SAMBA Health Benefit Plan

ESTABLISHED 1948

http://www.samba-insurance.com

2001

A fee-for-service plan with a preferred provider organization

Sponsored and administered by: the Special Agents Mutual Benefit Association

Who may enroll in this Plan: Active employees of the Federal Bureau of Investigation (FBI), the Drug Enforcement Administration (DEA), the Bureau of Alcohol, Tobacco, and Firearms (BATF), the Naval Investigative Service (NIS), the United States Marshals Service (USMS), the Department of Justice Office of the Inspector General (IG), the Criminal Investigation Division and the National Treasury Inspector General for Tax Administration (IRS), Civilian Employees of the Office of Special Investigations of the Department of the Air Force (OSI), the Executive Office of the United States Attorneys (EOUSA), the Offices, Boards and Divisions of the Department of Justice (OBD), the United States Customs Service (USCS), the Financial Crimes Enforcement Network (FinCEN) and all presidentially-appointed offices of the Inspectors General (IGs).

The only annuitants who may enroll in this Plan are persons who retired from the DEA on or after January 9, 1983, who retired from the BATF or the NIS on or after January 5, 1986, who retired from the USMS or the Department of Justice IG on or after January 14, 1990, who retired from the National Treasury IG on or after January 12, 1992, who retired from the OSI on or after January 10, 1993, who retired from the EOUSA or the OBD on or after January 8, 1995, who retired from the USCS or the FinCEN on or after January 4, 1998, who will retire from the presidentially-appointed offices of the IG on or after January 14, 2001, and all retired employees of the FBI.

Membership dues: There are no membership dues.

Enrollment codes for this Plan:

441 Self Only
442 Self and Family

Authorized for distribution by the:

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UNITED STATES
OFFICE OF PERSONNEL MANAGEMENT
RETIREMENT AND INSURANCE SERVICE
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FEHB
Federal Employees Health Benefits Program

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Table of Contents

Introduction

SAMBA Health Benefit Plan
11301 Old Georgetown Road
Rockville, MD 20852-2800

This brochure describes the benefits of the SAMBA Health Benefit Plan under our contract (CS 1074) with the Office of Personnel Management (OPM), as authorized by the Federal Employees Health Benefits law. This brochure is the official statement of benefits. No oral statement can modify or otherwise affect the benefits, limitations, and exclusions of this brochure.

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

OPM negotiates benefits and rates with each plan annually. Benefit changes are effective January 1, 2001, and are summarized on page 6. Rates are shown at the end of this brochure.

Plain Language

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

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

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

Section 1. Facts about this fee-for-service plan

This Plan is a fee-for-service (FFS) plan. You can choose your own physicians, hospitals, and other health care providers.

We reimburse you or your provider for your covered services, usually based on a percentage of the amount we allow. The type and extent of covered services, and the amount we allow, may be different from other plans. Read brochures carefully.

We also have Preferred Provider Organizations (PPO):

Our fee-for-service plan offers services through a PPO. When you use our PPO providers, you will receive covered services at reduced cost. Contact us for the names of PPO providers and to verify their continued participation. You can also go to our web page, which you can reach through the FEHB web site, www.opm.gov/insure. Do not call OPM or your agency for our provider directory.

PPO benefits apply only when you use a PPO provider. Provider networks may be more extensive in some areas than others. We cannot guarantee the availability of every specialty in all areas. If no PPO provider is available, or you do not use a PPO provider, the standard non-PPO benefits apply.

How we pay providers

When you use a PPO provider or facility, our Plan allowance is the negotiated rate for the service. You are not responsible for charges above the negotiated amount.

Non-PPO facilities and providers do not have special agreements with the Plan. Our payment is based on the Plan allowance for covered services. You may be responsible for amounts over the allowance.

We also obtain discounts from some non-PPO providers. When we obtain discounts through negotiations with providers (PPO or non-PPO), we pass along the savings to you.

Patients' Bill of Rights

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

- SAMBA was established in 1948
- SAMBA is a non-profit employee association

If you want more information about us, call 1-800/638-6589 or 301/984-1440 (for TDD, use 301/984-4155), or write to SAMBA 11301 Old Georgetown Road, Rockville, MD 20852-2800. You may also contact us by fax at 301/984-6224 or visit our website at www.samba-insurance.com.

Section 2. How we change for 2001

Program-wide changes

- The plain language team reorganized the brochure and the way we describe our benefits. We hope this will make it easier for you to compare plans.
- This year, the Federal Employees Health Benefits Program is implementing network mental health and substance abuse parity. This means that your coverage for mental health, substance abuse, medical, surgical, and hospital services from providers in our PPO network will be the same with regard to deductibles, coinsurance, copays, and day and visit limitations when you follow a treatment plan that we approve. SAMBA implemented this change in contract year 2000.
- Many healthcare organizations have turned their attention this past year to improving healthcare quality and patient safety. OPM asked all FEHB plans to join them in this effort. You can find specific information on our patient safety activities by calling SAMBA at 1-800/638-6589 or 301/984-1440 (for TDD, use 301/984-4155), or checking our website, www.samba-insurance.com. You can find out more about patient safety on the OPM website, www.opm.gov/insure. To improve your healthcare, take these five steps:
  - •• Speak up if you have questions or concerns.
  - •• Keep a list of all the medications you take.
  - •• Make sure you get the results of any test or procedure.
  - •• Talk with your doctor and health care team about your options if you need hospital care.
  - •• Make sure you understand what will happen if you need surgery.
- We clarified the language to show that anyone who needs a mastectomy may choose to have the procedure performed on an inpatient basis and remain in the hospital up to 48 hours after the procedure. Previously, the language referenced only women.
- North Dakota is deleted from the list of states designated as medically underserved in 2001. See page 8 for information on medically underserved areas.

Changes to this Plan

- SAMBA has contracted with Worldwide Assistance Services, Inc. to provide medical assistance, medical evacuation and other covered services to our members and their eligible family members through the Worldwide Assistance Program. Refer to separate brochure for a detailed description of this program.
- The Plan has contracted with the Pequot Pharmaceutical Network (PRxN), which will be the SAMBA Prescription Drug Program vendor for the retail pharmacy (through PCS Health Systems, Inc.) and mail order programs. Previously, PAID Prescriptions, Inc. and Merck-Medco Rx Services provided these services.
- The name brand single source (no generic equivalent) prescription drug copayment has increased from $15 to $20. Previously, if a generic equivalent was not available, you paid $15.
- The Plan's reasonable and customary fee schedule is now referred to as the "Plan allowance." In addition, for out-of-network services, the Plan's allowance is now based on the average PPO negotiated rate when you do not use a PPO network provider in areas where one is available.
- Under Mental Health and Substance Abuse Benefits a separate $300 per person per calendar year deductible has been added – except for in-network office visits, where you continue to pay a $15 copayment. The deductible is applied toward your catastrophic protection out-of-pocket maximums.
- The catastrophic protection limit has been increased from $1,500 to $2,500 for one person and from $2,000 to $3,500 for a family.
- Open enrollment in the SAMBA Health Benefit Plan has been extended to include the offices of all presidentially-appointed Inspectors General (IGs).
- Your share of the SAMBA premium will increase by 23.9% for Self Only or 20.6% for Self and Family.

Section 3. How you get care

Identification cards

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

If you do not receive your ID card within 30 days after the effective date of your enrollment, or if you need replacement cards, call us at 1-800/638-6589 or 301/984-1440 (for TDD, use 301/984-4155).

Where you get covered care

You can get care from any "covered provider" or "covered facility." How much we pay – and you pay – depends on the type of covered provider or facility you use. If you use our preferred providers, you will pay less.

