

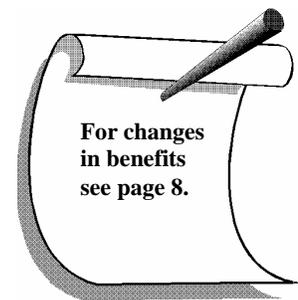
MD-Individual Practice Association, Inc.

<http://www.mamsi.com/federal>

A Health Maintenance Organization

**Serving: Washington, D.C., Maryland, Northern Virginia,
Roanoke, Richmond, and Tidewater areas**

**Enrollment in this plan is limited. You must live or work in our
Geographic service area to enroll. See pages 6 and 7 for
requirements.**



**Enrollment code for this Plan:
JP1 Self Only
JP2 Self and Family**



*This Plan has excellent accreditation
from NCQA. See the 2005 Guide for
more information on accreditation.*

Authorized for distribution by the:



Federal Employees
Health Benefits Program



**United States
Office of Personnel Management**

Center for
Retirement and Insurance Services
<http://www.opm.gov/insure>



UNITED STATES
OFFICE OF PERSONNEL MANAGEMENT
WASHINGTON, DC 20415-0001

OFFICE OF THE DIRECTOR

Dear Federal Employees Health Benefits Program Participant:

Welcome to the 2005 Open Season! By continuing to introduce pro-consumer health care ideas, the Office of Personnel Management (OPM) team has given you greater, cost effective choices. This year several national and local health plans are offering new options, strengthening the Federal Employees Health Benefits (FEHB) Program and highlighting once again its unique and distinctive market-oriented features. I remain firm in my belief that you, when fully informed as a Federal subscriber, are in the best position to make the decisions that meet your needs and those of your family. Plan brochures provide information to help subscribers make these fully informed decisions. Please take the time to review the plan's benefits, particularly Section 2, which explains plan changes.

Exciting new features this year give you additional opportunities to save and better manage your hard-earned dollars. For 2005, I am very pleased and enthusiastic about the new High Deductible Health Plans (HDHP) with a Health Savings Account (HSA) or Health Reimbursement Arrangement (HRA) component. This combination of health plan and savings vehicle provides a new opportunity to save and better manage your money. If an HDHP/HSA is not for you and you are not retired, I encourage you to consider a Flexible Spending Account (FSA) for health care. FSAs allow you to reduce your out-of-pocket health care costs by 20 to more than 40 percent by paying for certain health care expenses with tax-free dollars, instead of after-tax dollars.

Since prevention remains a major factor in the cost of health care, last year OPM launched the *HealthierFeds* campaign. Through this effort we are encouraging Federal team members to take greater responsibility for living a healthier lifestyle. The positive effect of a healthier lifestyle brings dividends for you and reduces the demands and costs within the health care system. This campaign embraces four key "actions" that can lead to a healthy America: be physically active every day, eat a nutritious diet, seek out preventative screenings, and make healthy lifestyle choices. Be sure to visit *HealthierFeds* at www.healthierfeds.opm.gov for more details on this important initiative. I also encourage you to visit the Department of Health and Human Services website on Wellness and Safety, www.hhs.gov/safety/index.shtml, which complements and broadens healthier lifestyle resources. The site provides extensive information from health care experts and organizations to support your personal interest in staying healthy.

The FEHB Program offers the Federal team the widest array of cost-effective health care options and the information needed to make the best choice for you and your family. You will find comprehensive health plan information in this brochure, in the 2005 Guide to FEHB Plans, and on the OPM Website at www.opm.gov/insure. I hope you find these resources useful, and thank you once again for your service to the nation.

Sincerely,

A handwritten signature in black ink, appearing to read "Kay C. James".

Kay Coles James

Director



Notice of the United States Office of Personnel Management's Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

By law, the United States Office of Personnel Management (OPM), which administers the Federal Employees Health Benefits (FEHB) Program, is required to protect the privacy of your personal medical information. OPM is also required to give you this notice to tell you how OPM may use and give out ("disclose") your personal medical information held by OPM.

OPM **will** use and give out your personal medical information:

- To you or someone who has the legal right to act for you (your personal representative),
- To the Secretary of the Department of Health and Human Services, if necessary, to make sure your privacy is protected,
- To law enforcement officials when investigating and/or prosecuting alleged or civil or criminal actions, and
- Where required by law.

OPM **has the right** to use and give out your personal medical information to administer the FEHB Program. For example:

- To communicate with your FEHB health plan when you or someone you have authorized to act on your behalf asks for our assistance regarding a benefit or customer service issue.
- To review, make a decision, or litigate your disputed claim.
- For OPM and the General Accounting Office when conducting audits.

OPM **may** use or give out your personal medical information for the following purposes under limited circumstances:

- For Government health care oversight activities (such as fraud and abuse investigations),
- For research studies that meet all privacy law requirements (such as for medical research or education), and
- To avoid a serious and imminent threat to health or safety.

By law, OPM must have your written permission (an "authorization") to use or give out your personal medical information for any purpose that is not set out in this notice. You may take back ("revoke") your written permission at any time, except if OPM has already acted based on your permission.

By law, you **have the right** to:

- See and get a copy of your personal medical information held by OPM.
- Amend any of your personal medical information created by OPM if you believe that it is wrong or if information is missing, and OPM agrees. If OPM disagrees, you may have a statement of your disagreement added to your personal medical information.
- Get a listing of those getting your personal medical information from OPM in the past 6 years. The listing will not cover your personal medical information that was given to you or your personal representative, any information that you authorized OPM to release, or that was given out for law enforcement purposes or to pay for your health care or a disputed claim.

- Ask OPM to communicate with you in a different manner or at a different place (for example, by sending materials to a P.O. Box instead of your home address).
- Ask OPM to limit how your personal medical information is used or given out. However, OPM may not be able to agree to your request if the information is used to conduct operations in the manner described above.
- Get a separate paper copy of this notice.

For more information on exercising your rights set out in this notice, look at www.opm.gov/insure on the Web. You may also call 202-606-0745 and ask for OPM's FEHB Program privacy official for this purpose.

If you believe OPM has violated your privacy rights set out in this notice, you may file a complaint with OPM at the following address:

Privacy Complaints
United States Office of Personnel Management
P.O. Box 707
Washington, DC 20004-0707

Filing a complaint will not affect your benefits under the FEHB Program. You also may file a complaint with the Secretary of the United States Department of Health and Human Services.

By law, OPM is required to follow the terms in this privacy notice. OPM has the right to change the way your personal medical information is used and given out. If OPM makes any changes, you will get a new notice by mail within 60 days of the change. The privacy practices listed in this notice are effective April 14, 2003.

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Introduction

This brochure describes the benefits of M.D.IPA under our contract (CS 1935) with the United States Office of Personnel Management (OPM), as authorized by the Federal Employees Health Benefits law. The address for M.D.IPA's administrative offices is:

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

This brochure is the official statement of benefits. No oral statement can modify or otherwise affect the benefits, limitations, and exclusions of this brochure. It is your responsibility to be informed about your health benefits.

If you are enrolled in this Plan, you are entitled to the benefits described in this brochure. If you are enrolled in 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, 2005, unless those benefits are also shown in this brochure.

OPM negotiates benefits and rates with each plan annually. Benefit changes are effective January 1, 2005, and changes are summarized on page 8. Rates are shown on the back cover of this brochure.

Plain Language

All FEHB brochures are written in plain language 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 M.D. IPA.
- We limit acronyms to ones you know. FEHB is the Federal Employees Health Benefits Program. OPM is the U.S. 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 U.S. Office of Personnel Management, Insurance Services Program, Program Planning & Evaluation Group, 1900 E Street, NW Washington, DC 20415-3650

Stop Health Care Fraud!

Fraud increases the cost of health care for everyone and increases your Federal Employees Health Benefits Program premium.

OPM's Office of the Inspector General investigates all allegations of fraud, waste, and abuse in the FEHB Program regardless of the agency that employs you or from which you retired.

Protect Yourself From Fraud – Here are some things that you can do to prevent fraud:

- Be wary of giving your plan identification (ID) number over the telephone or to people you do not know, except to your doctor, other provider, or authorized plan or OPM representative.
- Let only the appropriate medical professionals review your medical record or recommend services.
- Avoid using health care providers who say that an item or service is not usually covered, but they know how to bill us to get it paid.

- Carefully review explanations of benefits (EOBs) that you receive from us.
- Do not ask your doctor to make false entries on certificates, bills or records in order to get us to pay for an item or service.
- If you suspect that a provider 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 1-800-251-0956 and explain the situation.

If we do not resolve the issue:

**CALL – THE HEALTH CARE FRAUD HOTLINE
202-418-3300**

OR WRITE TO:

**United States Office of Personnel Management
Office of the Inspector General Fraud Hotline
1900 E Street, NW, Room 6400
Washington, DC 20415**

- Do not maintain as a family member on your policy:
 - Your former spouse after a divorce decree or annulment is final (even if a court order stipulates otherwise); or
 - Your child over age 22 (unless he/she is disabled and incapable of self support).
- If you have any questions about the eligibility of a dependent, check with your personnel office if you are employed, with your retirement office (such as OPM) if you are retired, or with the National Finance Center if you are enrolled under Temporary Continuation of Coverage.
- You can be prosecuted for fraud and your agency may take action against you if you falsify a claim to obtain FEHB benefits or try to obtain services for someone who is not an eligible family member or who is no longer enrolled in the Plan.

