prosthetic replacements provided less than 5 years after the last one we covered (except as needed to accommodate growth in children or for socket replacement for members with significant residual limb volume or weight changes)</i> • <i>external penile devices</i> • <i>speech prosthetics (except electrolarynx)</i> 	<i>All charges</i>

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. • surgical dressings not available over-the-counter <p>Note: Call us at 301/360-8080 or 1-800/251-0956 if your Plan physician prescribes this equipment and you need assistance locating a health care provider to rent or sell you durable medical equipment. You may also call us to see if a certain piece of equipment is covered. Most durable medical equipment must be preauthorized.</p>	50% of charges
<p>Hearing aids for children under age 19, prescribed, fitted and dispensed by a licensed audiologist</p>	50% of charges up to \$1,400 per ear every 36 months
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Power-operated vehicles</i> • <i>Duplicate or backup equipment</i> • <i>Parts and labor costs for supplies and accessories replaced due to wear and tear such as wheelchair tires and tubes</i> • <i>Educational, vocational, or environmental equipment</i> • <i>Deluxe or upgraded equipment and supplies</i> • <i>Home or vehicle modifications, seat lifts</i> • <i>Over-the-counter medical equipment and supplies</i> • <i>Activities of daily living aids (such as grab bars and utensil holders)</i> • <i>Personal hygiene equipment</i> • <i>Paraffin baths, whirlpools, and cold therapy</i> • <i>Augmentative communication devices</i> • <i>Infertility monitors</i> • <i>Physical fitness equipment</i> • <i>Hearing aids for those over 19 years old</i> • <i>Continuous pulse oximetry unless skilled nursing is involved in home care and it is part of their medically necessary equipment</i> 	<i>All charges</i>

Home health services	You pay
<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. • Medical foods prescribed by a physician when determined to be your sole source of nutrition 	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 the patient's family;</i> • <i>home care primarily for personal assistance that does not include a medical component and is not diagnostic, therapeutic, or rehabilitative;</i> • <i>foods that you can obtain without a prescription, even if prescribed by your physician or determined to be your sole source of nutrition.</i> 	<i>All charges</i>
Chiropractic	
<ul style="list-style-type: none"> • Chiropractic services are covered up to a maximum benefit of \$500 	50% of charges up to the maximum benefit and all charges thereafter.
Alternative treatments	
<ul style="list-style-type: none"> • Acupuncture – up to twelve (12) visits per calendar year for postoperative and chemotherapy nausea and vomiting, nausea of pregnancy, postoperative dental pain and as part of a comprehensive treatment program for chronic pain • Biofeedback – for pain management, migraine treatment, bowel training and pelvic floor training for urinary incontinence 	\$20 per office visit to a specialist \$50 per outpatient hospital visit
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>naturopathic services</i> • <i>hypnotherapy</i> • <i>massage therapy</i> • <i>herbal medicine</i> • <i>homeopathy</i> 	<i>All charges</i>
Educational classes and programs	
<p>Coverage is limited to:</p> <ul style="list-style-type: none"> • Diabetes self-management classes • Childbirth education classes. We will reimburse you up to \$50. • Smoking cessation program. We will reimburse you up to \$100. <p>When you complete the Childbirth education class or Smoking cessation program submit a copy of the certificate of completion with the dates attended, as well as a copy of your canceled check or receipt to P.O. Box 948, Frederick, Maryland 21705.</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.
- **YOUR PHYSICIAN MUST GET PRECERTIFICATION OF SOME SURGICAL PROCEDURES.** Please refer to the precertification information shown in Section 3 to be sure which services require precertification.

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Benefit Description	You pay
Surgical procedures	
<p>A comprehensive range of services, such as:</p> <ul style="list-style-type: none"> • Operative procedures • 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 <i>Reconstructive surgery</i>) • Surgical treatment of morbid obesity – a condition in which an individual’s Body Mass Index (BMI) is greater than 40. Eligible members must be age 18 or over. The member’s PCP must submit recent records documenting: a one year supervised weight loss program, comorbidities, and a BMI greater than 40. • Insertion of internal prosthetic devices. See 5(a) – <i>Orthopedic and prosthetic devices</i> for device coverage information. • 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>	<p>\$10 per office visit to your primary care physician</p> <p>\$20 per office visit to a specialist</p> <p>\$50 per outpatient hospital visit</p>
<p><i>Not Covered:</i></p> <ul style="list-style-type: none"> • <i>Reversal of voluntary sterilization</i> 	<p><i>All charges</i></p>

Reconstructive surgery	You pay
<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. Your physician must precertify repair of congenital anomalies. • 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 <i>Prosthetic devices</i>) <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>	<p>\$10 per office visit to your primary care physician</p> <p>\$20 per office visit to a specialist</p> <p>\$50 per outpatient hospital visit</p>
<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> 	<p><i>All charges</i></p>
Oral and maxillofacial surgery	
<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; facial defects due to congenital syndromes such as cleft lip/cleft palate, Crouzon's and Pierre-Robin's. • 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 to your primary care physician</p> <p>\$20 per office visit to a specialist</p> <p>\$50 per outpatient hospital visit</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	You pay
<p>Limited to:</p> <ul style="list-style-type: none"> • Cornea • Heart • Heart/lung • Kidney • Liver • Lung: Single-Double • Pancreas • Allogeneic (donor) bone marrow transplants • Autologous bone marrow transplants (autologous stem cell and peripheral stem cell support) for the following conditions: acute lymphocytic or non-lymphocytic leukemia; advanced Hodgkins lymphoma; advanced non-Hodgkin’s lymphoma; advanced neuroblastoma; breast cancer; multiple myeloma; epithelial ovarian cancer; and testicular, mediastinal, retroperitoneal and ovarian germ cell tumors. • Intestinal transplants (small intestine) and the small intestine with the liver or small intestine with multiple organs such as the liver, stomach, and pancreas <p>Limited Benefits – Treatment for breast cancer, multiple myeloma, and epithelial ovarian cancer may be provided in an NCI- or NIH-approved clinical trial at a Plan-designated center of excellence and if approved by the Plan’s medical director in accordance with the Plan’s protocols.</p> <p>Note: We cover related medical and hospital expenses of the donor when we cover the recipient.</p>	<p>\$10 per office visit to your primary care physician</p> <p>\$20 per office visit to a specialist</p> <p>\$50 per outpatient hospital visit</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> • <i>All services related to non-covered transplants</i> 	<p><i>All charges</i></p>
Anesthesia	
<p>Professional services provided in-</p> <ul style="list-style-type: none"> • Hospital (inpatient) • Hospital outpatient department • Skilled nursing facility • Ambulatory surgical center • Office 	<p>Nothing</p>