• This Plan's PPOs

We have entered into arrangements (geographically) with CareFirst BlueCross BlueShield (CareFirst) and First Health Group Corp. (First Health) to offer Preferred Provider Organization (PPO) Networks to SAMBA enrollees. See below to determine which PPO Network services your area.

- Enrollees who reside in the Washington, DC Metropolitan area, including the District of Columbia, the Maryland counties of Calvert, Charles, Frederick, Montgomery, Prince George's and St. Mary's, the Virginia counties of Arlington, Fairfax, Loudoun, Prince William, Spotsylvania, and Stafford, and the cities of Alexandria, Fairfax, Falls Church, and Fredericksburg and those in the Baltimore Metropolitan area including the city of Baltimore, and the Maryland counties of Anne Arundel, Baltimore, Carroll, Harford, and Howard may utilize the CareFirst PPO Network. Call CareFirst customer service toll-free, 1-877/691-5856, for information concerning the PPO.

- Enrollees outside the CareFirst service areas (listed above) may utilize the First Health PPO Network. Call First Health's Referral Management/Telephonic Provider Directory at 1-800/346-6755 to confirm provider participation and identify Network providers.

  •• **Managed Care Advisor (MCA) Program** — Enrollees in the First Health service areas lacking Network access (as determined by the Plan) may join the Plan's Managed Care Advisor (MCA) Program. Refer to Section 5(g) on page 47 for additional information.

PPO benefits apply only when you use a PPO provider. Provider networks may be more extensive in some areas than others. The availability of every specialty in all areas cannot be guaranteed. If no PPO provider is available the standard non-PPO benefits apply.

Note: Use of a participating Network doctor or hospital does not guarantee that the associated ancillary providers such as specialists, emergency room doctors, anesthesiologists, radiologists, and pathologists participate in the Network. Subject to the Plan's definitions, limitations and exclusions, the Plan pays its PPO benefits as outlined in this brochure when services are provided by a doctor or other provider participating in the Plan's PPO Network. If you use a non-PPO provider, the standard non-PPO benefits will apply as outlined in this brochure. When you phone for an appointment, please remember to verify that the physician or facility is still a PPO Network provider.

• Covered providers

We consider the following to be covered providers when they perform services within the scope of their license or certification:

- doctor of medicine (M.D.)
- doctor of osteopathy (D.O.)
- doctor of podiatry (D.P.M.)

Other covered providers include, but are not limited to:

- dentist (D.D.S., D.M.D.)
- chiropractor
- qualified clinical psychologist
- clinical social worker
- optometrist
- nurse midwife
- nurse practitioner/clinical specialist
- Christian Science practitioner listed in the Christian Science Journal

Medically underserved areas. Note: In medically underserved areas, we cover any licensed medical practitioner for any covered service performed within the scope of that license in states OPM determines are "medically underserved." For 2001, the states are: Alabama, Idaho, Kentucky, Louisiana, Mississippi, Missouri, New Mexico, South Carolina, South Dakota, Utah, and Wyoming.

• Covered facilities

Covered facilities include:

•• Ambulatory surgical center — a facility that operates primarily for the purpose of performing same-day surgical procedures.

•• Birthing center — a licensed or certified facility approved by the Plan, that provides services for nurse midwifery and related maternity services.

•• Convalescent nursing home — an institution that:

1) is legally operated
2) mainly provides services for persons recovering from illness or injury. The services are provided for a fee from its patients, and include both:
   (a) room and board; and
   (b) 24-hour-a-day nursing service.
3) provides the services under the full-time supervision of a doctor or registered graduate nurse (R.N.)
4) keeps adequate medical records, and
5) if not supervised by a doctor, it has the services of one available under a fixed agreement. But, Convalescent nursing home does not include an institution or part of one that is used mainly as a place of rest or for the aged.

•• Hospital —

1) An institution that is accredited under the hospital accreditation program of the Joint Commission on Accreditation of Healthcare Organizations, or
2) Any other institution that is operated pursuant to law, under the supervision of a staff of doctors and with 24-hour-a-day nursing service by a registered graduate nurse (R.N.) or a licensed practical nurse (L.P.N.), and primarily engaged in providing acute inpatient care and treatment of sick and injured persons through medical, diagnostic and major surgical facilities, all of which must be provided on its premises or under its control.

Christian Science sanatoriums operated, or listed as certified, by the First Church of Christ, Scientist, Boston, Massachusetts, are included.

•• Rehabilitation facility — an institution specifically engaged in the rehabilitation of persons suffering from alcoholism or drug addiction which meets all of these requirements:

1) It is operated pursuant to law.
2) It mainly provides services for persons receiving treatment for alcoholism or drug addiction. The services are provided for a fee from its patients, and include both: (a) room and board; and (b) 24-hour-a-day nursing service.
3) It provides the services under the full-time supervision of a doctor or registered graduate nurse (R.N.).
4) It keeps adequate patient records which include: (a) the course of treatment; and (b) the person's progress; and (c) discharge summary; and (d) follow-up programs.

•• Skilled nursing facility — an institution or that part of an institution that provides skilled nursing care 24 hours a day and is classified as a skilled nursing care facility under Medicare.

What you must do to get covered care

It depends on the kind of care you want to receive. You can go to any physician you want, but we must approve some care in advance.

Transitional care:

Specialty care: 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,

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: We pay for covered services from the effective date of your enrollment. However, if you are in the hospital when your enrollment in our Plan begins, call our customer service department immediately at 1-800/638-6589 or 301/984-1440 (for TDD, use 301/984-4155).

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.

How to Get Approval for…

• Your hospital stay

Precertification is the process by which – prior to your inpatient hospital admission – we evaluate the medical necessity of your proposed stay and the number of days required to treat your condition. Unless we are misled by the information given to us, we won't change our decision on medical necessity.

In most cases, your physician or hospital will take care of precertification. Because you are still responsible for ensuring that we are asked to precertify your care, you should always ask your physician or hospital whether they have contacted us.

Warning:

We will reduce our benefits for the inpatient hospital stay by $500 if no one contacts us for precertification. If the stay is not medically necessary, we will not pay any inpatient benefits.

How to precertify an admission:

- You, your representative, your doctor, or your hospital must call CareFirst or First Health before admission. If you live in the Washington, DC/Baltimore area, call CareFirst at 1-800/553-8700 toll-free. Call First Health from all other areas at 1-800/346-6755 toll-free.
- If you have an emergency admission due to a condition that you reasonably believe puts your life in danger or could cause serious damage to bodily function, you, your representative, the doctor, or the hospital must telephone us within two business days following the day of the emergency admission, even if you have been discharged from the hospital.

- Provide the following information:

  •• Enrollee's name and Plan identification number;

  •• Patient's name, birth date, and phone number;

  •• Reason for hospitalization, proposed treatment, or surgery;

  •• Name and phone number of admitting doctor;

  •• Name of hospital or facility; and

  •• Number of planned days of confinement.

- We will then tell the doctor and/or hospital the number of approved inpatient days and we will send written confirmation of our decision to you, your doctor, and the hospital.

Maternity care

You do not need to precertify a maternity admission for a routine delivery. However, if your medical condition requires you to stay more than 48 hours after a vaginal delivery or 96 hours after a cesarean section, then your physician or the hospital must contact us for precertification of additional days. Further, if your baby stays after you are discharged, then your physician or the hospital must contact us for precertification of additional days for your baby.

If your hospital stay needs to be extended:

If your hospital stay -- including for maternity care -- needs to be extended, your doctor or the hospital must ask us to approve the additional days.

What happens when you do not follow the precertification rules

- When we precertified the admission but you remained in the hospital beyond the number of days we approved and did not get the additional days precertified, then:

  •• for the part of the admission that was medically necessary, we will pay inpatient benefits, but

  •• for the part of the admission that was not medically necessary, we will only pay for medical services and supplies otherwise payable on an outpatient basis and will not pay inpatient benefits.