Preventing medical mistakes

An influential report from the Institute of Medicine estimates that up to 98,000 Americans die every year from medical mistakes in hospitals alone. That's about 3,230 preventable deaths in the FEHB Program a year. While death is the most tragic outcome, medical mistakes cause other problems such as permanent disabilities, extended hospital stays, longer recoveries, and even additional treatments. By asking questions, learning more and understanding your risks, you can improve the safety of your own health care, and that of your family members. Take these simple steps:

1. Ask questions if you have doubts or concerns.

- Ask questions and make sure you understand the answers.
- Choose a doctor with whom you feel comfortable talking.
- Take a relative or friend with you to help you ask questions and understand answers.

2. **Keep and bring a list of all the medicines you take.**

- Give your doctor and pharmacist a list of all the medicines that you take, including non-prescription medicines.
- Tell them about any drug allergies you have.
- Ask about side effects and what to avoid while taking the medicine.
- Read the label when you get your medicine, including all warnings.
- Make sure your medicine is what the doctor ordered and know how to use it.
- Ask the pharmacist about your medicine if it looks different than you expected.

3. **Get the results of any test or procedure.**

- Ask when and how you will get the results of tests or procedures.
- Don't assume the results are fine if you do not get them when expected, be it in person, by phone, or by mail.
- Call your doctor and ask for your results.
- Ask what the results mean for your care.

4. **Talk to your doctor about which hospital is best for your health needs.**

- Ask your doctor about which hospital has the best care and results for your condition if you have more than one hospital to choose from to get the health care you need.
- Be sure you understand the instructions you get about follow-up care when you leave the hospital.

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

- Make sure you, your doctor, and your surgeon all agree on exactly what will be done during the operation.
- Ask your doctor, "Who will manage my care when I am in the hospital?"
- Ask your surgeon:
 - Exactly what will you be doing?
 - About how long will it take?
 - What will happen after surgery?
 - How can I expect to feel during recovery?
- Tell the surgeon, anesthesiologist, and nurses about any allergies, bad reaction to anesthesia, and any medications you are taking.

Want more information on patient safety?

- www.ahrq.gov/consumer/pathqpack.html. The Agency for Healthcare Research and Quality makes available a wide-ranging list of topics not only to inform consumers about patient safety but to help choose quality health care providers and improve the quality of care you receive.
- www.npsf.org. The National Patient Safety Foundation has information on how to ensure safer health care for you and your family.
- www.talkaboutrx.org/consumer.html. The National Council on Patient Information and Education is dedicated to improving communication about the safe, appropriate use of medicines.
- www.leapfroggroup.org. The Leapfrog Group is active in promoting safe practices in hospital care.
- www.ahqa.org. The American Health Quality Association represents organizations and health care professionals working to improve patient safety.
- www.quic.gov/report. Find out what federal agencies are doing to identify threats to patient safety and help prevent mistakes in the nation's health care delivery system.

Section 1. Facts about this HMO plan

This Plan is a health maintenance organization (HMO). We require you to see specific physicians, hospitals, facilities and other health care practitioners who contract with us. These Plan physicians and health care practitioners coordinate your health care services. The Plan is solely responsible for the selection of these providers in your area. Contact the Plan at 301-360-8080 or at 1-800-251-0956 (TTY: 301-360-8111 or 1-800-553-7109) for a copy of their most recent *Directory of Health Care Professionals* or visit our website, www.mamsi.com/federal.

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 physicians and health care practitioners follow generally accepted medical practice when prescribing any course of treatment.

When you receive services from Plan physicians and health care practitioners, 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 physicians and health care practitioners, you may have to submit claim forms.

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

How we pay physicians, health care practitioners and facilities

We contract with individual physicians, medical groups, and hospitals to provide the benefits in this brochure. These Plan physicians and health care practitioners 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 of physicians, health care practitioners 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 M.D. IPA's Member Services Department 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, MD 21705. You may also contact us by fax at 301-360-8907 or visit our Website, www.mamsi.com/federal.

Service Area

To enroll in this Plan, you must live in or work in our service area. This is where our physicians and health care practitioners 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, Harrisonburg, Hopewell, Manassas, Manassas Park, Newport News, Norfolk, Norton, Petersburg, Poquoson, Portsmouth, Radford, Richmond, Roanoke, Salem, Staunton, Suffolk, Virginia Beach, Waynesboro, Williamsburg and Winchester.

Counties of:

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

Ordinarily, you must get your care from physicians and health care practitioners 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 2005

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

- In Section 9, we revised the **Medicare Primary Payer Chart** and updated the language regarding Medicare Advantage plans (formerly called Medicare + Choice plans).
- In Section 12, we revised the language regarding the Flexible Spending Account Program-*FSAFEDS* and the Federal Long Term Care Insurance Program.

Changes to this Plan

- Your share of the non-Postal premium will increase by 9.7% for Self Only coverage or 9.7% for Self and Family coverage.
- **Primary Care Physician**—We have eliminated the Primary Care Physician (PCP) copayment for any visit for children from infancy through age 12.
- **Service area expansion** – We have expanded our service area in the State of Virginia to include the City of Winchester and the counties of Frederick, and Shenandoah.

Section 3. How you get care

Identification cards

We will send you a health Plan 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 physician or health care practitioner, or fill a prescription at a Plan pharmacy. Until you receive your health Plan 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 or write to us at P.O. Box 943, Frederick, MD 21705. You may also request replacement cards through our website at www.mamsi.com/federal.

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 physicians and other licensed health care professionals in our service area contract with us 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 at 301-360-8080 or 1-800-251-0956.

We list Plan physicians and health care practitioners in our *Directory of Health Care Professionals*. The list is also on our website, www.mamsi.com/federal, which we update periodically. 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 our *Directory of Health Care Professionals*. The list is also on our website, www.mamsi.com/federal. 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 (PCP). This decision is important since your PCP provides or arranges for most of your health care. **Please see pages 41 and 42 for information on accessing Mental Health and Substance Abuse benefits.**

To choose a PCP check our *Directory of Health Care Professionals* or our website, www.mamsi.com/federal. 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, MD 21705.

- **Primary care**

Your Primary Care Physician (PCP) 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 PCP will provide most of your health care, or give you a referral to see a specialist.

You may change your Primary Care Physician (PCP) by submitting the “Federal Information Form”, by mail to P.O. Box 943, Frederick, MD 21705-0943, by fax to 301-360-8918, by calling the Member Services Department, or by submitting the change through our website. If we receive your request by the twentieth of the month, your change will become effective on the first day of the following month. If you change your PCP after the 20th of the month, the change will not be effective until the 1st day of the second month following the date of the change. For example, if you change your PCP on June 25, it would be effective August 1. If you want to change PCPs or if your PCP leaves the Plan, call us or visit our website. We will help you select a new one.

- **Specialty care**

Your Primary Care Physician (PCP) will refer you to a participating specialist for needed care. Your referral is valid for one visit/consultation unless your PCP authorized a certain number of visits without additional referrals. If you are changing your PCP and currently have in effect a referral to a Specialist, it will be necessary to request a new referral from your new PCP. All follow-up care must be authorized by your PCP issuing you a new referral, or by approving a Consultant Treatment Plan (CTP) submitted by the specialist. 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 refraction exams and dental care are also available from Plan physicians and health care practitioners 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 PCP will develop a treatment plan that allows you to see your specialist for a certain number of visits without additional referrals. Your PCP 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 PCP. He or she 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 PCP, 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 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. If your plan terminates participation in the FEHB Program in whole or in part, or if OPM orders an enrollment change, this continuation of coverage provision does not apply. In such case, the hospitalized family member's benefits under the new plan begin on the effective date of enrollment.

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 (PCP) has authority to refer you for most services. For certain services, however, your physician must obtain approval from us. All care must be arranged with Plan providers except for emergencies. 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 Reduction
- Reconstructive surgery

- Growth Hormone Therapy (GHT)
- Infertility Services
- Morbid Obesity Surgery
- Therapies (Physical Therapy, Occupational Therapy and Speech Therapy)
 - precertification is required for physical therapy and occupational therapy after the eighth (8th) visit for all members
 - precertification is required for speech therapy from the first (1st) visit, but only for members under age 10
- Dental services that are considered medical (not dental), except for fracture care and removal of cysts and tumors
- Temporomandibular Disorder and/or related Myofascial Pain Dysfunction (MPD) treatment
- Transplants
- Uvulopalatopharyngoplasty
- Durable Medical Equipment, Orthopedic and Prosthetic Devices
- Certain Mental Health and Substance Abuse services. See page 42

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

It is your **PCP's or specialist's responsibility** to obtain precertification for the procedures listed above before performing them. If the PCP or 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 PCP 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 PCP or specialist on your behalf, may appeal the decision.

Section 4. Your costs for covered services

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

Copayments

A copayment is a fixed amount of money you pay to the physician, health care practitioner, 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 are admitted to the hospital, you pay a copayment of \$100 per admission.

Deductible

We do not have a deductible.

Coinsurance

Coinsurance is the percentage of our allowance that you must pay for your care.

Example: In our Plan, you pay 50% of our allowance for most infertility services and durable medical equipment.