Section 5(c) Services provided by a hospital or other facility, and ambulance services

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

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- 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 and you must be hospitalized in a Plan facility
- 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 the facility (i.e., hospital or surgical center) or ambulance service for your surgery or care. Any costs associated with the professional charge (i.e., physicians, etc.) are covered in Sections 5(a) or (b).
- **YOUR ATTENDING PHYSICIAN MUST GET PREAUTHORIZATION FOR ELECTIVE HOSPITAL STAYS.**

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Benefit Description	You pay
Inpatient hospital	
<p>Room and board, such as</p> <ul style="list-style-type: none"> • Ward, semiprivate, or intensive care accommodations; • General nursing care; and • Meals and special diets. <p>NOTE: If you want a private room when it is not medically necessary, you pay the additional charge above the semiprivate room rate.</p> <p>Other hospital services and supplies, such as:</p> <ul style="list-style-type: none"> • Operating, recovery, maternity, and other treatment rooms • Prescribed drugs and medicines • Diagnostic laboratory tests and X-rays • Administration of blood and blood products • Blood products, derivatives and components, artificial blood products and biological serum. Blood products include any product created from a component of blood such as, but not limited to, plasma, packed red blood cells, platelets, albumin, Factor VIII, immunoglobulin, and prolactin. • Dressings, splints, casts, and sterile tray services • Medical supplies and equipment, including oxygen • Anesthetics, including nurse anesthetist services • Take-home items • Medical supplies, appliances, medical equipment, and any covered items billed by a hospital for use at home 	<p>Nothing</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Custodial care</i> • <i>Non-covered facilities, such as nursing homes and schools</i> • <i>Personal comfort items, such as telephone, television, barber services, guest meals and beds</i> • <i>Private nursing care</i> • <i>Whole blood and concentrated red blood cells not replaced by the member</i> 	<p><i>All charges</i></p>

Outpatient hospital or ambulatory surgical center	You pay
<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 products, derivatives and components, artificial blood products and biological serum. • Pre-surgical testing • Dressings, casts, and sterile tray services • Medical supplies, including oxygen • Anesthetics and anesthesia services <p>NOTE: We cover hospital services and supplies related to dental procedures when necessitated by a non-dental physical impairment.</p>	\$50 per visit
<p><i>Not covered: Whole blood and concentrated red blood cells blood and blood derivatives not replaced by the member</i></p>	All charges
Extended care benefits/skilled nursing care facility benefits	
<p>Extended care benefits: All necessary services provided for up to 60 days per calendar year in a skilled nursing facility when full-time nursing care is necessary and confinement in a skilled nursing facility is medically appropriate as determined by a Plan doctor and approved by the Plan.</p> <p>Services include:</p> <ul style="list-style-type: none"> • Bed, board and general nursing care • Drugs, biologicals, supplies and equipment ordinarily provided or arranged by the skilled nursing facility when prescribed by a Plan doctor 	Nothing
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>custodial care</i> • <i>rest cures, domiciliary or convalescent care</i> • <i>personal comfort items, such as telephone, television, barber services, guest meals and beds</i> 	All charges

Hospice Care	You pay
<p>Supportive or palliative care for a terminally ill member in the home or hospice facility. These services are provided under the direction of a Plan doctor who certifies that you are in the terminal stages of illness, with a life expectancy of approximately six (6) months or less.</p> <p>Services include:</p> <ul style="list-style-type: none"> • Inpatient and outpatient care • Family counseling 	Nothing
<p><i>Not covered: Independent nursing, private duty nursing, homemaker services</i></p>	All charges
Ambulance	
<ul style="list-style-type: none"> • Professional ambulance service when medically appropriate 	Nothing

Section 5(d) Emergency services/accidents

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

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- 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.
- 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, 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 or outside our service area:

If you are in an emergency situation, please call your primary care physician. In extreme emergencies, if you are unable to contact your doctor, contact the local emergency system (e.g., the 911 telephone system) or go to the nearest hospital emergency room. Be sure to tell the emergency room personnel that you are a Plan member so they can notify the Plan. You or a family member should notify the Plan within 48 hours, unless it was not reasonably possible to notify us within that time. It is your responsibility to ensure that the Plan has been timely notified.

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

Benefit Description	You pay
Emergency within or outside our service area	
<ul style="list-style-type: none"> • Emergency care at a doctor's office 	\$10 per office visit to your primary care physician \$20 per office visit to a specialist
<ul style="list-style-type: none"> • Emergency care at an urgent care center 	\$25 per visit

Emergency within or outside our service area (continued)	You pay
<ul style="list-style-type: none"> • Emergency care at an emergency room. 	\$50 per visit, waived if the emergency results in an admission to a hospital
<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, including air ambulance, 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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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>	Your cost sharing responsibilities are no greater than for other illness or conditions
<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>\$20 per office visit to a specialist</p> <p>\$50 per outpatient hospital visit</p>
<ul style="list-style-type: none"> • Diagnostic tests 	<p>\$20 per office visit to a specialist</p> <p>\$50 per outpatient hospital visit</p>
<ul style="list-style-type: none"> • Services provided by a hospital or other facility while an inpatient 	Nothing
<ul style="list-style-type: none"> • Services provided by a hospital or other facility while an outpatient. This includes partial hospitalization and facility based intensive outpatient treatment. 	<p>\$20 per office visit</p> <p>\$50 per outpatient hospital visit</p>
<ul style="list-style-type: none"> • Services in approved alternative care settings such as half-way house and residential treatment. <p>Note: The services covered in approved alternative settings are limited to those provided by participating licensed professionals according to a treatment plan that has been approved by a Plan psychiatrist and Primary Care Physician.</p>	\$20 per office visit