- If no one contacted us, we will decide whether the hospital stay was medically necessary.

  •• If we determine that the stay was medically necessary, we will pay the inpatient charges, less the $500 penalty.

  •• If we determine that it was not medically necessary for you to be an inpatient, we will not pay inpatient hospital benefits. We will only pay for any covered medical supplies and services that are otherwise payable on an outpatient basis.

- If we denied the precertification request, we will not pay inpatient hospital benefits. We will only pay for any covered medical supplies and services that are otherwise payable on an outpatient basis.

Exceptions: You do not need precertification in these cases:

- You are admitted to a hospital outside the United States.
- You have another group health insurance policy that is the primary payer for the hospital stay.
- Your Medicare Part A is the primary payer for the hospital stay. Note: If you exhaust your Medicare hospital benefits and do not want to use your Medicare lifetime reserve days, then we will become the primary payer and you do need precertification.

• Other services

Some services require a referral, precertification, or prior authorization.

- Rental or purchase (at the Plan's option) of covered durable medical equipment (DME) or orthopedic and prosthetic devices requires preauthorization once accumulated rental charges or single purchase price exceeds $1,000. Call SAMBA at 1-800/638-6589 or 301/984-1440 (for TDD, use 301/984-4155) to obtain preauthorization
- Private duty nursing services must be preauthorized by SAMBA; call 1-800/638-6589 or 301/984-1440 (for TDD, use 301/984-4155).
- Preauthorization is required for covered outpatient services for the treatment of mental conditions and substance abuse when treatment continues beyond 10 visits per person, per calendar year. Call 1-800/999-9849 in the Washington, DC and Baltimore Metropolitan areas, in all other areas call 1-800/346-6755 to obtain preauthorization.

Warning: We will reduce our benefits to 80% of the benefit otherwise payable if no one contacts us for preauthorization. In addition, if the services are not medically necessary, we will not pay any benefits.

- We cover Growth hormone therapy (GHT) drugs in Section 5(f) when we preauthorize the treatment. Call SAMBA at 1-800/638-6589 or 301/984-1440 (for TDD, use 301/984-4155) for preauthorization. If we determine GHT is not medically necessary, we will not cover the GHT or related services and supplies.

Note: The precertification process for organ transplants is more extensive than the normal precertification process. See Section 5(b) on page 30.

Section 4. Your costs for covered services

This is what you will pay out-of-pocket for your covered care:

• Copayments

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

Example: When you see your PPO physician you pay a copayment of $15 per visit.

We also have a separate copayment for:
•• Inpatient hospital confinement; $200 per admission
•• Outpatient services facility charge; $100 per facility, per day

• Deductible

A deductible is a fixed amount of covered expenses you must incur for certain covered services and supplies before we start paying benefits for them. Copayments, coinsurance and prescription drug program charges do not count toward any deductible.

•• The calendar year deductible is $300 per person. Under a family enrollment, the deductible is satisfied for all family members when the combined covered expenses applied to the calendar year deductible for family members reach $600.

•• We also have separate deductibles for:

- Certain covered expenses for the treatment of mental health and substance abuse. The calendar year deductible is $300 per person/$600 per family.
- Expenses for dental treatment of an accidental injury to sound, natural teeth; $100 per person, per accident.

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

• Coinsurance

Coinsurance is the percentage of our allowance that you must pay for your care. Coinsurance doesn't begin until you meet your deductible.

Example: You pay 10% of our allowance for in-network or 30% of our allowance for out of network laboratory services.

Note: If your provider routinely waives (does not require you to pay) your copayments, deductibles, or coinsurance, the provider is misstating the fee and may be violating the law. In this case, when we calculate our share, we will reduce the provider's fee by the amount waived.

For example, if your physician ordinarily charges $100 for a service but routinely waives your 30% coinsurance, the actual charge is $70. We will pay $49 (70% of the actual charge of $70).

- **Differences between our allowance and the bill**

Our "Plan allowance" is the amount we use to calculate our payment for covered services. Fee-for-service plans arrive at their allowances in different ways, so their allowances vary. For more information about how we determine our Plan allowance, see the definition of Plan allowance in Section 10.

Often, the provider's bill is more than a fee-for-service plan's allowance. Whether or not you have to pay the difference between our allowance and the bill will depend on the provider you use.

- **PPO providers** agree to limit what they will bill you. Because of that, when you use a preferred provider, your share of covered charges consists only of your deductible and coinsurance. Here is an example: You see a PPO physician who charges $150, but our allowance is $100. If you have met your deductible, you are only responsible for your coinsurance. That is, you pay just -- 10% of our $100 allowance ($10). Because of the agreement, your PPO physician will not bill you for the $50 difference between our allowance and his bill.

- **Non-PPO providers**, on the other hand, have no agreement to limit what they will bill you. When you use a non-PPO provider, you will pay your deductible and coinsurance -- **plus** any difference between our allowance and charges on the bill. Here is an example: You see a non-PPO physician who charges $150 and our allowance is again $100. Because you've met your deductible, you are responsible for your coinsurance, so you pay 30% of our $100 allowance ($30). Plus, because there is no agreement between the non-PPO physician and us, he can bill you for the $50 difference between our allowance and his bill.

The following table illustrates the examples of how much you have to pay out-of-pocket for services from a PPO physician vs. a non-PPO physician. The table uses our example of a service for which the physician charges $150 and our allowance is $100. The table shows the amount you pay if you have met your calendar year deductible.

EXAMPLE	PPO provider	Non-PPO provider
Laboratory charge	$150	$150
Our allowance	We set it at: 100	We set it at: 100
We pay	90% of our allowance: 90	70% of our allowance: 70
You owe: Coinsurance	10% of our allowance: 10	30% of our allowance: 30
+Difference up to charge?	No: 0	Yes: 50
TOTAL YOU PAY	$10	$80

Your out-of-pocket maximum for deductibles, coinsurance, and copayments

For those services with coinsurance, we pay 100% of the plan allowance for the remainder of the calendar year after out-of-pocket expenses for the deductibles, copayments and coinsurance in that calendar year exceed $2,500 for one person or $3,500 for you and any covered family members. Out-of-pocket expenses for the purposes of this benefit are the:

- $300 calendar year deductible,
- $300 mental health deductible,
- $200 per inpatient hospital confinement copayment,
- $100 outpatient facility services copayment,
- $15 copayment under PPO benefits and the coinsurance you pay for:
  - •• Medical services and supplies provided by physicians and other health care professionals;
  - •• Surgical and anesthesia services provided by physicians and other health care professionals;
  - •• Services provided by a hospital or other facility, and ambulance services;
  - •• Emergency services/accidents (after 72 hours); and
  - •• Mental health and substance abuse benefits

The following cannot be counted toward out-of-pocket expenses:

- the dental accident deductible;
- expenses in excess of the Plan allowance or maximum benefit limitations;
- coinsurance for orthopedic and prosthetic devices, durable medical equipment (DME) or private duty nursing care not authorized (see Section 3, page 12);
- copayments under prescription drug benefits;
- the cost difference between a name brand drug and its generic equivalent; and
- any portion of the $700 out-of-pocket expenses you pay for inpatient hospice care.

• Carryover

If you changed to this Plan during open season from a plan with a catastrophic protection benefit and the effective date of the change was after January 1, any expenses that would have applied to that plan's catastrophic protection benefit during the prior year will be covered by your old plan if they are for care you got in January before the effective date of your coverage in this Plan. If you have already met the covered out-of-pocket maximum expense level in full, your old plan's catastrophic protection benefit will continue to apply until the effective date. If you have not met this expense level in full, your old plan will first apply your covered out-of-pocket expenses until the prior year's catastrophic level is reached and then apply the catastrophic protection benefit to covered out-of-pocket expenses incurred from that point until the effective date. The old plan will pay these covered expenses according to this year's benefits; benefit changes are effective January 1.