Your catastrophic protection out-of-pocket maximum

After your copayment 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 catastrophic protection out-of-pocket maximum, and you must continue to pay copayments and coinsurance for these services:

- Prescription drugs
- Dental Discount Benefits
- 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 66 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 (TTY: 301-360-8111 or 1-800-553-7109), or at our website, www.mamsi.com/federal.

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Section 5(a) Medical services and supplies provided by physicians and other health care professionals

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.
- 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.
- **YOUR PHYSICIAN MUST GET PRECERTIFICATION FOR SOME SERVICES AND/OR 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
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	You Pay
<p>Tests, such as:</p> <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 	<p>Nothing if you receive these services during your office visit; otherwise,</p> <p>\$20 per office visit to a specialist</p> <p>\$50 per outpatient hospital visit</p>
Preventive care, adult	
<p>Routine screenings, such as:</p> <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 or – Double contrast barium enema-every five years starting at age 50 or – Colonoscopy screening-every ten years starting at age 50 	<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>Routine Prostate Specific Antigen (PSA) test– one annually for men age 40 and older</p>	<p>\$10 per office visit to your Primary Care Physician</p> <p>\$20 per office visit to a specialist</p>
<p>Routine pap test</p> <p>Note: The office visit is covered if pap test is received on the same day; see <i>Diagnostic and Treatment services</i>, above.</p>	<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>

Preventive care, adult—continued on next page

Preventive care, adult (<i>continued</i>)	You Pay
<p>Routine mammogram – covered for women age 35 and older, as follows:</p> <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 	<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>Routine immunizations limited to:</p> <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 at age 65 or older 	<p>\$10 per office visit to your Primary Care Physician</p> <p>\$20 per office visit to a specialist</p>
<p><i>Not covered: Physical exams and immunizations required for obtaining or continuing employment or insurance, attending schools or camp, or travel.</i></p>	<p><i>All charges</i></p>
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) 	<p>\$10 per office visit to your Primary Care Physician ages 13 and up, nothing for children through age 12</p> <p>\$20 per office visit to a specialist</p>
<ul style="list-style-type: none"> • Well-child care for routine examinations, immunizations and care (up to age 22) • 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) 	<p>\$10 per office visit to your Primary Care Physician ages 13 and up, nothing for children through age 12</p> <p>\$20 per office visit to a specialist</p>
<p>Eye exams to determine the need for vision correction</p> <p>Note: You do not have to obtain a referral from your Primary Care Physician for this service</p>	<p>\$25 per office visit to a specialist</p>

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 copayments 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 laboratory 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. Note: Medically necessary circumcisions following the newborn stay are covered under the surgical benefit at the applicable copayment • We pay hospitalization and surgeon services (delivery) the same as for illness and injury. See Hospital benefits (Section 5c) and Surgery benefits (Section 5b). • We cover delivery services by a midwife only at accredited birthing centers and hospitals 	<p>Single \$20 copayment for routine obstetrical care per pregnancy; otherwise, \$10 per office visit to your Primary Care Physician \$20 per office visit to a specialist Nothing per visit to a Certified Nurse Midwife</p>

Family planning	You Pay
<p>A broad range of voluntary family planning services, limited to:</p> <ul style="list-style-type: none"> • Voluntary sterilization (See Surgical procedures 5 (b)) • Surgically implanted contraceptives • Administration of injectable contraceptive drugs (such as Depo provera) • Intrauterine devices (IUDs) • Diaphragms <p>Note: We cover oral and injectable 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	
<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 is covered for married members 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 (not due to voluntary sterilization), 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 (an attempt is counted toward this limit when injectable medications are started).</p> <p>Note: We cover injectable and oral fertility drugs for covered in-vitro fertilization services. We cover Clomid (clomiphene) for other infertility services. When covered, all infertility drugs are covered 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 physicians or health care practitioners</p>

Infertility services-continued on next page

Infertility services (<i>continued</i>)	You Pay
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • Assisted reproductive technology (ART) procedures, such as: <ul style="list-style-type: none"> – embryo transplant, gamete intrafallopian transfer (GIFT), zygote intrafallopian transfer (ZIFT), sex selection, surrogacy, host uterus, gene therapy, cryopreservation, and pre-implantation genetic diagnosis • Other services and supplies related to ART procedures • Cost of donor sperm, donor eggs, and related costs • Infertility services after reversal of voluntary sterilization 	<p><i>All charges</i></p>
Allergy care	
<ul style="list-style-type: none"> • Testing and treatment • Allergy injections 	<p>\$10 per office visit to your Primary Care Physician</p> <p>\$20 per office visit to a specialist</p>
Allergy serum	Nothing
<i>Not covered: provocative food testing and sublingual allergy desensitization.</i>	<i>All charges</i>
Treatment therapies	
<ul style="list-style-type: none"> • Chemotherapy and radiation therapy <p>Note: High dose chemotherapy in association with autologous bone marrow transplants is limited to those transplants listed under Organ/Tissue Transplants on page 31.</p> <ul style="list-style-type: none"> • Respiratory and inhalation therapy • Dialysis – hemodialysis and peritoneal dialysis • Intravenous (IV)/Infusion Therapy – Home IV and antibiotic therapy • Growth hormone therapy (GHT) <p>Note: Growth hormone is covered under the prescription drug benefit. We will only cover GHT when we preauthorize 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 and occupational therapies	You pay
<p>Up to two months or 60 visits (whichever is more) per condition, for the services of the following:</p> <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> <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>	<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"> • long-term rehabilitative therapy • exercise programs, gym or pool memberships • work hardening/functional capacity programs or evaluations 	<p><i>All charges</i></p>
Speech therapy	
<p>Up to two months or 60 visits (whichever is more) per condition</p>	<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"> • Speech therapy • Occupational therapy; and • Physical therapy <p>Note: 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>Includes medically necessary habilitative services coverage for children with Autism, an Autism Spectrum disorder, or Cerebral Palsy</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>. 	<p>\$10 per office visit to your Primary Care Physician</p> <p>\$20 per office visit to a specialist</p>
<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> 	<p><i>All charges</i></p>
Vision services (testing, treatment, and supplies)	
<ul style="list-style-type: none"> Diagnosis and treatment of diseases of the eye 	<p>\$10 per office visit to your Primary Care Physician</p> <p>\$20 per office visit to a specialist</p>
<ul style="list-style-type: none"> One pair of eyeglasses or contact lenses per lifetime to correct an impairment directly caused by accidental ocular injury or intraocular surgery (such as for cataracts) 	<p>50% of charges</p>
<ul style="list-style-type: none"> Annual eye refraction exams to provide a written lens prescription <p>Note: You do not have to obtain a referral from your Primary Care Physician for this service</p>	<p>\$25 per office visit to a specialist</p>
<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> 	<p><i>All charges</i></p>
Foot care	
<p>Routine foot care when you are under active treatment for a metabolic or peripheral vascular disease, such as diabetes.</p> <p>Note: See Orthopedic and prosthetic devices for information on podiatric shoe inserts.</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>Cutting, trimming or removal of corns, calluses, or the free edge of toenails, and similar routine treatment of conditions of the foot, except as stated above</i> <i>Treatment of weak, strained or flat feet or bunions or spurs; and of any instability, imbalance or subluxation of the foot (unless the treatment is by open cutting surgery)</i> 	<p><i>All charges</i></p>

Orthopedic and prosthetic devices	You pay
<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 • 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 Durable Medical Equipment) • 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: Most orthopedic and prosthetic devices must be preauthorized. Call us at 301-360-8080 or 1-800-251-0956 if your Plan physician prescribes this and you need assistance locating a health care physician or health care practitioner to sell or rent you orthopedic or prosthetic equipment. You may also call us to determine if a certain device is covered. 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>	<p>50% of charges</p>
<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> 	<p><i>All charges</i></p>

Durable medical equipment (DME)	You pay
<p>Rental or purchase, at our option, including repair and adjustment, of durable medical equipment prescribed by your Plan physician, such as oxygen and dialysis equipment. Under this benefit, we also cover:</p> <ul style="list-style-type: none"> • hospital beds; • wheelchairs; • crutches; • walkers; • blood glucose monitors; and • insulin pumps and insulin pump supplies • surgical dressings not available over-the-counter <p>Note: Most durable medical equipment must be preauthorized. 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 physician or health care practitioner to rent or sell you durable medical equipment. You may also call us to see if a certain piece of equipment is covered.</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"> • Medically necessary 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 administration of oxygen therapy, intravenous therapy and medications. • Medical foods prescribed by a physician, for inherited metabolic diseases, when determined to be your sole source of nutrition • Foods used to treat inherited metabolic diseases 	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>private duty nursing;</i> • <i>foods that you can obtain over the counter (without a prescription), even if prescribed by your physician, except for foods used to treat inherited metabolic diseases;</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 	<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>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	You Pay
<ul style="list-style-type: none"> • Childbirth education classes: <p>When you complete the childbirth education class, 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, MD 21705.</p>	<p>All charges – we will reimburse up to \$50 for childbirth education classes</p>
<ul style="list-style-type: none"> • Smoking cessation program <p>When you complete the 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, MD 21705.</p>	<p>All charges – we will reimburse up to \$100 for the smoking cessation program</p>
<ul style="list-style-type: none"> • Diabetes self-management classes 	<p>\$10 per office visit to your Primary Care Physician \$20 per office visit to a specialist \$50 per outpatient hospital visit</p>