Mental health and substance abuse benefits <i>(continued)</i>	You pay
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Services we have not approved</i> • <i>Psychiatric evaluation or therapy on court order or as a condition of parole or probation, unless determined by a Plan doctor to be necessary and appropriate</i> 	<p><i>All charges</i></p>

Preauthorization

To be eligible to receive these benefits you must follow your treatment plan and all the following authorization processes:

- Once you have been referred for mental health services, **you must be evaluated by a Psychiatric Physician.** This physician will discuss with you a recommended course of treatment at the appropriate provider level.
- We list mental health and substance abuse providers in the provider directory, which we update periodically. The list is also on our website, www.mamsi.com. Information in the directory is subject to change; for this reason, we recommend that you access our website to look up the most up-to-date information.

Limitation

We may limit your benefits if you do not obtain a treatment plan.

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.
- Certain drugs require your doctor to get prior authorization from us before they can be prescribed under the plan. The Plan requires prior authorization for these drugs to make sure that they are being prescribed and consumed according to FDA approved indications and dosing schedules. If your pharmacist tells you that your prescription drug requires prior authorization, ask your pharmacist or doctor to call Pharmacy Services at 1-800/205-3636 for further instructions.
- 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 physician or licensed dentist must write the prescription
- **Where you can obtain them.** You must fill the prescription at a plan pharmacy. You may fill prescriptions for maintenance medications either by mail or at a retail pharmacy. Maintenance medications are those drugs used on a continual basis, for six months or longer, for the treatment of chronic health conditions such as high blood pressure, asthma, or diabetes. To locate the name of a participating pharmacy near you, refer to your Directory, call our Member Services Department at 301/360-8080 or 1-800/251-0956, or visit our website at www.mamsi.com.
- **We use a formulary.** A formulary is a listing of prescription drugs that are preferred by the Plan for use. All generic drugs are on the formulary, as well as certain name brand drugs. Drugs that are on the formulary are selected based on safety, efficacy and cost. This listing is periodically reviewed and updated by a team of doctors and pharmacists. M.D. IPA uses an open formulary. This means you are covered for all prescription medications written in accordance with FDA guidelines for a particular therapeutic indication whether or not the medication appears on the formulary, except for prescription drugs or classes of drugs listed under "Not Covered" in this section of the brochure. However drugs not specifically listed on our formulary are subject to a non-formulary copay. Drugs requiring prior authorization will be covered once reviewed and approved by the Plan.

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 copy of the formulary, call Member Services at 301/360-8080 or 1-800/251-0956.
- **These are the dispensing limitations.** You may obtain up to a 34-day supply of non-maintenance prescription drugs at a Plan pharmacy or by mail order. Prescriptions for covered maintenance medications may be filled or refilled at a Plan retail pharmacy, or through the mail by Merck-Medco Rx Services. You may obtain up to a consecutive 90-day supply of maintenance prescription medications, with one copay for each month's supply. For more information on mail order benefits, you can reach Merck-Medco Rx Services at 1-800-711-3813. A prescription can be refilled when you have used 75% of the medication. For example, a prescription that was filled for a 34-day supply could be refilled after 26 days.
- We follow FDA dispensing guidelines. Generic drugs will be dispensed when substitution is permissible for prescriptions filled at a retail pharmacy or through mail order. If generic substitution is permissible (i.e., a generic drug is available and the prescribing doctor does not require the use of a name brand drug), but you request the name brand drug, you pay the name brand copay plus the cost difference between the generic and the name brand drug. If you fill a prescription for a name brand drug and there is no generic available, you will be responsible for either the formulary or non-formulary name brand copay.

- **Why use generic drugs?** Generic drugs are lower-priced drugs that are the therapeutic equivalent to more expensive brand-name drugs. They must contain the same active ingredients and must be equivalent in strength and dosage to the original brand-name product. Generics cost less than the equivalent brand-name product. The U.S. Food and Drug Administration sets quality standards for generic drugs to ensure that these drugs meet the same standards of quality and strength as brand-name drugs. You can save money by using generic drugs. However, you and your physician have the option to request a name-brand if a generic option is available.
- **When you have to file a claim.** Usually, there are no claim forms to fill out when you fill a prescription at a Plan pharmacy. In some cases, however, you may pay out-of-pocket, such as when you are outside the service area in a medical emergency. If this happens, send the following information to P.O. Box 948, Frederick, Maryland 21705.
 - your receipt
 - the drug NDC number
 - the pharmacy's NABP number, and
 - the prescribing doctor or dentist's DEA number

Benefit Description	You pay
<p>Covered medications and supplies</p> <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 and medicines that by Federal law of the United States require a physician's prescription for their purchase, except those listed as <i>Not covered</i>. • Insulin, with a copay charge applied to each vial • Diabetic supplies, including insulin syringes, needles, glucose test tablets and test tape, Benedict's solution or equivalent, and acetone test tablets. • Disposable needles and syringes for the administration of covered, prescribed medications • Oral contraceptive drugs (you may obtain up to three cycles of oral contraceptive drugs at one time with a copay charge applied to each cycle); contraceptive devices. <p>Limited Benefits</p> <ul style="list-style-type: none"> • Drugs to treat sexual dysfunction are limited. Contact the Plan for dosage limits. 	<p>\$ 5 per generic drug</p> <p>\$ 15 per name brand drug in the Plan's formulary</p> <p>\$ 30 per name brand drug not in the Plan's formulary</p> <p>20% up to \$50 for injectable drugs, except for insulin.</p> <p>Note: If there is no generic equivalent available, you will still have to pay the brand name copay.</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Drugs and supplies for cosmetic purposes, including drugs for weight loss or control</i> • <i>Nonprescription medicines</i> • <i>Vitamins and nutritional substances that can be purchased without a prescription</i> • <i>Medical supplies such as dressings and antiseptics</i> • <i>Fertility drugs except Clomid (clomiphene) for artificial insemination (oral and injectable drugs are covered for in-vitro fertilization)</i> • <i>Drugs to enhance athletic performance</i> • <i>Drugs obtained at a non-Plan pharmacy; except for out-of-area emergencies</i> • <i>Replacement Prescription Drug Products resulting from loss, theft, spoilage, or breakage of original product</i> 	<p><i>All charges</i></p>