When government facilities bill us

Facilities of the Department of Veterans Affairs, the Department of Defense, and the Indian Health Service are entitled to seek reimbursement from us for certain services and supplies they provide to you or a family member. They may not seek more than their governing laws allow.

If we overpay you

We will make diligent efforts to recover benefit payments we made in error but in good faith. We may reduce subsequent benefit payments to offset overpayments.

When you are age 65 or over and you do not have Medicare

Under the FEHB law, we must limit our payments for those benefits you would be entitled to if you had Medicare. And, your physician and hospital must follow Medicare rules and cannot bill you for more than they could bill you if you had Medicare. The following chart has more information about the limits.

If you…

- are age 65 or over, and
- do not have Medicare Part A, Part B, or both; and
- have this Plan as an annuitant or as a former spouse, **or** as a family member of an annuitant or former spouse; and
- are not employed in a position that gives FEHB coverage. (Your employing office can tell you if this applies.)

Then, for your inpatient hospital care,

- The law requires us to base our payment on an amount -- the "equivalent Medicare amount" -- set by Medicare's rules for what Medicare would pay, not on the actual charge;
- You are responsible for your applicable deductibles, coinsurance, or copayments you owe under this Plan;
- You are not responsible for any charges greater than the equivalent Medicare amount; we will show that amount on the explanation of benefits; and
- The law prohibits a hospital from collecting more than the Medicare equivalent amount.

And, for your physician care, the law requires us to base our payment and your coinsurance on…

- an amount -- set by Medicare and called the "Medicare approved amount," or
- the actual charge if it is lower than the Medicare approved amount.

If your physician…	Then you are responsible for…
Participates with Medicare or accepts Medicare assignment for the claim and is a member of our PPO network,	your deductibles, coinsurance, and copayments;
Participates with Medicare and is not in our PPO network,	your deductibles, coinsurance, copayments, and any balance up to the Medicare approved amount;
Does not participate with Medicare,	your deductibles, coinsurance, copayments, and any balance up to 115% of the Medicare approved amount

It is generally to your financial advantage to use a physician who participates with Medicare. Such physicians are only permitted to collect up to the Medicare approved amount.

Our explanation of benefits (EOB) form will tell you how much the physician or hospital can collect from you. If your physician or hospital tries to collect more than allowed by law, ask the physician or hospital to reduce the charges. If you have paid more than allowed, ask for a refund. If you need further assistance, call us.

When you have the Original Medicare Plan

We limit our payment to an amount that supplements the benefits that Medicare would pay under Part A (Hospital insurance) and Part B (Medical insurance), regardless of whether Medicare pays. Note: We pay our regular benefits for emergency services to an institutional provider, such as a hospital, that does not participate with Medicare and is not reimbursed by Medicare.

If you are covered by Medicare Part B and it is primary, your out of pocket costs for services both Medicare Part B and we cover depend on whether your physician accepts Medicare assignment for the claim.

- If your physician accepts Medicare assignment, then you pay nothing for covered charges.

- If your physician does not accept Medicare assignment, then you pay the difference between our payment combined with Medicare's payment and the charge.

Note: The physician who does not accept Medicare assignment may not bill you for more than 115% of the amount Medicare bases its payment on, called the "limiting charge." The Medicare Summary Notice (MSN) that Medicare will send you will have more information about the limiting charge. If your physician tries to collect more than allowed by law, ask them to reduce their charges. If they do not, report them to your Medicare carrier who sent you the MSN form. Call us if you need further assistance.

When you have a Medicare Private Contract

A physician may ask you to sign a private contract agreeing that you can be billed directly for service ordinarily covered by Medicare. Should you sign an agreement, Medicare will not pay any portion of the charges, and we will not increase our payment. We will still limit our payment to the amount we would have paid after Medicare's payment.

Please see Section 9, Coordinating benefits with other coverage, for more information about how we coordinate benefits with Medicare.

Section 5. Benefits -- OVERVIEW

(See page 6 for how our benefits changed this year and page 71 for a benefits summary.)

NOTE: This benefits section is divided into subsections. Please read the important things you should keep in mind at the beginning of each subsection. Also read the General Exclusions in Section 6; they apply to the benefits in the following subsections. To obtain claim forms, claims filing advice, or more information about our benefits, contact us at 1-800/638-6589 or 301/984-1440 (for TDD, use 301/984-4155) or at our website at www.samba-insurance.com.

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

IMPORTANT

Here are some important things you should 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.
- The calendar year deductible is: $300 per person ($600 per family). The calendar year deductible applies to almost all benefits in this Section. We added "(No deductible)" to show when the calendar year deductible does not apply.
- Be sure to read Section 4, *Your costs for covered services* for valuable information about how cost sharing works, with special sections for members who are age 65 or over. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

IMPORTANT

Benefit Description	You pay After the calendar year deductible…
NOTE: The calendar year deductible applies to almost all benefits in this Section. We say "No deductible" when it does not apply.	
Diagnostic and treatment services	
Professional services of physicians • office visits and consultations, including second surgical opinion. • Same day services performed and billed by the doctor in conjunction with the office visit. Note: We cover one routine physical exam and one routine gynecologic exam for women age 18 and older, per calendar year.	PPO: $15 copayment per office visit (No deductible) Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount
Professional services of physicians • In an urgent care center • During a hospital stay • In a skilled nursing facility • examination during a hospital stay of a newborn child covered under a family enrollment	PPO: 10% of the Plan allowance Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount

Lab, X-ray and other diagnostic tests	You pay
Tests, such as: • Blood tests • Urinalysis • Non-routine pap tests • Pathology • X-rays • Non-routine Mammograms • CAT Scans/MRI • Ultrasound • Electrocardiogram and EEG Note: We cover lab, X-ray and other diagnostic tests related to one routine physical exam and one routine gynecologic exam for women age 18 and older, per calendar year.	PPO: 10% of the Plan allowance Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount Note: If your PPO provider uses a non-PPO lab or radiologist, we will pay non-PPO benefits for any lab and X-ray charges.
Preventive care, adult	
Cancer screenings, including: • Fecal occult blood test for members age 40 and older • Prostate Specific Antigen (PSA test) – one annually for men age 40 and older • Routine pap test	PPO: Nothing (No deductible) Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount
• Sigmoidoscopy, screening – every five years starting at age 50	PPO: 10% of the Plan allowance Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount
Routine mammogram – covered for women age 35 and older, as follows: • 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	PPO: Nothing (No deductible) Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount
Routine immunizations, limited to: • Tetanus-diphtheria (Td) booster – once every 10 years, ages 19 and over (except as provided for under Childhood immunizations) • Influenza/Pneumococcal vaccines, annually	PPO: 10% of the Plan allowance Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount
Not covered: routine immunizations not listed above.	*All charges.*