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

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.
- 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.
- In certain geographic areas, the Health Plan has designated Centers for Cardiac Surgery, Ambulatory Surgery, Transplants and Joint Replacement.
- The amounts listed below are for the charges billed by a physician or other health care professional for your surgical care. Look in Section 5(c) for charges associated with the facility (i.e. hospital, surgical center, etc.).-
- **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 reconstructive surgery) • Surgical treatment of morbid obesity – a condition in which an individual’s Body Mass Index (BMI) is greater than 35, with documented comorbidities, or 40 without documented comorbidities. Eligible members must be age 18 or over. The member’s PCP must submit clinical records documenting the member’s participation in a physician supervised weight loss regimen. Documentation must show the member attended at least one visit per month for six consecutive months of supervised weight loss regimen through the PCP or Nutritionist during the latest twelve month period. 	<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>

Surgical procedures-continued on next page

Surgical procedures (<i>continued</i>)	You Pay
<ul style="list-style-type: none"> • Insertion of internal prosthetic devices. See 5(a) – Orthopedic and prosthetic devices for device coverage information. • Voluntary sterilization (e.g. Tubal ligation, Vasectomy) • Surgically implanted contraceptives 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 \$20 per office visit to a specialist \$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	
<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 for cancer, such as: <ul style="list-style-type: none"> – surgery to produce a symmetrical appearance on the other breast; – treatment of any physical complications, such as lymphedemas; – breast prostheses and surgical bras and replacements (see Prosthetic devices) <p>Note: If you need a mastectomy, you may choose to have the procedure performed on an inpatient basis and remain in the hospital up to 48 hours after the procedure.</p>	<p>\$10 per office visit to your Primary Care Physician \$20 per office visit to a specialist \$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	You pay
<p>Oral surgical procedures, limited to:</p> <ul style="list-style-type: none"> • Reduction of fractures of the jaws or facial bones; • Surgical correction of cleft lip, cleft palate or severe functional malocclusion; 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 • Services provided by a physician, dentist, or other licensed practitioner which are medically necessary and commonly accepted for treatment of Temporomandibular Disorder (TMD) and/or related Myofacial Pain Dysfunction (MPD). Note: We will only cover these services when we preauthorize the treatment. See <i>Services requiring our prior approval</i> in Section 3. 	<p>\$10 per office visit to your Primary Care Physician \$20 per office visit to a specialist \$50 per outpatient hospital visit</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Oral implants and related procedures, including bone grafts to support implants</i> • <i>Procedures that involve the teeth or their supporting structures (such as the periodontal membrane, gingival, 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 at a Medicare approved center. <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 for Cardiac Surgery, Transplants and Joint Replacement 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 \$20 per office visit to a specialist \$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> • <i>All services associated with complications resulting from the removal of an organ from a non-member</i> 	<p><i>All charges</i></p>

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

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.
- 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 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
<p>Inpatient hospital</p> <ul style="list-style-type: none"> • Room and board, such as • 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> <ul style="list-style-type: none"> • Other hospital services and supplies, such as: • 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>\$100 per admission</p>

Inpatient hospital - continued on next page.

Inpatient hospital (<i>continued</i>)	You Pay
<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 duty nursing care</i> 	<p><i>All charges</i></p>
Outpatient hospital or ambulatory surgical center	
<ul style="list-style-type: none"> • Operating, recovery, and other treatment rooms • Prescribed drugs and medicines • Diagnostic laboratory tests, X-rays, and pathology services • Administration of blood, blood plasma, and other biologicals • Blood 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>	<p>\$50 per visit</p>
Extended care benefits/Skilled nursing care facility benefits	
<p>Extended care benefits:</p> <p>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 physician 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 physician 	<p>Nothing</p>
<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> 	<p><i>All charges</i></p>

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 physician 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"> • In home care or hospice facility • Family counseling 	Nothing
<p><i>Not covered: Independent nursing, private duty nursing, homemaker services</i></p>	<i>All charges</i>
Ambulance	
<ul style="list-style-type: none"> • Professional ambulance service when medically appropriate 	Nothing

Section 5(d) Emergency services/accidents

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

- Please remember that all benefits are subject to the definitions, limitations and exclusions in this brochure 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 physician, 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 or Primary Care Physician 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 physicians 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 physicians or health care practitioners in a medical emergency only if delay in reaching a Plan physician or health care practitioner 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 physicians or health care practitioners must be approved by the Plan or provided by Plan physicians or health care practitioners.

Emergency services/accidents-continued on next page

Benefit Description	You pay
Emergency within or outside our service area	
<ul style="list-style-type: none"> Emergency care at a physician'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
<ul style="list-style-type: none"> Emergency care at an emergency room 	\$50 per visit, waived if admitted, then the inpatient hospital copayment applies
<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	
Professional ambulance service, including air ambulance, when medically appropriate. See 5(c) for non-emergency service.	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 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.
- **YOU MUST GET PREAUTHORIZATION FOR 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 physician or health care practitioner and contained in a treatment plan that we approve. The treatment plan may include services, drugs, and supplies described elsewhere in this brochure.</p> <p>Note: Plan benefits are payable only when we determine the care is clinically appropriate to treat your condition and only when you receive the care as part of a treatment plan that we approve.</p>	<p>Your cost sharing responsibilities are no greater than for other illness or conditions</p>
<ul style="list-style-type: none"> • Professional services, including individual or group therapy by participating health care practitioners such as psychiatrists, psychologists, or clinical social workers • Medication management 	<p>\$20 per office visit to a specialist \$50 per outpatient hospital visit</p>
<ul style="list-style-type: none"> • Diagnostic tests 	<p>\$20 per office visit to a specialist \$50 per outpatient hospital visit</p>
<ul style="list-style-type: none"> • Services provided by a hospital or substance abuse facility while an inpatient 	<p>\$100 per admission</p>
<p>Services provided by a participating hospital or other facility while an outpatient. This includes partial hospitalization and facility based intensive outpatient treatment.</p>	<p>\$50 per outpatient hospital visit</p>

Mental health and substance abuse benefits-continued on next page

Mental health and substance abuse benefits (<i>continued</i>)	You Pay
<ul style="list-style-type: none"> Professional services in licensed alternative care settings such as half-way house and residential treatment. <p>Note: The professional services covered in licensed alternative care settings are limited to those provided by participating licensed mental health professionals according to a treatment plan that has been approved by a Plan psychiatrist and Primary Care Physician.</p>	\$20 per office visit
<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 physician to be necessary and appropriate</i> <i>Services and supplies when paid for directly or indirectly by a local, State, or Federal Government agency</i> <p>Note: OPM will generally base its review of disputes about treatment plans on the treatment plan's clinical appropriateness. OPM will generally not order us to pay or provide one clinically appropriate treatment plan in favor of another.</p>	<i>All charges</i>

- Preauthorization** To be eligible to receive these benefits you must follow your treatment plan and your participating behavioral health care practitioner must obtain preauthorization for some services, including, but not limited to the following:
 - All substance abuse treatments
 - Psychological testing, Neuropsychological testing and Extended Developmental testing
 - Partial hospitalization
 - Intensive outpatient treatment
 - Electro-convulsive therapy (ECT)

Your participating behavioral health practitioner must also use the following authorization processes:

 - Once you have been referred for mental health services, **you must be evaluated by a participating 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 physicians and health care practitioners in our *Directory of Health Care Professional*, which we update periodically. The list is also on our website, www.mamsi.com/federal. 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 and follow a treatment plan.

Section 5(f) Prescription drug benefits

I M P O R T A N T	<p>Here are some important things to keep in mind about these benefits:</p> <ul style="list-style-type: none"> • 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 physician 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 physician to call the Pharmacy Services Department at 1-800-205-3636 for further instructions. You will find valuable information about our formulary, MAMSI Meds, as well as information about prior authorization on our website, www.mamsi.com. Once you've logged on to our site, select "Members" and then select "MAMSI Meds". • Be sure to read Section 4, <i>Your costs for covered services</i>, for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare. 	I M P O R T A N T
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There are important features you should be aware of. These include:

- **Who can write your prescription?** A licensed physician must write the prescription.
- **Where you can obtain them.** You may 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 of Health Care Professionals*, call our Member Services Department at 301-360-8080 or 1-800-251-0956 (TTY: 301-360-8111 or 1-800-553-7109), or visit our website, www.mamsi.com/federal.
- **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 physicians 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 copayment. Drugs requiring prior authorization will be covered once reviewed and approved by the Plan. You will find valuable information about our formulary, MAMSI Meds, as well as information about prior authorization on our website, www.mamsi.com. Once you've logged on to our site, select "Members" and then select "MAMSI Meds".

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 the Member Services Department at 301-360-8080 or 1-800-251-0956 (TTY: 301-360-8111 or 1-800-553-7109).

- **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 Express Scripts, Inc. You may obtain up to a consecutive 90-day supply of prescription medications as follows:

- For maintenance medications, you pay one copayment for each month's supply after the first 34 day supply,
- For all contraceptive drugs, you pay one copayment for up to a 90-day supply per prescription or refill.

For more information on mail order benefits, you can reach Express Scripts, Inc. at 1-888-828-2579. A prescription can be refilled when you have used 75 percent of the medication. For example, a prescription that was filled for a 34-day supply can be refilled after 26 days. M.D. IPA will give special consideration to filling prescriptions for members covered under the FEHB

if:

- You are called to active duty, or
- You are officially called off-site as a result of a national or other emergency.