Section 5 (g). Special features

Feature	Description
Flexible benefits option	<p>Under the flexible benefits option, we determine the most effective way to provide services.</p> <ul style="list-style-type: none"> • We may identify medically appropriate alternatives to traditional care and coordinate other benefits as a less costly alternative benefit. • Alternative benefits are subject to our ongoing review. • By approving an alternative benefit, we cannot guarantee you will get it in the future. • The decision to offer an alternative benefit is solely ours, and we may withdraw it at any time and resume regular contract benefits. <p>Our decision to offer or withdraw alternative benefits is not subject to OPM review under the disputed claims process.</p>
Centers of Excellence	<p>We use specific institutions called Centers of Excellence that offer “best practices” to treat certain conditions or to perform specific procedures. We have Centers of Excellence for cardiac care, transplants and joint replacement. A list of our Centers of Excellence can be found in the provider directory, or you can call the Member Services Department at 301/360-8080 or 1-800/251-0956 for an up-to-date listing.</p>
WeeCall Programs	<p>Our maternity programs offer women support and education throughout pregnancy. We will mail you educational materials, and obstetrical nurses are available to talk to you on the telephone at no cost. Call the Member Services Department at 301/360-8080 or 1-800/251-0956 for more information about our maternity programs.</p>
Plan Publications	<p>There are several publications that are available to you at no cost. They include:</p> <ul style="list-style-type: none"> • Advance Directives • <i>HealthLine</i> (immunization and preventive health check-up schedule) • HealthSense Member Newsletter • Healthy Living Series • HomeCall Hospice Services, Inc. • Provider Directory • <i>Wee Call</i> Pregnancy Education • Vaccination Facts <p>Call the Member Services Department at 301/360-8080 or 1-800/251-0956 to request a copy of any of these items.</p>
Health Education and Disease Management Programs	<p>Healthwise® Knowledgebase – on-line source for members to research health questions</p> <p>Diabetes care</p> <p>Behavioral Health/Depression care</p> <p>Asthma</p> <p>Disease Management</p> <p>Cardiovascular Prevention</p> <p>Breast Cancer Prevention</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
- This plan is a discount program. 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
- 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

You pay

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 must request treatment within seventy-two (72) hours after the accident occurs. If your injury cannot be reasonably treated within seventy-two (72) hours (example: if you have sustained medical injuries to such an extent to render dental treatment during this time period impossible), an extension may be granted if you make the request within sixty (60) days of the date of injury.

\$20 per visit.

Dental treatment for accidental injury is a limited benefit intended to stabilize your dental condition and includes only the following:

- Emergency examination
- Periapical and panoramic radiographs
- Root canal therapy
- Emergency, temporary splinting of the teeth
- Prefabricated post and core
- Simple, minimal restorative procedures (fillings)
- Emergency extractions
- Post-traumatic crowns are covered if it is the only treatment available

Note: Injury as a result of chewing, biting or poor dental hygiene is not covered

Dental Discount benefits

The following list summarizes the fees for dental services provided by a participating PLAN GENERAL DENTIST ONLY. All services rendered by a Plan dental specialist are provided at a 25% reduction of costs; the copays listed below do not reflect the payment to a Plan dental specialist. You do not have to obtain a referral from your primary care physician to obtain the following dental care services. For a complete list of fees, or a list of participating dentists, contact us at 301/360-8080 or 1-800/251-0956. The list is also on our website, www.mamsi.com.

Service		You pay
Type I	Diagnostic and Preventive Services	
D1203	Topical Application of Fluoride (Prophylaxis not Included) – Child	N/C
D0120	Periodic Oral Examination	\$17.00
D0150	Comprehensive Oral Evaluation	\$25.00
D1110	Prophylaxis – Adult	\$30.00
D1120	Prophylaxis – Child	\$23.00
	Radiological Services	
D0210	Intraoral – Complete Series (including bitewings)	\$47.00
D0220	Intraoral – Periapical – First Film	\$10.00
D0272	Bitewings – 2 Films	\$18.00
D0330	Panoramic Film	\$45.00
Type II	Basic Dental Services, Silver Restorations and All Other Services	
	Amalgam Restorations – Adult	
D2150	Amalgam – 2 Surfaces, Permanent	\$51.00
	Amalgam Restorations – Child	
D1351	Sealant – Per Tooth	\$19.00
D2120	Amalgam – 2 Surfaces, Primary	\$46.00
	Composite Restorations (White Filling)	
D2331	Resin – 2 Surfaces, Anterior	\$58.00
D2381	Resin – 2 Surfaces, Posterior – Primary	\$62.00
D2386	Resin – 2 Surfaces, Posterior – Permanent	\$72.00
D2920	Recement Crown	\$32.00
D2950	Core Buildup, Including Any Pins	\$60.00
Type III	Major Dental Services	
	Crown and Inlay	
D2530	Inlay – Metallic – 3 or more Surfaces	\$340.00
D2752	Crown – Porcelain Fused to Noble Metal	\$460.00
D2952	Cast Post and Core In Addition to Crown	\$135.00
D2954	Prefabricated Post and Core In Addition to Crown	\$110.00
	Bridge Services	
D6242	Bridge Pontic (Porcelain Fused to Noble Metal)	\$460.00
D6752	Crown – Abutment (Porcelain Fused to High Noble Metal)	\$475.00
	Cosmetic and Esthetic Services	
D2961	Labial Veneer (Resin Laminate) – Laboratory	\$272.00
	Endodontic Services	
D3110	Pulp Cap – Direct (Excluding Final Restoration)	\$ 23.00
D3310	Anterior (Excluding Final Restoration)	\$295.00
D3330	Molar (Excluding Final Restoration)	\$441.00
	Periodontics Services	
D4341	Periodontal Scaling and Root Planing – Per Quadrant	\$ 76.00
	Prosthodontics – Removable	
D5110	Complete Denture – Maxillary	\$509.00
D5213	Maxillary Partial Denture – Cast Metal Framework with Resin Denture Bases (Including any Conventional Clasps, Rest and Teeth)	\$562.00
D5650	Add Tooth to Existing Partial Denture	\$ 30.00*
D5730	Reline Complete Maxillary Denture (Chairside)	\$110.00
D5750	Reline Complete Maxillary Denture (Laboratory_)	\$160.00*
	*Plus invoice lab costs	
	Oral Surgery Services	
D7110	Single Tooth	\$ 60.00
D7210	Surgical Removal of Erupted Tooth Requiring Evaluation of Mucoperiosteal Flap And Removal of Bone and/or Section of Tooth	\$ 81.00
D7230	Removal of Impacted Tooth – Partially Bony	\$175.00
D7240	Removal of Impacted Tooth – Completely Bony	\$210.00
For all services performed by a Dental Specialist (including Orthodontic Services) and any services not listed above, you pay a fee of 75% Of the Dentist’s Usual and Customary fee.		