Preventive care, children	You pay
• Childhood immunizations recommended by the American Academy of Pediatrics	PPO: Nothing (No deductible) Non-PPO: Nothing (No deductible)
• The office visit for routine well-child care examinations, • Same day services performed and billed by the doctor in conjunction with the office visit.	PPO: $15 copayment per office visit (No deductible) Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount
• Laboratory tests, including blood lead level screenings	PPO: 10% of the Plan allowance Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount
Maternity care	
Complete maternity (obstetrical) care, such as: • Prenatal care • Delivery • Postnatal care Note: Here are some things to keep in mind: • You do not need to precertify your normal delivery; see page 11 for other circumstances, such as extended stays for you or your baby. • You may remain in the hospital up to 48 hours after a regular delivery and 96 hours after a caesarean delivery. We will cover an extended stay, if medically necessary, but you must precertify.	PPO: 10% of the Plan allowance Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount
• 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 if we cover the infant under a Self and Family enrollment. • We pay hospitalization and surgeon services (delivery) the same as for illness and injury. See Hospital benefits (Section 5(c)) and Surgery benefits (Section 5(b)).	*(see above)*
Not covered: • *Routine sonograms to determine fetal age, size or sex* • *Stand-by doctor for caesarean section* • *Services before enrollment in the Plan begins or after enrollment ends*	*All charges*

Family planning	You pay
• Voluntary sterilization • Surgically implanted contraceptives • Injectable contraceptive drugs • Intrauterine devices (IUDs) Note: We cover contraceptive drugs in Section 5(f).	PPO: 10% of the Plan allowance Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount
Not covered: • *Reversal of voluntary surgical sterilization* • *Genetic counseling*	*All charges.*
Infertility services	
Diagnosis and treatment of infertility, except as excluded. Coverage is limited to – $5,000 per person, per lifetime, including fertility drugs covered in Section 5(f).	PPO: 10% of the Plan allowance Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount
Not covered: • *Assisted reproductive technology (ART) procedures, such as:* •• *artificial insemination* •• *in vitro fertilization* •• *embryo transfer and GIFT* •• *intravaginal insemination (IVI)* •• *intracervical insemination (ICI)* •• *intrauterine insemination (IUI)* • *Services and supplies related to ART procedures.*	*All charges.*
Allergy care	
Allergy injections, testing and treatment, including materials (such as allergy serum)	PPO: 10% of the Plan allowance Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount

Treatment therapies	You pay
• Chemotherapy and radiation therapy • Dialysis – Renal dialysis, hemodialysis and peritoneal dialysis • Intravenous (IV)/Infusion Therapy – Home IV and antibiotic therapy • Transparenteral nutrition (TPN) • Growth hormone therapy (GHT) Note: – We only cover GHT when we preauthorize the treatment. Call 1-800/638-6589 or 301/984-1440 (for TDD, use 301/984-4155) for preauthorization. We will ask you to submit information that establishes that the GHT is medically necessary. See *Other Services* in Section 3. • Respiratory and inhalation therapies	PPO: 10% of the Plan allowance Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount
Rehabilitative therapies	
Physical therapy – Limited to: • $3,000 per person, per calendar year for the services of a qualified physical therapist	PPO: 10% of the Plan allowance Non-PPO: 50% of the Plan allowance and any difference between our allowance and the billed amount
Other therapies: • Cardiac rehabilitation • Occupational therapy	PPO: 10% of the Plan allowance Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount
Speech therapy – Note: Covered expenses are limited to charges of a licensed speech therapist for speech loss or impairment due to (a) congenital anomaly or defect, whether or not surgically corrected or (b) due to any other illness or surgery, except for speech loss or impairment due to a functional nervous disorder.	PPO: 10% of the Plan allowance Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount
Not covered: • *Long-term rehabilitative therapy* • *Exercise programs* • *Speech therapy for speech loss or impairment due to a functional nervous disorder*	*All charges.*

Hearing services (testing, treatment, and supplies)	You pay
First hearing aid and testing only when necessitated by accidental injury	PPO: 10% of the Plan allowance Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount
Not covered: • *Hearing testing* • *Hearing aids, testing and examinations for them, except for accidental injury*	*All charges.*
Vision services (testing, treatment, and supplies)	
• One pair of eyeglasses or contact lenses to correct an impairment directly caused by accidental ocular injury or intraocular surgery (such as for cataracts) • Vision therapy, such as eye exercises or orthoptics	PPO: 10% of the Plan allowance Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount
Not covered: • *Eyeglasses or contact lenses and examinations for them except as noted above* • *Radial keratotomy, lasik and other refractive surgery*	*All charges.*
Foot care	
• Routine foot care when you are under active treatment for a metabolic or peripheral vascular disease, such as diabetes. • Removal of nail root See *Orthopedic and prosthetic devices* for information on podiatric shoe inserts.	PPO: $15 copayment for the office visit (No deductible) plus 10% of the Plan allowance for other services Note: Same day services performed and billed by the doctor in conjunction with the office visit are paid at 100% of the Plan allowance. Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount
Not covered: • *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* • *Treatment of weak, strained or flat feet or bunions; and of any instability, imbalance or subluxation of the foot (unless the treatment is by open cutting surgery)*	*All charges*

Orthopedic and prosthetic devices	You pay
• Artificial limbs and eyes; stump hose • Orthopedic and corrective shoes, arch supports, foot orthotics, heel pads and heel cups • Externally worn breast prostheses and surgical bras, including necessary replacements following a mastectomy • Lumbosacral supports • Crutches, surgical dressings, splints, casts, and similar supplies • Braces, corsets, trusses, elastic stockings, support hose, and other supportive devices • Internal prosthetic devices, such as artificial joints, pacemakers, cochlear implants, and surgically implanted breast implant following mastectomy. Note: See 5(b) for coverage of the surgery to insert the device. Note: Certain services listed above require precertification (refer to Section 3). Dental prosthetic appliances are covered under Section 5(h).	PPO: 10% of the Plan allowance Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount
Durable medical equipment (DME)	
Durable medical equipment (DME) is equipment and supplies that: 1. Are prescribed by your attending physician (i.e., the physician who is treating your illness or injury); 2. Are medically necessary; 3. Are primarily and customarily used only for a medical purpose; 4. Are generally useful only to a person with an illness or injury; 5. Are designed for prolonged use; and 6. Serve a specific therapeutic purpose in the treatment of an illness or injury. We cover rental or purchase, at our option, including repair and adjustment, of durable medical equipment, such as: • Oxygen equipment and oxygen • Hospital beds • Wheelchairs • Walkers Note: Certain services listed above require precertification (refer to Section 3).	PPO: 10% of the Plan allowance Non-PPO: 50% of the Plan allowance and any difference between our allowance and the billed amount
Not covered: air conditioners, humidifiers, dehumidifiers, purifiers and other items that do not meet the definition of durable medical equipment	*All charges*

Home health services	You pay
Home health aide services, limited to: • 100 visits per person per calendar year for covered services of a home health aide. Services must be furnished by a home health care agency in accordance with a home health care plan as defined in Section 10, page 65. Note: Each visit taking 4 hours or less is counted as one visit. If a visit exceeds 4 hours, each 4 hours or fraction is counted as a separate visit.	PPO: 10% and all charges after 100 visits Non-PPO: 30% and all charges after 100 visits
Private duty nursing care, limited to: • $10,000 per person, per calendar year for covered services of a registered nurse (R.N.), licensed practical nurse (L.P.N.), licensed vocational nurse (L.V.N.), or Christian Science nurse. Note: Private duty nursing requires precertification. Refer to Section 3, *Other services.*	PPO: 10% and all charges after we pay $10,000 Non-PPO: 50% and all charges after we pay $10,000
Not covered: • *Nursing care requested by, or for the convenience of, the patient or the patient's family;* • *Nursing care primarily for hygiene, feeding, exercising, moving the patient, homemaking, companionship or giving oral medication.*	*All charges.*
Alternative treatments	
• Acupuncture by a doctor of medicine or osteopathy for pain relief, limited to $500 per calendar year • Services of a chiropractor, such as manipulation and X-rays, limited to $500 per calendar year	PPO: 10% of the Plan allowance Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount
Not covered: • *Naturopathic practitioner* • *Massage therapist* *(Note: benefits of certain alternative treatment providers may be covered in medically underserved areas; see page 8)*	*All charges*
Educational classes and programs	
Coverage is limited to: • Smoking Cessation – Up to $100 for one smoking cessation program per member per lifetime, including all related expenses such as drugs. • Diabetes self management.	PPO: 10% of the Plan allowance Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount

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

IMPORTANT

Here are some important things you should 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.
- The calendar year deductible is: $300 per person ($600 per family). The calendar year deductible applies to almost all benefits in this Section. We added "No deductible" to show when the calendar year deductible does not apply.
- Be sure to read Section 4, *Your costs for covered services* for valuable information about how cost sharing works, with special sections for members who are age 65 or over. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- The amounts listed below are for the charges billed by a physician or other health care professional for your surgical care. Look in Section 5(c) for charges associated with the facility (i.e. hospital, surgical center, etc.).