In order to fill the prescription, your physician may need to request prior authorization from M.D. IPA. If you need to fill a prescription for either of the reasons listed above, ask your physician to contact M.D. IPA to request prior authorization, if applicable.

- **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 physician does not require the use of a brand name drug), but you request the brand name drug, you pay the name brand copayment plus the cost difference between the generic and the name brand drug. If you fill a prescription for a brand name and there is no generic available, you will be responsible for either the formulary or non-formulary brand name copayment.
- **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 brand name if a generic option is available. A generic equivalent will be dispensed if it is available, unless your physician specifically requires a name brand. If you receive a name brand drug when a Federally-approved generic drug is available, and your physician has not specified Dispense as Written for the name brand drug, you have to pay the difference in cost between the name brand drug and the generic.

Benefit Description	You pay
Covered medications and supplies	
<p>We cover the following medications and supplies prescribed by a Plan physician and obtained from a Plan pharmacy or through our mail order program:</p> <ul style="list-style-type: none"> • Drugs 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 copayment charge applied to each 34 day supply. • Diabetic supplies, including insulin syringes, needles, glucose test tablets and test tape, Benedict’s solution or equivalent, and acetone tests tablets. • Disposable needles and syringes for the administration of covered, prescribed medications. • Oral and injectable contraceptive drugs; contraceptive devices. Note: All contraceptive drugs are subject to one copayment for up to a 90-day supply per prescription or refill. • Fertility drugs – injectable and oral fertility drugs for authorized in-vitro fertilization procedures; only Clomid (clomiphene) is covered for artificial insemination. <p>Limited Benefits</p> <ul style="list-style-type: none"> • Drugs to treat sexual dysfunction are limited. Contact the Plan for dosage limits. • Drugs prescribed for smoking cessation are limited to 90 day supply within a 365 day period. 	<p>Generic - \$8</p> <p>Formulary brand name - \$20</p> <p>Non-formulary brand name - \$35</p> <p>Injectable drugs (except insulin) - 20% up to \$50</p> <p>Note: If there is no generic equivalent available, you will still have to pay the brand name copayment.</p>

Covered medications and supplies (<i>continued</i>)	You Pay
<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>Artificial insemination fertility drugs except Clomid (clomiphene)</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> • <i>Drugs available over-the-counter that do not require a prescription order by federal or state law before being dispensed, and any drug that is therapeutically equivalent to an over-the-counter drug</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 for Cardiac Surgery, Transplants and Joint Replacement	<p>We use specific institutions called Centers for Cardiac Surgery, Transplants and Joint Replacement. These Centers do a large volume of these procedures each year and have a comprehensive program of care. A list of these facilities can be found in the <i>Directory of Health Care</i>, 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 Program	<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 available to you at no cost. They include:</p> <ul style="list-style-type: none"> • HealthLine (immunization and preventive health check-up schedule) • HealthSense Member Newsletter • <i>Directory of Health Care Professionals</i> • <i>WeeCall</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 publications.</p>
Health Education and Disease Management Programs	<ul style="list-style-type: none"> • Healthwise® Knowledgebase – online source for members to research health questions • Preventive Health, for men, women, and children • Managing Your Risks for Heart Disease and Stroke-a prevention program • Heart Health Next Steps Program for secondary prevention of vascular disease • Heart Health, for Heart Failure Management • Stay Ahead, for Diabetes Mellitus Management • Managing your Asthma, for Asthma Management • Depression Management Program • Education on other behavioral health topics such as eating disorders

Section 5(h) Dental benefits

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

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.-
- 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. See Section 5 (c) for inpatient hospital benefits.
- 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
<p>We cover dental services to promptly repair sound natural teeth, as a result of traumatic injury. Treatment must be initiated within seventy-two (72) hours after the accident occurs. If the injury cannot be reasonably treated within seventy-two (72) hours due to extenuating circumstances (such as prolonged hospitalization), an extension may be granted by M.D. IPA, provided you request an extension within sixty (60) days of the accidental injury. All accidental injury services must be completed within one hundred eighty (180) days of the injury.</p> <p>Dental treatment for accidental injury is a limited benefit intended to stabilize your dental condition and includes only the following:</p> <ul style="list-style-type: none"> • 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 • Replacement of a tooth lost due to accidental injury <p>Note: Injury as a result of chewing, biting or poor dental hygiene is not covered. Only teeth damaged as a result of an accident are covered. Undamaged teeth that may be needed to support a bridge or denture are not covered.</p>	<p>\$20 per visit</p>

Dental benefits

This section pertains only to the Dental Discount Program, which is the only dental benefit provided under the FEHB contract. The non-FEHB dental plans, described in Section 5(i), are PPO benefits.

The following list summarizes the fees for dental services provided by a participating PLAN GENERAL DENTIST ONLY. Services rendered by a plan general dentist that are not on the fee schedule, are provided at a 25 percent reduction of usual and customary (UCR) costs. Services (whether on the fee schedule or not) rendered by a Plan dental specialist are also provided at a 25 percent reduction of costs. The fees listed on this page, and the following page, do not reflect the payment to a Plan dental specialist. Cosmetic and implant-related services (implants, abutments, posts, screws and implant-supported prosthetics) are provided at a 10 percent discount by both plan general and specialist dentists. You do not have to obtain a referral from your Primary Care Physician to obtain the following dental care services. For additional information, contact us at 301-360-8080 or 1-800-251-0956; for a complete list of fees, or a list of participating dentists, please refer to the M.D. IPA 2004 Federal Plan Dental Guide. The list is also on our website, www.mamsi.com/federal.

	Service	You pay
Type I	Diagnostic and Preventive Services	
D1203	Topical Application of Fluoride (Prophylaxis not Included) – Child	N/C
D0120	Periodic Oral Examination	\$20.00
D0150	Comprehensive Oral Evaluation	\$34.00
D1110	Prophylaxis – Adult	\$35.00
D1120	Prophylaxis – Child	\$27.00
	Radiological Services	
D0210	Intraoral – Complete Series (including bitewings)	\$55.00
D0220	Intraoral – Periapical – First Film	\$11.00
D0272	Bitewings – 2 Films	\$19.00
D0330	Panoramic Film	\$53.00
Type II	Basic Dental Services, Silver Restorations and All Other Services	
D1352	Sealant, per tooth	\$22.00
	Amalgam Restorations – Adult or child	
D2150	Amalgam – 2 Surfaces	\$67.00
	Composite Restorations (White Filling)	
D2331	Resin – 2 Surfaces, Anterior	\$74.00
D2392	Resin – 2 Surfaces, Posterior – Primary	\$89.00
Type III	Major Dental Services	
	Crown and Inlay Services	
D2920	Recement Crown	\$44.00
D2930	Prefabricated Stainless Steel Crown--Primary Tooth	\$119.00
D2950	Core Buildup, Including Any Pins	\$70.00
D2952	Cast Post and Core In Addition to Crown	\$174.00
D2954	Prefabricated Post and Core In Addition to Crown	\$144.00
	Bridge Services	
D6930	Recement Bridge	\$60.00
D6970	Cast Post and Core in Addition to Bridge	\$151.00
	Endodontic Services	
D3110	Pulp Cap – Direct (Excluding Final Restoration)	\$34.00
D3310	Anterior (Excluding Final Restoration)	\$337.00
D3330	Molar (Excluding Final Restoration)	\$551.00

Dental Discount benefits-continued on next page

	Service	You Pay
	Periodontic Services	
D4341	Periodontal Scaling and Root Planing – Per Quadrant	\$90.00
D4910	Periodontal Maintenance Procedures (Following Active Therapy)	\$65.00
	Prosthodontics – Removable	
D5110	Complete Denture – Maxillary	\$599.00
D5213	Maxillary Partial Denture – Cast Metal Framework with Resin Denture Bases (Including any Conventional Clasps, Rest and Teeth)	\$662.00
D5730	Reline Complete Maxillary Denture (Chairside)	\$137.00
D5740	Reline Partial Maxillary Denture (Chairside)	\$126.00
	Oral Surgery Services	
D7140	Single Tooth	\$66.00
D7210	Surgical Removal of Erupted Tooth Requiring Evaluation of Mucoperiosteal Flap And Removal of Bone and/or Section of Tooth	\$95.00
D7230	Removal of Impacted Tooth – Partially Bony	\$190.00
D7240	Removal of Impacted Tooth – Completely Bony	\$230.00

For all services performed by a Dental Specialist (including Orthodontic Services) and any services not listed above, you pay a fee of 75 percent of the Dentist's Usual and Customary fee. Cosmetic and implant-related services are offered by both General and Specialist dentists, for which you pay 90 percent 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 catastrophic protection out-of-pocket maximums.

New! Eyewear Benefits

New for 2005, M.D. IPA will automatically provide a new eyewear benefit **at no additional premium** to all of our FEHB members. The benefit includes coverage for prescribed eyeglasses or contacts once every 24 months. You may use Preferred, Participating, or out-of-network providers. *See the 2005 Federal Employees Health Benefits Summary for more benefit details and a listing of preferred and participating providers.*

Alternatively, discounts are still available on eyewear and related services at participating optical centers listed in the Plan's *Directory of Health care Professionals*, and TLC Laser Eye Centers offer M.D. IPA members preferred savings for laser vision correction.