Section 5 (i). 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.

PPO DENTAL PLAN

In addition to the Dental Discount benefit described in Section 5 (h) of this brochure, M.D. IPA provides a PPO dental Plan to all 2002 Federal members. There is no additional premium for this benefit and enrollment is automatic when you enroll in M.D IPA's FEHB health Plan (JN) for 2002.

Members may go to the dentist of their choice; however, the benefit is usually better when you visit a dentist who participates in the PPO. The benefit provides reimbursement of up to \$1,000 per contract year for covered dental procedures. The PPO dental Plan covers diagnostic (e.g., x-rays), preventive (e.g., exams, cleanings), basic (e.g., fillings), and major procedures (e.g., root canals, crowns).

Members will get a separate I.D. card for this benefit in their enrollment kit. It is issued by MAMSI Life and Health insurance Company (MLH), who provides and administers this benefit.

Look for important details about this Plan, its usage, as well as a listing of participating dentists, in the 2002 Dental Benefits Guide. This Guide is in the enrollment packet, or can be obtained by calling Member Services at 1-800/251-0956, or 301/360-8080. You can also find information about the dental Program on our website (www.mamsi.com/federal).

TLC LASER VISION CORRECTION DISCOUNT

TLC Laser Eye Centers offer M.D.IPA members a preferred savings of 25% to a maximum of \$1,800 per eye for laser vision correction. For more information on this benefit, please contact TLC toll-free at 1-877-PLAN TLC.

ASHN COMPLEMENTARY HEALTH CARE ACCESS PROGRAM

As a member with M.D IPA, you will receive a 25% discount on services rendered by an American Specialty Health Networks (ASHN) participating chiropractor, acupuncturist or massage therapist that are not reimbursed under your FEHB benefits. For more information about the ASHN Access Program, please call ASHN at 1-877-327-2746, or select the Healthyroads.com link on our website (www.mamsi.com).

OPTICAL SERVICES

Discounts are available on eyewear and related services at participating optical centers listed in the Plan's Provider Directory. Members simply show their member identification card at a participating center to receive a discount on eyeglasses, including single, multifocal or designer, and other optical services.

Contact lenses may also be available at a discount. Please contact Member Services for the names of participating practitioners.

NATIONAL FITNESS NETWORK DISCOUNT

The National Fitness Network offers discounts at area health and fitness clubs of up to 30% to M.D.IPA members. For more information or for questions regarding registration, call National Fitness Network at 1-800-811-5454, or visit their website at www.nationalfitnessnetwork.com.

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 and we agree, as discussed under *What Services Require Our Prior Approval* on page 12.**

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; or
- Services, drugs, or supplies you receive from a provider or facility barred from the FEHB Program.

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 or coinsurance.

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 at 301/360-8080 or at 1-800/251-0956.

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 of the 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: P.O. Box 948, Frederick, MD 21705

Prescription drugs

Usually, there are no claim forms to fill out when you fill a prescription at a Plan pharmacy. In some cases, however, you may pay out-of-pocket, such as when you are outside the service area in a medical emergency. If this happens, send the following information to P.O. Box 948, Frederick, Maryland 21705:

- your receipt
- the drug NDC number
- the pharmacy's NABP number, and
- the prescribing doctor or dentist's DEA number

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** Ask us in writing to reconsider our initial decision. You must:
 - (a) Write to us within 6 months from the date of our decision; and
 - (b) Send your request to us at: Customer Support, P.O. Box 933, Frederick, MD 21705
 - (c) Include a statement about why you believe our initial decision was wrong, based on specific benefit provisions in this brochure; and
 - (d) Include copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms.

- 2** We have 30 days from the date we receive your request to:
 - (a) Pay the claim (or, if applicable, arrange for the health care provider to give you the care); or
 - (b) Write to you and maintain our denial – go to step 4; or
 - (c) Ask 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** You or your provider must send the information so that we receive it within 60 days of your request. We will then decide within 30 more days.

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.

We will write to you with our decision.

- 4** If you do not agree with our decision, you may ask OPM to review it.

You must write to OPM within:

- 90 days after the date of our letter upholding our initial decision; or
- 120 days after you first wrote to us – if we did not answer that request in some way within 30 days; or
- 120 days after we asked for additional information.

Write to OPM at: Office of Personnel Management, Office of Insurance Programs, Contracts Division 3, 1900 E Street, NW, Washington, DC 20415-3630.

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 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 include 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.

Disputed Claims process (Continued)

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, or from the year in which you were denied precertification or prior approval. 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 at 301/360-8080 or 1-800/251-0956, 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 3 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. If you or your spouse worked for at least 10 years in Medicare-covered employment, you should be able to qualify for premium-free part A insurance. (Someone who was a Federal employee on January 1, 1983 or since automatically qualifies). Otherwise, if you are age 65 or older, you may be able to buy it. Contact 1-800-MEDICARE for more information.
- **Part B (Medical Insurance).** Most people pay monthly for Part B. Generally, Part B premiums are withheld from your monthly Social Security check or your retirement check.