IMPORTANT

Benefit Description	You pay After the calendar year deductible…
NOTE: The calendar year deductible applies to almost all benefits in this Section. We say "No deductible" when it does not apply	
Surgical procedures	
• 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 weighs 100 pounds or 100% over his or her normal weight according to current underwriting standards; eligible members must be age 18 or over • Insertion of internal prosthetic devices. See 5(a) – *Orthopedic braces and prosthetic devices* for device coverage information • Voluntary sterilization, Norplant (a surgically implanted contraceptive), and intrauterine devices (IUDs) • Treatment of burns • Assistant surgeons- we cover up to 20% of our allowance for the surgeon's charge	PPO: 10% of the Plan allowance Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount

Surgical procedures – Continued on next page

Surgical procedures *(continued)*	**You pay**
When multiple or bilateral surgical procedures performed during the same operative session add time or complexity to patient care, our benefits are: • For the primary procedure: •• PPO: 90% of the Plan allowance or •• Non-PPO: 70% of the Plan allowance • For the secondary procedure(s): •• PPO: 90% of one-half of the Plan allowance or •• Non-PPO: 70% of one-half of the Plan allowance Note: Multiple or bilateral surgical procedures performed through the same incision are "incidental" to the primary surgery. That is, the procedure would not add time or complexity to patient care. We do not pay extra for incidental procedures.	PPO: 10% of the Plan allowance for the primary procedure and 10% of one-half of the Plan allowance for the secondary procedure(s) Non-PPO: 30% of the Plan allowance for the primary procedure and 30% of one-half of the Plan allowance for the secondary procedure(s); and any difference between our payment and the billed amount
Not covered: • *Reversal of voluntary sterilization* • *Services of a standby surgeon, except during angioplasty or other high risk procedures when we determine standbys are medically necessary* • *Routine treatment of conditions of the foot; see Foot care* • *Eye surgery, such as radial keratotomy, lasik and laser surgery when the primary purpose is to correct myopia (nearsightedness), hyperopia (farsightedness) or astigmatism (blurring)*	*All charges.*
Reconstructive surgery	
• Surgery to correct a functional defect • Surgery to correct a condition caused by injury or illness if: •• 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; and webbed fingers and toes. • All stages of breast reconstruction surgery following a mastectomy, such as: •• 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 *Orthopedic and prosthetic devices* for coverage)	PPO: 10% of the Plan allowance Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount

Reconstructive surgery – Continued on next page

Reconstructive surgery (*continued)*	**You pay**
Note: We pay for internal breast prostheses as orthopedic and prosthetic devices, see Section 5(a). 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.	
Not covered: • *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* • *Surgeries related to sex transformation or sexual dysfunction*	*All charges*
Oral and maxillofacial surgery	
Oral surgical procedures, limited to: • Reduction of fractures of the jaws or facial bones • Surgical correction of cleft lip, cleft palate or severe functional malocclusion • Removal of stones from salivary ducts • Excision of impacted teeth, bony cysts of the jaw, torus palatinus, leukoplakia or malignancies • Excision of cysts and incision of abscesses not involving the teeth • Other surgical procedures that do not involve the teeth or their supporting structures • Freeing of muscle attachments	PPO: 10% of the Plan allowance Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount
Not covered: • *Oral implants and transplants* • *Procedures that involve the teeth or their supporting structures (such as the periodontal membrane, gingiva, and alveolar bone)*	*All charges*

Organ/tissue transplants	You pay
Limited to: • Cornea • Heart • Heart/lung • Kidney • Liver • Lung: Single; Double • Pancreas • Bone marrow transplants as follows: – Allogeneic (donor) bone marrow transplants – Autologous bone marrow transplants (autologous stem cell support) and autologous peripheral stem cell support for: acute lymphocytic or non-lymphocytic leukemia; advanced Hodgkin's lymphoma; advanced non-Hodgkin's lymphoma; advanced neuroblastoma; breast cancer; multiple myeloma; epithelial ovarian cancer; and testicular, mediastinal, retroperitoneal and ovarian germ cell tumors.	Nothing when performed through the First Health National Transplant Program or CareFirst's Centers of Excellence, except for cornea and pancreas. Note: When services are rendered outside the above programs, the standard Plan benefits apply and are limited to $100,000 per transplant.
National Transplant Program/Centers of Excellence - The Plan pays 100% of covered expenses for the organ transplants as listed (except cornea and pancreas) when performed through the First Health National Transplant Program or CareFirst's Centers of Excellence. Covered expenses are: • The pretransplant evaluation; • Organ procurement, including donor expenses (except donor screening tests); • The transplant procedure itself (hospital and doctor fees); Transplant-related follow-up care for up to one year; and • Pharmacy costs for immunosuppressant and other transplant-related medication. Note: As a potential candidate for an organ transplant procedure, you or your doctor must contact the First Health National Transplant Program at 1-800/346-6755 or CareFirst's Centers of Excellence (Washington, DC and Baltimore area) at 1-800/553-8700 to initiate the pretransplant evaluation. The clinical results of the evaluation will be reviewed to determine if the proposed procedure meets the Plan's definition of medically necessary. A case manager will assist the patient in accessing the appropriate transplant facility. This includes providing information to facilitate travel and lodging arrangements and coordinating the pretransplant evaluation.	

Organ/tissue transplants – Continued on next page

Organ/tissue transplants *(continued)*	**You pay**
Limited Benefits - If you do not use either the First Health National Transplant Program or a CareFirst Centers of Excellence facility, standard Plan benefits will be applied to your expenses. Total benefit payments, including donor expenses, the transplant procedure itself (hospital and doctor fees), transplant-related follow-up care for one year, and pharmacy costs for immunosuppressant and other transplant-related medication will be limited to a maximum payment of $100,000 per transplant. The travel and lodging allowance will not be available. Travel/Lodging Benefit – If the recipient lives more than 50 miles from a designated transplant facility, the Plan will provide an allowance for preapproved travel and lodging expenses up to $10,000 per transplant. The allowance will provide coverage of reasonable travel and temporary lodging expenses for the recipient and one companion (two companions if the recipient is a minor). Travel and lodging to a designated facility for the pretransplant evaluation is covered under this benefit even if the transplant is not eventually certified as medically necessary. Cornea and pancreas transplants are not available through the above programs; therefore, the Travel/Lodging Benefit is not available and standard Plan benefits apply. Note: We cover related medical and hospital expenses of the donor when we cover the recipient.	
Not covered: • *Donor screening tests and donor search expenses, except those performed for the actual donor* • *Implants of artificial organs* • *Transplants and related services not listed as covered*	*All charges*
Anesthesia	
Professional services provided in – • Hospital (inpatient)	PPO: 10% of the Plan allowance (No deductible) Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount (No deductible) Note: If you use a PPO facility, we pay PPO benefits if you receive treatment from an anesthesiologist who is not a PPO provider.