PPO Dental Plans

PPO BASIC DENTAL - In addition to the Dental Discount benefit described in Section 5 (h) of this brochure, M.D. IPA provides a PPO Basic dental Plan to all 2005 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 (JP) for 2005.

The PPO Basic Dental Plan covers diagnostic (e.g., X-rays), preventive (e.g., exams, cleanings), basic (e.g., fillings), and some major procedures (e.g. root canals, surgical extractions). The annual maximum benefit is \$1,000.

Look for important details about this Plan, its usage, as well as a listing of participating dentists, in the 2005 Federal Employees Health Benefits Summary.

During open season members have the option to buy up to a higher non-FEHB benefit level – the PPOplus, the details of which are also found in the *MAMSI Complete* chapter of the 2005 Federal Employees Health Benefits Summary

MAMSI Complete Benefits

For 2005, M.D. IPA continues to offer MAMSI Complete benefits for an additional premium to allow members to select voluntary, **short-term disability income coverage** and upgraded dental coverage for their families. Please see the brochure in your enrollment kit for specific benefit information and enrollment forms. Information on these products is also available on our website, www.mamsi.com/federal. MAMSI Complete includes:

- **PPOplus Dental Plan** - Receive a higher benefit level for many basic procedures, and add coverage for major procedures such as crowns, bridgework, dentures and orthodontia for children.
- **Sickness and Accident Disability Income Coverage**-Helps replace lost pay resulting from sickness or off-the-job injury through monthly, tax-free benefits, for an additional premium.

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 physician determines it is medically necessary to prevent, diagnose, or treat your illness, disease, injury or condition and we agree, as discussed under *Services Requiring Our Prior Approval* on page 11.

We do not cover the following:

- Care by non-Plan physicians or health care practitioners except for authorized referrals or emergencies (see Emergency Benefits);
- Services, drugs, or supplies you receive while you are not enrolled in this Plan;
- Services, drugs, or supplies that are not medically necessary;
- Services, drugs, or supplies not required according to accepted standards of medical, dental, or psychiatric practice;
- Experimental or investigational procedures, treatments, drugs or devices;
- Services, drugs, or supplies related to abortions, except when the life of the mother would be endangered if the fetus were carried to term or when the pregnancy is the result of an act of rape or incest;
- Services, drugs, or supplies related to sex transformations;
- Services, drugs, or supplies you receive from a physician, health care practitioner or facility barred from the FEHB Program; or
- Services, drugs or supplies you receive without charge while in active military service.

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 health Plan identification card and pay your copayment or coinsurance.

You will only need to file a claim when you receive emergency services from non-Plan physicians or health care practitioners. Sometimes these physicians or health care practitioners bill us directly. Check with the physician or health care practitioner. 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. Your facility will file on the UB-92 form. . For claims questions and assistance, call us at 301-360-8080 or at 1-800-251-0956 (TTY: 301-360-8111 or 1-800-553-7109).

When you must file a claim – such as for services you receive outside the Plan’s service area – 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, MD 21705:

- your receipt
- the drug NDC number
- the pharmacy’s NABP number, and
- the prescribing physician’s 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	<p>Ask us in writing to reconsider our initial decision. You must:</p> <ol style="list-style-type: none">Write to us within 6 months from the date of our decision; andSend your request to us at: Customer Support, P.O. Box 933, Frederick, MD 21705; andInclude a statement about why you believe our initial decision was wrong, based on specific benefit provisions in this brochure; andInclude copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms.
2	<p>We have 30 days from the date we receive your request to:</p> <ol style="list-style-type: none">Pay the claim (or, if applicable, arrange for the physician or health care practitioners to give you the care); orWrite to you and maintain our denial – go to step 4; orAsk you or your physician or health care practitioner for more information. If we ask your physician or health care practitioner, we will send you a copy of our request —go to step 3.
3	<p>You or your physician or health care practitioner must send the information so that we receive it within 60 days of your request. We will then decide within 30 more days.</p> <p>If we do not receive the information within 60 days, we will decide within 30 days of the date the information was due. We will base our decision on the information we already have.</p> <p>We will write to you with our decision.</p>
4	<p>If you do not agree with our decision, you may ask OPM to review it.</p> <p>You must write to OPM within:</p> <ul style="list-style-type: none">90 days after the date of our letter upholding our initial decision; or120 days after you first wrote to us – if we did not answer that request in some way within 30 days; or120 days after we asked for additional information. <p>Write to OPM at: United States Office of Personnel Management, Insurance Services Programs, Health Insurance Group 3, 1900 E Street, NW, Washington, DC 20415-3630.</p> <p>Send OPM the following information:</p> <ul style="list-style-type: none">A statement about why you believe our decision was wrong, based on specific benefit provisions in this brochure;Copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms;Copies of all letters you sent to us about the claim;Copies of all letters we sent to you about the claim; andYour daytime phone number and the best time to call. <p>Note: If you want OPM to review more than one claim, you must clearly identify which documents apply to which claim.</p>

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.

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.

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 may call OPM's Health Insurance Group 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 or a covered family member have coverage 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 or 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.

• Should I enroll in Medicare?

The decision to enroll in Medicare is yours. We encourage you to apply for Medicare benefits 3 months before you turn age 65. It’s easy. Just call the Social Security Administration toll-free number 1-800-772-1213 to set up an appointment to apply. If you do not apply for one or both Parts of Medicare, you can still be covered under the FEHB Program.

If you can get premium-free Part A coverage, we advise you to enroll in it. Most Federal employees and annuitants are entitled to Medicare Part A at age 65 **without cost**. When you don’t have to pay premiums for Medicare Part A, it makes good sense to obtain the coverage. It can reduce your out-of-pocket expenses as well as costs to the FEHB, which can help keep FEHB premiums down.

Everyone is charged a premium for Medicare Part B coverage. The Social Security Administration can provide you with premium and benefit information. Review the information and decide if it makes sense for you to buy the Medicare Part B coverage.

If you are eligible for Medicare, you may have choices in how you get your health care. Medicare Advantage is the term used to describe the various private health plan choices available to Medicare beneficiaries. The information in the next few pages shows how we coordinate benefits with Medicare, depending on whether you are in the Original Medicare Plan or a private Medicare Advantage plan.

• The Original Medicare Plan (Part A or Part B)

The Original Medicare Plan (Original Medicare) 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, such as most prescription drugs (but coverage through private prescription drug plans will be available starting in 2006).

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.

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 claim will be coordinated automatically and we will then provide secondary benefits for covered charges. You will not need to do anything. To find out if you need to do something to file your claim, call us at 301-360-8080 or 1-800-251-0956, or visit our website, www.mamsi.com/federal.

We waive some costs if the Original Medicare Plan is your primary payer. We will waive some out-of-pocket costs as follows:

- All copayment and coinsurance amounts will be applied until you meet your Medicare Part B deductible. 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 always makes the final determination as to whether they are the primary payer. The following chart illustrates whether 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 you - or your covered spouse - are age 65 or over and have Medicare and you...	The primary payer for the individual with Medicare is...	
	Medicare	This Plan
1) Have FEHB coverage on your own as an active employee or through your spouse who is an active employee		✓
2) Have FEHB coverage on your own as an annuitant or through your spouse who is an annuitant	✓	
3) Are a reemployed annuitant with the Federal government and your position is excluded from the FEHB (your employing office will know if this is the case) and you are not covered under FEHB through your spouse under #1 above	✓	
4) Are a reemployed annuitant with the Federal government and your position is not excluded from the FEHB (your employing office will know if this is the case) and ... You have FEHB coverage on your own or through your spouse who is also an active employee You have FEHB coverage through your spouse who is an annuitant	✓	✓
5) 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) and you are not covered under FEHB through your spouse under #1 above	✓	
6) Are enrolled in Part B only, regardless of your employment status	✓ for Part B services	✓ for other services
7) 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	✓*	
B. When you or a covered family member...		
1) Have Medicare solely based on end stage renal disease (ESRD) and... • It is within the first 30 months of eligibility for or entitlement to Medicare due to ESRD (30-month coordination period) • It is beyond the 30-month coordination period and you or a family member are still entitled to Medicare due to ESRD		✓
2) Become eligible for Medicare due to ESRD while already a Medicare beneficiary and... • This Plan was the primary payer before eligibility due to ESRD • Medicare was the primary payer before eligibility due to ESRD		✓ for 30-month coordination period
C. When either you or a covered family member are eligible for Medicare solely due to disability and you...		
1) Have FEHB coverage on your own as an active employee or through a family member who is an active employee		✓
2) Have FEHB coverage on your own as an annuitant or through a family member who is an annuitant	✓	
D. When you are covered under the FEHB Spouse Equity provision as a former spouse	✓	

*Workers' Compensation is primary for claims related to your condition under Workers' Compensation

- **Medicare Advantage**

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

If you enroll in a Medicare Advantage plan, the following options are available to you:

This Plan and another Plan's Medicare Advantage plan: You may enroll in another Plan's Medicare Advantage plan and also remain enrolled in our FEHB Plan. We will still provide benefits when your Medicare Advantage plan is primary, even out of the Medicare Advantage plan's network and/or service area (if you use our Plan providers), but we will not waive any of our copayments, coinsurance, or deductibles. If you enroll in a Medicare Advantage plan, tell us. We will need to know whether you are in the Original Medicare Plan or in a Medicare Advantage plan so we can correctly coordinate benefits with Medicare.