If you are eligible for Medicare, you may have choices in how you get your health care. Medicare + Choice is a 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 (Part A or Part B)**

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

When you are enrolled in Original Medicare along with this Plan, 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.

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 ESRC 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, or		✓
c) Are a former spouse of an annuitant, or	✓	
d) Are a former spouse of an active employee		✓

Claims process when you have the Original Medicare Plan – You probably will never have to file a claim form when you have both our Plan and the Original Medicare Plan.

- 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 at 301/360-8080 or 1-800/251-0956

We waive some costs when you have the Original Medicare Plan.

When Original Medicare is the primary payer, we will waive some out-of-pocket costs until you meet your Medicare Part B deductible. All copayment and coinsurance amounts will be applied. Once the Medicare Part B deductible has been met, all copayments and coinsurance are waived. We will pay all amounts identified as “patient responsibility” on the Medicare Explanation of Benefits as long as the service rendered is a covered benefit. We will pay the Inpatient Medicare deductible.

- **Medicare managed care plan**

If you are eligible for Medicare, you may choose to enroll in and get your Medicare benefits from another type of Medicare + Choice Plan -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 provide all the benefits that Original Medicare covers. 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, but we will not waive any of our copayments, coinsurance, or deductibles. If you enroll in a Medicare managed care plan, tell us. We will need to know whether you are in the Original Medicare Plan or in a Medicare managed care plan so we can correctly coordinate benefits with Medicare.

Suspended FEHB coverage to enroll in a Medicare managed care plan: If you are an annuitant or former spouse, you can suspend your FEHB coverage and 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 managed care plan’s service area.

- **If you do not enroll in Medicare Part A or Part B** If you do not have one or both parts of Medicare, you can still be covered under the FEHB Program. We will not require you to enroll in Medicare Part B and, if you can't get premium-free Part A, we will not ask you to enroll in it.

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 illness 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 care. 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 other 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.
Coinsurance	Coinsurance is the percentage of our allowance that you must pay for your care. See page 13.
Copayment	A copayment is a fixed amount of money you pay when you receive covered services. See page 13.
Covered services	Care we provide benefits for, as described in this brochure.
Custodial care	Medical or non-medical services: <ul style="list-style-type: none">• Which are furnished mainly to assist you in the activities of daily living;• For which professional skills or training is not required; and• Which are not likely to result in the improvement of your condition or in your recovery
Experimental or investigational services	<p>A drug, device, treatment or procedure is considered experimental if:</p> <ul style="list-style-type: none">• It is not recognized, in accordance with generally accepted medical standards, as being safe and effective for your condition• It requires approval by a governmental authority (including the U.S. Food and Drug Administration) before you can use it, but they have not granted that approval; or• It is the subject of a written protocol used by the treating facility for research, clinical trials, or other tests or studies to evaluate its safety, effectiveness, toxicity, or maximum tolerated dose. <p>We evaluate investigational/experimental treatments on a case-by-case basis as well as on a continual basis as new and emerging treatments become available. We use a variety of resources to assist the Medical Director in deciding if a service is experimental or investigational including specific database searches of the National Institutes of Health (NIH) and the Health care Financing Administration (HCFA), review by independent medical experts and an independent technology assessment firm.</p>
Medical necessity	Services which are reasonably necessary in the exercise of good medical practice in accordance with professional standards accepted in the United States for the treatment of an active illness or injury. We determine medical necessity.
Plan allowance	Plan allowance is the amount we use to determine our payment and your coinsurance for covered services. Plans determine their allowances in different ways. MD-IPA's plan allowance is based on an internally-developed fee schedule. Each CPT, HCPC or ADA procedure code is assigned a regional rate, based on your provider's office address. This rate includes your copayment or coinsurance amount. Participating providers accept this rate, including your copayment or coinsurance amount, as payment in full.
Us/We	Us and we refer to MD-IPA.
You	You refers to the enrollee and each covered 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 along. 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 joined this Plan during Open Season, your coverage begins on the first day of your first pay period that starts on or after January 1. Annuitants' coverage and premiums begin on January 1. If you joined at any other time during the year, your employing office will tell you the effective date of coverage.

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 contact;
- 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 identify; 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 RI70-5, the *Guide to Federal Employees Health Benefits Plans for Temporary Continuation of Coverage and Former Spouse Enrollees*, or other information about your coverage choices.

- **Temporary Continuation Coverage (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, if you lose your job, if you are a covered dependent child and you turn 22 or marry, etc..

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

Enrolling in TCC: 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. It explains what you have to do to enroll.

- **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

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is a Federal law that offers limited Federal protections for health coverage availability and continuity to people who lose employer group 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.

For more information, get OPM pamphlet RI 79-27, Temporary Continuation of Coverage (TCC) under the FEHB Program. See also the FEHB web site (www.opm.gov/insure/health); refer to the “TCC and HIPAA” frequently asked questions. These highlight HIPAA rules, such as the requirement that federal employees must exhaust any TCC eligibility as one condition for guaranteed access to individual health coverage under HIPAA, and have information about Federal and State agencies you can contact for more information.

Long Term Care Insurance Is Coming Later in 2002!

- Many FEHB enrollees think that their health plan and/or Medicare will cover their long-term care needs. Unfortunately, they are *WRONG!*
- How are YOU planning to pay for the future custodial or chronic care you may need?
- You should consider buying long-term care insurance.

The Office of Personnel Management (OPM) will sponsor a high-quality long term care insurance program effective in October 2002. As part of its educational effort, OPM asks you to consider these questions:

What is long term care (LTC) insurance?

- It's insurance to help pay for long term care services you may need if you can't take care of yourself because of an extended illness or injury, or an age-related disease such as Alzheimer's.
- LTC insurance can provide broad, flexible benefits for nursing home care, care in an assisted living facility, care in your home, adult day care, hospice care, and more. *LTC insurance can supplement care provided by family members, reducing the burden you place on them.*

I'm healthy. I won't need long term care. Or, will I?