Anesthesia – Continued on next page

Anesthesia *(continued)*	**You Pay**
Professional services provided in – • Hospital outpatient department • Skilled nursing facility • Ambulatory surgical center • Office	PPO: 10% of the Plan allowance Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount Note: If your PPO provider uses a non-PPO anesthesiologist, we will pay non-PPO benefits for any anesthesia charges.

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

IMPORTANT

Here are some important things you should 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.
- Unlike Sections (a) and (b), in this section the calendar year deductible applies to only a few benefits. In that case, we added "(calendar year deductible applies)".
- Be sure to read Section 4, *Your costs for covered services* for valuable information about how cost sharing works, with special sections for members who are age 65 or over. 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 in Section 5(a) or (b).
- **YOU MUST GET PRECERTIFICATION OF HOSPITAL STAYS; FAILURE TO DO SO WILL RESULT IN A $500 PENALTY.** Please refer to the precertification information shown in Section 3 to be sure which services require precertification.

IMPORTANT

Benefit Description	You pay
NOTE: The calendar year deductible applies ONLY when we say below: "calendar year deductible applies".	
Inpatient hospital	
Room and board, such as • ward, semiprivate, or intensive care accommodations; • general nursing care; and • meals and special diets. Note: We only cover a private room when you must be isolated to prevent contagion. Otherwise, we will pay the hospital's average charge for semiprivate accommodations. If the hospital only has private rooms, we base our payment on the lowest rate for a private room. Note: When the non-PPO hospital bills a flat rate, we prorate the charges to determine how to pay them, as follows: 30% room and board and 70% other charges.	PPO: $200 copayment per confinement Non-PPO: $200 copayment per confinement and 30% of the Plan allowance Note: A confinement is defined in Section 10, page 63.

Inpatient hospital - Continued on next page.

Inpatient hospital *(continued)*	**You pay**
Other hospital services and supplies, such as: • Operating, recovery, maternity, and other treatment rooms • Prescribed drugs and medicines • Diagnostic laboratory tests and X-rays • Blood or blood plasma, if not donated or replaced • Dressings, splints, casts, and sterile tray services • Medical supplies and equipment, including oxygen • Anesthetics Note: We base payment on whether the facility or a health care professional bills for the services or supplies. For example, when the hospital bills for anesthetic services, we pay Hospital benefits and when the anesthesiologist bills, we pay Anesthesia benefits.	PPO: 10% of the Plan allowance Non-PPO: 30% of the Plan allowance Note: If you use a PPO facility, we pay PPO benefits if you receive treatment from a radiologist, pathologist, or anesthesiologist who is not a PPO provider.
Not covered: • *Any part of a hospital admission that is not medically necessary (see definition), such as when you do not need acute hospital inpatient (overnight) care, but could receive care in some other setting without adversely affecting your condition or the quality of your medical care. Note: In this event, we pay benefits for services and supplies other than room and board and in-hospital physician care at the level they would have been covered if provided in an alternative setting* • *Custodial care; see definition.* • *Non-covered facilities or any facility used principally for convalescence, for rest, for a nursing home, for the aged, for domiciliary or custodial care, or as a school,* • *Personal comfort items, such as telephone, television, barber services, guest meals and beds*	*All charges.*
Outpatient hospital or ambulatory surgical center	
• Operating, recovery, and other treatment rooms • Prescribed drugs and medicines • Diagnostic laboratory tests, X-rays, and pathology services • Administration of blood, blood plasma, and other biologicals • Blood and blood plasma, if not donated or replaced • Pre-surgical testing • Dressings, casts, and sterile tray services • Medical supplies, including oxygen • Anesthetics and anesthesia service Note: – We cover hospital services and supplies related to dental procedures when necessitated by a non-dental physical impairment..	PPO: $100 copayment per outpatient facility charge and 10% of the Plan allowance (calendar year deductible applies) Non-PPO: $100 copayment per outpatient facility charge and 30% of the Plan allowance and any difference between our allowance and the billed amount (calendar year deductible applies) Note: You pay the $100 copayment per facility per day

Extended care benefits/Skilled nursing care facility benefits	You pay
Skilled nursing facility (SNF)/Convalescent nursing home (CNH): We cover services and supplies in a SNF/CNH for up to 60 days per confinement when: 1) you are admitted within 10 days after a precertified hospital stay of at least 3 consecutive days; and 2) your doctor recommends transfer to a SNF/CNH in lieu of continued hospitalization Coverage limited to: One-half of the standard semiprivate room rate of the hospital in which the patient was confined (limited to 60 days)	Nothing Note: You pay charges above the Plan's limit.
Not covered: • *Custodial care* • *Personal comfort services such as beauty and barber services*	*All charges.*
Hospice care	
Hospice is a coordinated program of maintenance and supportive care for the terminally ill provided by a medically supervised team under the direction of a Plan-approved independent hospice administration. Note: A terminally ill person is a covered family member whose life expectancy is six months or less, as certified by the primary doctor.	
Inpatient hospice care • We pay 60 days of inpatient care, up to $300 per day until you incur $700 of out-of-pocket expenses. We then pay 100% of covered charges during the remainder of the 60-day period of care.	You pay charges in excess of $300 per day, up to a $700 out-of-pocket maximum, then nothing until the 60 day limit is met.
Outpatient hospice care • We pay $2000 of covered outpatient services and supplies for each period of hospice care.	Nothing until benefits stop at $2000
Not covered: charges incurred during a period of remission. *Definition: A remission is a halt or actual reduction in the progression of illness resulting in discharge from a hospice care program with no further expenses incurred. A re-admission within 3 months of a prior discharge is considered the same period of care. A new period begins 3 months after a prior discharge, with maximum benefits available*	*All charges.*

Ambulance	You pay
Local professional ambulance service only to and from a hospital, when medically appropriate	PPO: 10% of Plan allowance Non-PPO: 30% of Plan allowance and any difference between our allowance and the billed amount
All other local ambulance service when medically appropriate	PPO: 10% of Plan allowance (calendar year deductible applies) Non-PPO: 30% of Plan allowance and any difference between our allowance and the billed amount (calendar year deductible applies)
Blood and plasma	
Blood and plasma to the extent not donated or replaced when not otherwise payable under *Inpatient hospital benefits*.	Nothing

Section 5 (d). Emergency services/accidents

IMPORTANT

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.
- The calendar year deductible is: $300 per person ($600 per family). The calendar year deductible applies to almost all benefits in this Section. We added "(No deductible)" to show when the calendar year deductible does not apply.
- Be sure to read Section 4, *Your costs for covered services* for valuable information about how cost sharing works, with special sections for members who are age 65 or over. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

IMPORTANT

What is an accidental injury?

An accidental injury is a bodily injury sustained solely through violent, external, and accidental means, such as broken bones, animal bites, and poisonings. See Section 5(h) for dental care for accidental injury.