Suspended FEHB coverage to enroll in a Medicare Advantage plan: If you are an annuitant or former spouse, you can suspend your FEHB coverage to enroll in a Medicare Advantage plan, eliminating your FEHB premium. (OPM does not contribute to your Medicare Advantage 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 Advantage plan's service area.

TRICARE and CHAMPVA

TRICARE is the health care program for eligible dependents of military persons, and retirees of the military. TRICARE includes the CHAMPUS program. CHAMPVA provides health coverage to disabled Veterans and their eligible dependents. IF TRICARE or CHAMPVA and this Plan cover you, we pay first. See your TRICARE or CHAMPVA Health Benefits Advisor if you have questions about these programs.

Suspended FEHB coverage to enroll in TRICARE or CHAMPVA: If you are an annuitant or former spouse, you can suspend your FEHB coverage to enroll in one of these programs, eliminating your FEHB premium. (OPM does not contribute to any applicable plan premiums.) 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 under the program.

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.

Medicaid

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

Suspended FEHB coverage to enroll in Medicaid or a similar State-sponsored program of medical assistance: If you are an annuitant or former spouse, you can suspend your FEHB coverage to enroll in one of these State programs, eliminating your FEHB 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 under the State program.

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• Custodial care that lasts 90 days or more is sometimes known as long term care
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>
Infertility	The inability to achieve pregnancy after one year of unprotected intercourse.
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. M.D. 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 physician's or health care practitioner's office address. This rate includes your copayment or coinsurance amount. Participating physicians or health care practitioners accept this rate, including your copayment or coinsurance amount, as payment in full.
Us/We	Us and we refer to M.D. IPA.
You	You refers to the enrollee and each covered member.

Section 11. FEHB Facts

Coverage information

- **No pre-existing condition limitation**

We will not refuse to cover the treatment of a condition 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 your FEHB coverage. These materials tell you:

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

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

- **Types of coverage available for you and your family**

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

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

Your employing or retirement office will **not** notify you when a family member is no longer eligible to receive 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.

- **Children’s Equity Act**

OPM has implemented the Federal Employees Health Benefits Children’s Equity Act of 2000. This law mandates that you be enrolled for Self and Family coverage in the FEHB Program, if you are an employee subject to a court or administrative order requiring you to provide health benefits for your child(ren).

If this law applies to you, you must enroll for Self and Family coverage in a health plan that provides full benefits in the area where your children live or provide documentation to your employing office that you have obtained other health benefits coverage for your children. If you do not do so, your employing office will enroll you involuntarily as follows:

- If you have no FEHB coverage, your employing office will enroll you for Self and Family coverage in the Blue Cross and Blue Shield Service Benefit Plan’s Basic Option;
- If you have a Self Only enrollment in a fee-for-service plan or in an HMO that serves the area where your children live, your employing office will change your enrollment to Self and Family in the same option of the same plan; or
- If you are enrolled in an HMO that does not serve the area where the children live, your employing office will change your enrollment to Self and Family in the Blue Cross and Blue Shield Service Benefit Plan’s Basic Option.

As long as the court/administrative order is in effect, and you have at least one child identified in the order who is still eligible under the FEHB Program, you cannot cancel your enrollment, change to Self Only, or change to a plan that doesn’t serve the area in which your children live, unless you provide documentation that you have other coverage for the children. If the court/administrative order is still in effect when you retire, and you have at least one child still eligible for FEHB coverage, you must continue your FEHB coverage into retirement (if eligible) and cannot cancel your coverage, change to Self Only, or change to a plan that doesn’t serve the area in which your children live as long as the court/administrative order is in effect. Contact your employing office for further information.

- **When benefits and premiums start**

The benefits in this brochure are effective 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. If you changed plans or plan options during Open Season and you receive care between January 1 and the effective date of coverage under your new plan or option, your claims will be paid according to the 2005 benefits of your old plan or option. However, if your old plan left the FEHB Program at the end of the year, you are covered under that plan’s 2004 benefits until the effective date of your coverage with your new plan. 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.

- **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 (TCC), or a conversion policy (a non-FEHB individual policy.)

- **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. This is the case even when the court has ordered your former spouse to provide health coverage to you. But, you may be eligible for your own FEHB coverage under the spouse equity law or Temporary Continuation of Coverage (TCC). If you are recently divorced or are anticipating a divorce, contact your ex-spouse’s employing or retirement office to get RI 70-5, the *Guide To Federal Employees Health Benefits Plans for Temporary Continuation of Coverage and Former Spouse Enrollees*, or other information about your coverage choices. You can also download the guide from OPM’s Website, www.opm.gov/insure.

- **Temporary Continuation of 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 Federal 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 Website at 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 information about Federal and State agencies you can contact for more information.

Section 12. Two Federal Programs complement FEHB benefits

Important information

OPM wants to make sure you are aware of two Federal programs that complement the FEHB Program. First, the **Federal Flexible Spending Account (FSA) Program**, also known as **FSAFEDS**, lets you set aside pre-tax money to pay for health and dependent care expenses. The result can be a discount of 20% to more than 40% on services you routinely pay for out-of-pocket. Second, the **Federal Long Term Care Insurance Program (FLTCIP)** helps cover long term care costs, which are not covered under the FEHB.

The Federal Flexible Spending Account Program – *FSAFEDS*

- **What is an FSA?**

It is a tax-favored benefit that allows you to set aside pre-tax money from your paychecks to pay for a variety of eligible expenses. *By using an FSA, you can reduce your taxes while paying for services you would have to pay for anyway, producing a discount that can be over 40%.*

There are two types of FSAs offered by FSAFEDS:

- **Health Care Flexible Spending Account (HCFSA)**

- Covers eligible health care expenses not reimbursed by this Plan, or any other medical, dental, or vision care plan you or your dependents may have.
- Eligible dependents for this account include anyone you claim on your Federal Income Tax return as a qualified dependent under the U.S. Internal Revenue Service (IRS) definition and/or with whom you jointly file your Federal Income Tax return, even if you don't have self and family health benefits coverage. *Note:* The IRS has a broader definition of a "family member" than is used under the FEHB Program to provide benefits by your FEHB Plan.
- The maximum annual amount that can be allotted for the HCFSA is \$4,000. *Note:* The Federal workforce includes a number of employees married to each other. If each spouse/employee is eligible for FEHB coverage, both may enroll for a HCFSA up to the maximum of \$4,000 each (\$8,000 total). Both are covered under each other's HCFSA. The minimum annual amount is \$250.

- **Dependent Care Flexible Spending Account (DCFSA)**

- Covers eligible dependent care expenses incurred so you, and your spouse, if married, can work, look for work, or attend school full-time.
- Qualifying dependents for this account include your dependent children under age 13, or any person of any age whom you claim as a dependent on your Federal Income Tax return (and who is mentally or physically incapable of self care).
- The maximum annual amount that can be allotted for the DCFSA is \$5,000. The minimum annual amount is \$250. *Note:* The IRS limits contributions to a DCFSA. For single taxpayers and taxpayers filing a joint return, the maximum is \$5,000 per year. For taxpayers who file their taxes separately with a spouse, the maximum is \$2,500 per year. The limit includes any child care subsidy you may receive.

- **Enroll during Open Season**

You **must make an election** to enroll in an FSA during the 2005 FEHB Open Season. Even if you enrolled during 2004, you must make a new election to continue participating in 2005. Enrollment is easy!

- **Online:** visit www.FSAFEDS.com and click on **Enroll**.
- Telephone: call an FSAFEDS Benefits Counselor toll-free at 1-877-FSAFEDS (372-3337), Monday through Friday, from 9 a.m. until 9 p.m., Eastern Time. TTY: 1-800-952-0450.

What is SHPS?

SHPS is a third-party administrator hired by OPM to manage the FSAFEDS Program. SHPS is the largest FSA administrator in the nation and is responsible for enrollment, claims processing, customer service, and day-to-day operations of FSAFEDS.

Who is eligible to enroll?

If you are a Federal employee eligible for FEHB – even if you’re not enrolled in FEHB – you can choose to participate in either, or both, of the FSAs. *However, if you enroll in a High Deductible Health Plan (HDHP) with a Health Savings Account (HSA), you are not eligible to participate in an HCFSA.*

Almost all Federal employees are eligible to enroll for a DCFSA. The only exception is intermittent (also called “when actually employed” [WAE]) employees expected to work fewer than 180 days during the year.

Note: FSAFEDS is the FSA Program established for all Executive Branch employees and Legislative Branch employees whose employers have signed on to participate. Under IRS law, FSAs are not available to annuitants. Also, the U.S. Postal Service and the Judicial Branch, among others, have their own plans with slightly different rules. However, the advantages of having an FSA are the same regardless of the agency for which you work.

• How much should I contribute to my FSA?

Plan carefully when deciding how much to contribute to an FSA. Because of the tax benefits an FSA provides, the IRS places strict guidelines on how the money can be used. Under current IRS tax rules, you are required to forfeit any money for which you did not incur an eligible expense under your FSA account(s) during the Plan Year. This is known as the “use-it-or-lose-it” rule. You will have until April 30, following the end of the Plan Year to submit claims for your eligible expenses incurred from January 1 through December 31. For example if you enroll in FSAFEDS for the 2005 Plan Year, you will have until April 30, 2006 to submit claims for eligible expenses.