- Welcome to the club!
- 76% of Americans believe they will never need long term care, but the facts are that about half of them will. And it's not just the old folks. About 40% of people needing long term care are under age 65. They may need chronic care due to a serious accident, a stroke, or developing multiple sclerosis, etc.
- We hope you will never need long term care, but everyone should have a plan just in case. *Many people now consider long term care insurance to be vital to their financial and retirement planning.*

Is long term care expensive?

- Yes, it can be very expensive. A year in a nursing home can exceed \$50,000. Home care for only three 8- hour shifts a week can exceed \$20,000 a year. And that's before inflation!
- Long term care can easily exhaust your savings. *Long term care insurance can protect your savings.*

But won't my FEHB plan, Medicare or Medicaid cover my long term care?

- Not FEHB. Look at the "Not covered" blocks in sections 5(a) and 5(c) of your FEHB brochure. Health plans don't cover custodial care or a stay in an assisted living facility or a continuing need for a home health aide to help you get in and out of bed and with other activities of daily living. Limited stays in skilled nursing facilities can be covered in some circumstances.
- Medicare only covers skilled nursing home care (the highest level of nursing care) after a hospitalization for those who are blind, age 65 or older or fully disabled. It also has a 100 day limit.
- Medicaid covers long term care for those who meet their state's poverty guidelines, but has restrictions on covered services and where they can be received. *Long term care insurance can provide choices of care and preserve your independence.*

When will I get more information on how to apply for this new insurance coverage?

- Employees will get more information from their agencies during the LTC open enrollment period in the late summer/early fall of 2002.
- Retirees will receive information at home.

How can I find out more about the program NOW?

- Our toll-free teleservice center will begin in mid-2002. In the meantime, you can learn more about the program on our web site at www.opm.gov/insure/ltc.

Department of Defense/FEHB Demonstration Project

What is it?

The Department of Defense/FEHB Demonstration Project allows some active and retired uniformed service members and their dependents to enroll in the FEHB Program. The demonstration will last for three years and began with the 1999 open season for the year 2000. Open season enrollments will be effective January 1, 2002. DoD and OPM have set up some special procedures to implement the Demonstration Project, noted below. Otherwise, the provisions described in this brochure apply.

Who is eligible

DoD determines who is eligible to enroll in the FEHB Project. Generally, you may enroll if:

- You are an active or retired uniformed service member and are eligible for Medicare;
- You are a dependent of an active or retired uniformed service member and are eligible for Medicare;
- You are a qualified former spouse of an active or retired uniformed service member and you have not remarried; or
- You are a survivor dependent of a deceased active or retired uniformed service member; and
- You live in one of the geographic demonstration areas.

If you are eligible to enroll in a plan under the regular Federal Employees Health Benefits Program, you are not eligible to enroll under the DoD/FEHB Demonstration Project.

The demonstration areas

- Dover AFB, DE
- Fort Knox, KY
- Dallas, TX
- New Orleans, LA
- Adair County, IA
- Commonwealth of Puerto Rico
- Greensboro/Winston Salem/High Point, NC
- Humboldt County, CA area
- Naval Hospital, Camp Pendleton, CA
- Coffee County, GA

When you can join

You may enroll under the FEHB/DoD Demonstration Project during the 2001 open season, November 12, 2001, through December 10, 2001. Your coverage will begin January 1, 2002. DoD has set-up an Information Processing Center (IPC) in Iowa to provide you with information about how to enroll. IPC staff will verify your eligibility and provide you with FEHB Program information, plan brochures, enrollment instructions and forms. The toll-free phone number for the IPC is 1-877/DOD-FEHB (1-877/363-3343).

You may select coverage for yourself (Self Only) or for you and your family (Self and Family) during open season. Your coverage will begin January 1, 2002. If you become eligible for the DoD/FEHB Demonstration Project outside of open season, contact the IPC to find out how to enroll and when your coverage will begin.

DoD has a web site devoted to the Demonstration Project. You can view information such as their Marketing/Beneficiary Education Plan, Frequently Asked Questions, demonstration area locations and zip code lists at www.tricare.osd.mil/fehbp. You can also view information about the demonstration project, including "The 2002 Guide to Federal Employees Health Benefits Plans Participating in the DoD/FEHB Demonstration Project," on the OPM web site at www.opm.gov.

Temporary Continuation Coverage (TCC)

See Section 11, FEHB Facts; it explains temporary continuation of coverage (TCC). Under this DoD/FEHB Demonstration Project the **only** individual eligible for TCC is one who ceases to be eligible as a “member of family” under your self and family enrollment. This occurs when a child turns 22, for example, or if you divorce and your spouse does not qualify to enroll as an unremarried former spouse under title 10, United States Code. For these individuals, TCC begins the day after their enrollment in the DoD/FEHB Demonstration Project ends. TCC enrollment terminates after 36 months or the end of the Demonstration Project, whichever occurs first. You, your child, or another person must notify the IPC when a family member loses eligibility for coverage under the DoD/FEHB Demonstration Project.

TCC is not available if you move out of a DoD/FEHB Demonstration Project area, you cancel your coverage, or your coverage is terminated for any reason. TCC is not available when the demonstration project ends.

Other features

The 31-day extension of coverage and right to convert do not apply to the DoD/FEHB Demonstration Project.

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Do not rely on this page; it is for your convenience and may not show all pages where the terms appear.

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Summary of benefits for the MD-IPA Health Plan – 2002

- **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; \$20 specialist	15
Services provided by a hospital:		
• Inpatient	Nothing	27
• Outpatient	\$50 copay	28
Emergency benefits:		
• In or out-of-area	\$25 per urgent care center visit	30
	\$50 per emergency room visit	31
Mental health and substance abuse treatment	Regular cost sharing	32
Prescription drugs.....	\$5 per generic drug	34
	\$15 per name brand drug in the Plan's formulary	
	\$30 per name brand drug not in the Plan's formulary	
	20% up to \$50 for injectable drugs, except for insulin.	
Dental Care	Discount fee schedule	37
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	Some costs do not count toward this protection	

**Vea otro lado
para español.**

Five Steps to Safer Health Care

1. Speak up if you have questions or concerns.

Choose a doctor who you feel comfortable talking to about your health and treatment. Take a relative or friend with you if this will help you ask questions and understand the answers. It's okay to ask questions and to expect answers you can understand.