The FSAFEDS Calculator at www.FSAFEDS.com will help you plan your FSA allocations and provide an estimate of your tax savings based on your individual situation.

• What can my HCFSA pay for?

Every FEHB plan includes cost sharing features, such as deductibles you must meet before the Plan provides benefits, coinsurance or copayments that you pay when you and the Plan share costs, and medical services and supplies that are not covered by the Plan and for which you must pay. These out-of-pocket costs are summarized on page xx and detailed throughout this brochure. Your HCFSA will reimburse you when those costs are for qualified medical care that you, your spouse and/or your dependents receive that is NOT covered or reimbursed by this FEHB Plan or any other coverage that you have.

Under this Plan, typical out-of-pocket expenses include:

- Copayments for primary care physicians, specialist visits, prescription drugs, inpatient and outpatient care, or
- Care by non-Plan physicians or health care practitioners except for authorized referrals or emergencies, eyeglasses or contact lenses, and experimental or investigational procedures, treatments, drugs or devices, are expenses not covered by the Plan.

The IRS governs expenses reimbursable by a HCFSA. See Publication 502 for a comprehensive list of tax-deductible medical expenses. **Note: While you will see insurance premiums listed in Publication 502, they are NOT a reimbursable expense for FSA purposes.** Publication 502 can be found on the IRS Website at <http://www.irs.gov/pub/irs-pdf/p502.pdf>. The FSAFEDS Website also has a comprehensive list of eligible expenses at www.FSAFEDS.com/fsafeds/eligibleexpenses.asp. If you do not see your service or expense listed please call an FSAFEDS Benefits Counselor at 1-877-FSAFEDS (372-3337), who will be able to answer your specific questions.

- **Tax savings with an FSA**

An FSA lets you allot money for eligible expenses *before* your agency deducts taxes from your paycheck. This means the amount of income that your taxes are based on will be lower, so your tax liability will be less. Without an FSA, you would still pay for these expenses, but you would do so using money remaining in your paycheck after Federal (and often state and local) taxes are deducted. The following chart illustrates a typical tax savings example:

Annual Tax Savings Example	With FSA	Without FSA
If your taxable income is:	\$50,000	\$50,000
And you deposit this amount into an FSA:	\$2,000	-\$0-
Your taxable income is now:	\$48,000	\$50,000
Subtract Federal & Social Security taxes:	\$13,807	\$14,383
If you spend after-tax dollars for expenses:	-\$0-	\$2,000
Your real spendable income is:	\$34,193	\$33,617
Your tax savings:	\$576	-\$0-

Note: This example is intended to demonstrate a typical tax savings based on 27% Federal and 7.65% FICA taxes. Actual savings will vary based upon the retirement system in which you are enrolled (CSRS or FERS), your state of residence, and your individual tax situation. In this example, the individual received \$2,000 in services for \$1,424 - a discount of almost 36%! You may also wish to consult a tax professional for more information on the tax implications of an FSA.

- **Tax credits and deductions**

You *cannot* claim expenses on your Federal Income Tax return if you receive reimbursement for them from your HCFSA or DCFSA. Below are some guidelines that may help you decide whether to participate in FSAFEDS.

- **Health care expenses**

The HCFSA is Federal Income Tax-free from the first dollar. In addition, you may be reimbursed from your HCFSA at any time during the year for expenses up to the annual amount you've elected to contribute.

Only health care expenses exceeding 7.5% of your adjusted gross income are eligible to be deducted on your Federal Income Tax return. Using the example shown above, only health care expenses exceeding \$3,750 (7.5% of \$50,000) would be eligible to be deducted on your Federal Income Tax return. In addition, money set aside through an HCFSA is also exempt from FICA taxes. This exemption is not available on your Federal Income Tax return.

Paperless Reimbursement – This plan participates in the FSAFEDS paperless reimbursement program. When you enroll for your HCFSA, you will have the opportunity to enroll for paperless reimbursement. If you do, we will send FSAFEDS the information they need to reimburse you for your out-of-pocket costs so you can avoid filing paper claims.

- **Dependent care expenses**

The DCFSA generally allows many families to save more than they would with the Federal tax credit for dependent care expenses. Note that you may only be reimbursed from the DCFSA up to your current account balance. If you file a claim for more than your current balance, it will be held until additional payroll allotments have been added to your account.

Visit www.FSAFEDS.com and download the [Dependent Care Tax Credit Worksheet](#) from the Forms and Literature page to help you determine what is best for your situation. You may also wish to consult a tax professional for more details.

- **Does it cost me anything to participate in FSAFEDS?**

No. Section 1127 of the National Defense Authorization Act (Public Law 108-136) requires agencies that offer FSAFEDS to employees to cover the administrative fee(s) on behalf of their employees. However, remember that participating in FSAFEDS can cost you money if you don't spend your entire account balance by the end of the Plan Year, resulting in the forfeiture of funds remaining in your account (the IRS "use-it-or-lose-it" rule).

- **Contact us**

To learn more or to enroll, please visit the **FSAFEDS Website** at www.FSAFEDS.com, or contact SHPS directly via email or by phone. FSAFEDS Benefits Counselors are available Monday through Friday, from 9:00 a.m. until 9:00 p.m. Eastern Time.

- E-mail: FSAFEDS@shps.net
- Telephone: 1-877-FSAFEDS (1-877-372-3337)
- TTY: 1-800-952-0450

The Federal Long Term Care Insurance Program

- **It's important protection**

Why should you consider applying for coverage under the Federal Long Term Care Insurance Program (FLTCIP)?

- **FEHB plans do not cover the cost of long term care.** Also called "custodial care," long term care is help you receive to perform activities of daily living – such as bathing or dressing yourself - or supervision you receive because of a severe cognitive impairment. The need for long term care can strike anyone at any age and the cost of care can be substantial.
- **The Federal Long Term Care Insurance Program can help protect you from the potentially high cost of long term care.** This coverage gives you options regarding the type of care you receive and where you receive it. With FLTCIP coverage, you won't have to worry about relying on your loved ones to provide or pay for your care.
- **It's to your advantage to apply sooner rather than later.** In order to qualify for coverage under the FLTCIP, you must apply and pass a medical screening (called underwriting). Certain medical conditions, or combinations of conditions, will prevent some people from being approved for coverage. By applying while you're in good health, you could avoid the risk of having a future change in your health disqualify you from obtaining coverage. Also, the younger you are when you apply, the lower your premiums.
- **You don't have to wait for an open season to apply.** The Federal Long Term Care Insurance Program accepts applications from eligible persons at any time. You will have to complete a full underwriting application, which asks a number of questions about your health. However, if you are a new or newly eligible employee, you (and your spouse, if applicable) have a limited opportunity to apply using the abbreviated underwriting application, which asks fewer questions. Newly married spouses of employees also have a limited opportunity to apply using abbreviated underwriting.
- **Qualified relatives are also eligible to apply.** Qualified relatives include spouses and adult children of employees and annuitants, and parents, parents-in-law, and stepparents of employees.

- **To find out more and to request an application**

Call 1-800-LTC-FEDS (1-800-582-3337) (TTY 1-800-843-3557) or visit www.ltcfeds.com.

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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 M.D. IPA Health Plan – 2005

- **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 physicians: <ul style="list-style-type: none"> • Diagnostic and treatment services provided in the office 	Office visit copayment: \$10 per office visit to your Primary Care Physician ages 13 and up, nothing for children through age 12	16
Services provided by a hospital: <ul style="list-style-type: none"> • Inpatient • Outpatient 	\$100 per admission \$50 copayment	33 34
Emergency benefits <ul style="list-style-type: none"> • In or out-of-area 	\$25 per urgent care center visit \$50 per emergency room visit	37
Mental health and substance abuse treatment	Regular cost sharing	38
Prescription drugs	\$8 per generic drug \$20 per brand name drug in the Plan's formulary \$35 per brand name drug not in the Plan's formulary 20% up to \$50 for injectable drugs, except for insulin All contraceptive drugs-one copayment up to a 90-day supply per prescription or refill	40
Dental care	Discount fee schedule	44
Vision care	\$25 copayment for eye refraction exam	23
Special features: Centers for Cardiac Surgery, Transplants, and Joint Replacement, WeeCall, Plan Publications, Health Education and Disease Management Programs		43
Protection against catastrophic costs (your catastrophic protection out-of-pocket maximum)	Nothing after \$1,800/Self Only or \$4,800/Family enrollment per year Some costs do not count toward this protection	13

2005 Rate Information for M.D.IPA

Non-Postal rates apply to most non-Postal employees. 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 a special FEHB guide is published 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 who are not career postal employees. Refer to the applicable FEHB Guide.

		<i>Non-Postal Premium</i>				<i>Postal Premium</i>	
		<u>Biweekly</u>		<u>Monthly</u>		<u>Biweekly</u>	
Type of Enrollment	Code	Gov't Share	Your Share	Gov't Share	Your Share	USPS Share	Your Share
Washington, D.C. area, all of Maryland and N.Va/Central Va/Richmond/Tidewater/Roanoke							
Self Only	JP1	\$ 120.83	\$ 40.27	\$ 261.79	\$ 87.26	\$ 142.98	\$ 18.12
Self and Family	JP2	\$ 290.02	\$ 96.67	\$ 628.37	\$ 209.46	\$ 343.19	\$43.50