2. Keep a list of all the medicines you take.

Tell your doctor and pharmacist about the medicines that you take, including over-the-counter medicines such as aspirin, ibuprofen, and dietary supplements like vitamins and herbals. Tell them about any drug allergies you have. Ask the pharmacist about side effects and what foods or other things to avoid while taking the medicine. When you get your medicine, read the label, including warnings. Make sure it is what your doctor ordered, and you know how to use it. If the medicine looks different than you expected, ask the pharmacist about it.

3. Make sure you get the results of any test or procedure.

Ask your doctor or nurse when and how you will get the results of tests or procedures. If you do not get them when expected – in person, on the phone, or in the mail – don't assume the results are fine. Call your doctor and ask for them. Ask what the results mean for your care.

4. Talk with your doctor and health care team about your options if you need hospital care.

If you have more than one hospital to choose from, ask your doctor which one has the best care and results for your condition. Hospitals do a good job of treating a wide range of problems. However, for some procedures (such as heart bypass surgery), research shows results often are better at hospitals doing a lot of these procedures.* Also, before you leave the hospital, be sure to ask about follow-up care, and be sure you understand the instructions.

5. Make sure you understand what will happen if you need surgery.

Ask your doctor and surgeon: Who will take charge of my care while I'm in the hospital? Exactly what will you be doing? How long will it take? What will happen after the surgery? How can I expect to feel during recovery? Tell the surgeon, anesthesiologist, and nurses if you have allergies or have ever had a bad reaction to anesthesia. Make sure you, your doctor, and your surgeon all agree on exactly what will be done during the operation.

This information is brought to you in cooperation with The Federal Government's Office of Personnel Management and the Quality Interagency Task Force (7/00).

* Source: US News and World Report, 7/17/00

Cinco Recomendaciones para Recibir una Mejor Atención Médica

- 1. No se quede callado si tiene preguntas o inquietudes.** Escoja a un médico de confianza. Cuando haga la cita con su médico, pregunte si hay un traductor para ayudarle hacer preguntas y comprender adecuadamente las respuestas. Si no, invite a un pariente o a un amigo que pueda ayudarle a entender. Es importante que haga preguntas y que se asegure de que entiende las respuestas.
- 2. Asegúrese de mantener una lista de todos los remedios y medicamentos que toma.** Hable con su médico y con su farmacéutico sobre la importancia de mantener una lista de todos los remedios que toma. Incluya en la lista cualquier remedio, inclusive los medicamentos que están disponibles sin receta médica, tales como la aspirina, y suplementos dietéticos, tales como vitaminas y productos de hierbas naturales. Infórmeles acerca de cualquier tipo de alergia que tenga a medicamentos. Pregunte al farmacéutico sobre los riesgos de combinar los medicamentos y sobre los productos alimenticios y otras cosas que deba evitar mientras los toma. Cuando le entreguen su medicina, lea la etiqueta, incluyendo las advertencias. Asegúrese de que lo que le han dado sea lo que ha recetado el médico y que sepa cómo debe usarlo. Si la medicina se ve diferente a lo que usted esperaba, pregúntele al farmacéutico sobre ello.
- 3. Asegúrese de obtener los resultados de cualquier examen o análisis médico que le hagan.** Pregunte a su médico o enfermera cuándo y de qué manera recibirá los resultados de los exámenes realizados. No presuma que todo está bien si no los recibe cuando usted lo esperaba. Es importante que usted llame a su médico y le pida los resultados aunque se sienta bien. Usted tiene el derecho de pedirlos y recibirlos. Pregunte también qué significan los resultados con respeto a su condición médica.
- 4. Si necesita atención hospitalaria, hable con su médico y con los otros miembros del equipo médico que serán responsables de su cuidado, acerca de las opciones que tiene disponibles.** Pregúntele a su médico cual hospital ofrece la mejor atención para su condición. Los hospitales hacen una buena labor tratando una amplia variedad de problemas. Sin embargo, para algunos procedimientos (por ejemplo, una operación de corazón) las investigaciones muestran que los hospitales que realizan muchos procedimientos de este tipo tienden a tener los mejores resultados. También, antes de salir del hospital, no se olvide de preguntar sobre el cuidado a seguir, y asegúrese de que comprende bien las instrucciones.
- 5. Si necesita tener cirugía, asegúrese de que entiende qué sucederá.** Pregunte a su médico y a su cirujano sobre quién será responsable de su cuidado mientras esté en el hospital, qué le van a hacer, qué sucederá después de la cirugía y sobre cómo se sentirá después. Informe al cirujano, a los anestesiólogos y a las enfermeras si tiene alergias o si alguna vez ha tenido una mala reacción a la anestesia. Dado que su médico y su cirujano no son necesariamente la misma persona, asegúrese de que los dos están de acuerdo respecto a lo que exactamente se va a hacer durante la operación.

2002 Rate Information for M.D. IPA: The Quality Care Health Plan

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

Washington, DC area

Self Only	JP1	\$90.41	\$30.14	\$195.89	\$65.30	\$106.99	\$13.56
Self and Family	JP2	\$217.02	\$72.34	\$470.21	\$156.74	\$256.81	\$32.55

N.VA/Central VA/Richmond/Tidewater/Roanoke

Self Only	JP1	\$90.41	\$30.14	\$195.89	\$65.30	\$106.99	\$13.56
Self and Family	JP2	\$217.02	\$72.34	\$470.21	\$156.74	\$256.81	\$32.55

All of Maryland

Self Only	JP1	\$90.41	\$30.14	\$195.89	\$65.30	\$106.99	\$13.56
Self and Family	JP2	\$217.02	\$72.34	\$470.21	\$156.74	\$256.81	\$32.55