Benefit Description	You pay After the calendar year deductible…
NOTE: The calendar year deductible applies to almost all benefits in this Section. We say "No deductible" when it does not apply.	
Accidental injury	
If you receive care for your accidental injury within 72 hours, we cover: • All medically necessary physician services and supplies • Related hospital services Note: Services received after 72 hours are considered the same as any other illness and standard Plan benefits will apply.	PPO: Nothing (No deductible) Non-PPO: Only the difference between our allowance and the billed amount. (No deductible)
Medical emergency	
Medical emergencies are considered the same as any other illness and standard Plan benefits apply.	Regular benefits
Ambulance	
Accidental injury – Professional ambulance service, including medically necessary air ambulance • We pay 100% when services are rendered within 72 hours of your accidental injury. Note: See 5(c) for non-emergency service.	PPO: Nothing (no deductible) Non-PPO: Only the difference between our allowance and the billed amount (No deductible)

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

IMPORTANT

Parity

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

You may choose to get care Out-of-Network or In-Network. When you receive In-Network care, you must get our approval for services and follow a treatment plan we approve. If you do, cost-sharing and limitations for In-Network 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:

- Services must be provided by an in-network provider to receive PPO benefits.
- All benefits are subject to the definitions, limitations, and exclusions in this brochure.
- We have a separate $300 per person ($600 per family) calendar year deductible which applies to almost all benefits for the treatment of mental health and substance abuse. For example, doctors' inpatient hospital visits for a physical illness or disease applies to the Plan's standard calendar year deductible. If the services are rendered to treat mental health or substance abuse, the separate mental health and substance abuse calendar year deductible applies. We added "(No deductible)" to show when a deductible does not apply.
- Be sure to read Section 4, *Your costs for covered services* for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- **YOU MUST GET PREAUTHORIZATION OF THESE SERVICES.** See the instructions after the benefits descriptions below.
- In-Network mental health and substance abuse benefits are below, then Out-of-Network benefits begin on page 41.

IMPORTANT

Benefit Description	You pay After the calendar year deductible…
NOTE: The calendar year deductible applies to almost all benefits in this Section. We say "No deductible" when it does not apply.	
In-Network benefits	
All diagnostic and treatment services contained in a treatment plan that we approve. The treatment plan may include services, drugs, and supplies described elsewhere in this brochure. Note: In-Network 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.	Your cost sharing responsibilities are no greater than for other illness or conditions.

In-Network mental health and substance abuse benefits – Continued on next page

In-Network benefits *(continued)*	**You pay**
• Outpatient professional services by providers such as psychiatrists, psychologists, or clinical social workers including: •• individual or group therapy •• collateral visits with members of the patient's immediate family •• convulsive therapy visits • Medication management Note: Preauthorization is required; see page 40.	$15 copayment per visit (no deductible)
Other outpatient care including: • Day or after care (partial hospitalization) in a hospital Note: Preauthorization is required; see page 40.	10% of the Plan allowance
• Diagnostic tests	10% of the Plan allowance
Covered inpatient hospital and rehabilitation facility charges including: • Room and board, including general nursing care, in semiprivate accommodations • Other charges for hospital services and supplies (other than professional services) including but not limited to the use of operating, treatment and recovery rooms; X-rays; surgical dressings; and drugs and medicines Note: Precertification is required for an inpatient confinement; see page 40.	$200 per confinement copayment, nothing for room and board and 10% of Plan allowance for other hospital services (no deductible) Note: A confinement is defined in Section 10, page 63.
• Services of a doctor for inpatient hospital visits	10% of the Plan allowance
Not covered: • *Services we have not approved.* *Note: OPM will base its review of disputes about treatment plans on the treatment plan's clinical appropriateness. OPM will generally not order us to pay or provide one clinically appropriate treatment plan in favor of another.*	*All charges.*

In-Network mental health and substance abuse benefits – Continued on next page

In-Network benefits *(continued)*	
Preauthorization	To be eligible to receive enhanced mental health and substance abuse benefits you must follow your treatment plan and our authorization processes. These include obtaining Plan certification for: • The medical necessity of your admission to a hospital or other covered facility prior to admission. Emergency admissions must be reported within two business days following the day of admission even if you have been discharged. Otherwise, the benefits payable will be reduced by $500. • Outpatient treatment beyond 10 visits per person, per calendar year, and day or aftercare treatment (partial hospitalization). If preauthorization is not obtained, benefits will be reduced to 80% of the benefit otherwise payable. Note: To obtain preauthorization and to locate a Network provider, call 1-800/999-9849 in the Washington, DC and Baltimore Metropolitan areas. In all other areas, call 1-800/346-6755.
Special transitional benefit	If a mental health or substance abuse professional provider is treating you under our plan as of January 1, 2001, you will be eligible for continued coverage with your provider for up to 90 days under the following condition: • If your mental health or substance abuse professional provider with whom you are currently in treatment leaves the plan at our request for other than cause. If this condition applies to you, we will allow you reasonable time to transfer your care to a network mental health or substance abuse professional provider. During the transitional period, you may continue to see your treating provider and will not pay any more out-of-pocket than you did in the year 2000 for services. This transitional period will begin with our notice to you of the change in coverage and will end 90 days after you receive our notice. If we write to you before October 1, 2000, the 90-day period ends before January 1 and this transitional benefit does not apply.
Network limitation	If you do not obtain and follow an approved treatment plan, we will provide only Out-of-Network benefits.

Out-of-Network benefits	You pay
We will cover the office visit fee for therapy sessions rendered by providers such as psychiatrists, psychologists, or clinical social workers. Therapy sessions include: • Office visits, group therapy, and collateral visits with members of the patient's immediate family Limited benefits: • $100 per visit and 50 visits per person per calendar year – including visits you paid for while satisfying the mental health and substance abuse calendar year deductible. Other outpatient care includes: • Convulsive therapy visits, and • Day or after care (partial hospitalization) in a hospital Note: Almost all benefits for the treatment of mental health and substance abuse require precertification, see page 42. During the precertification process, we may establish an approved treatment plan.	50% of the Plan allowance and any difference between our allowance and the billed amount Note: You pay any charges above the Plan's limits.
Covered inpatient hospital and rehabilitation facility charges include: • Room and board including general nursing care, in semiprivate accommodations • Other charges for hospital services and supplies (other than professional services) including but not limited to the use of operating, treatment and recovery rooms; X-rays; surgical dressings; and drugs and medicines Limited benefits: Confinement in a rehabilitation facility is limited to 1) a maximum of 30 days per confinement and 2) two confinements per person per lifetime. Note: Precertification is required for an inpatient confinement, see page 42.	$200 per confinement copayment plus 30% of the Plan allowance and any difference between our allowance and the billed amount (no deductible) Note: You pay any charges above the Plan's limits
• Services of a doctor for inpatient hospital visits	30% of the Plan allowance and any difference between our allowance and the billed amount
Not covered out-of-network: • *The same exclusions contained in this brochure that apply to other benefits apply to mental health and substance abuse benefits. OPM's review of disputes about out-of-network treatment plans will be based on the treatment plan's clinical appropriateness. OPM will generally not order one clinically appropriate treatment plan in favor of another.* • *Marital counseling* • *Treatment for learning disabilities*	*All charges*

Out-of-Network benefits – Continued on next page

Out-of-Network benefits *(continued)*	
Lifetime maximum	Out-of-Network inpatient care for the treatment of alcoholism and drug abuse is limited to two treatment programs (30-day each maximum) per lifetime.
Precertification	To be eligible to receive mental health and substance abuse benefits you must follow your treatment plan and all of our authorization processes. These include obtaining Plan certification for: • The medical necessity of your admission to a hospital or other covered facility prior to admission. Emergency admissions must be reported within two business days following the day of admission even if you have been discharged. Otherwise, the benefits payable will be reduced by $500. See Section 3 for details. • Outpatient treatment beyond 10 visits per person, per calendar year and day or aftercare treatment (partial hospitalization). If preauthorization is not obtained, benefits will be reduced to 80% of the benefit otherwise payable. To obtain preauthorization, call 1-800/999-9849 toll-free in the Washington, DC and Baltimore Metropolitan areas. In all other areas call 1-800/346-6755 toll-free.

See these sections of the brochure for more valuable information about these benefits:

- Section 3, *How you get care*, for information about catastrophic protection for these benefits.
- Section 7, *Filing a claim for covered services*, for information about submitting out-of-network claims.

Section 5 (f). Prescription drug benefits

IMPORTANT

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

- We cover prescribed drugs and medications, as described in the chart beginning on the next page.
- All benefits are subject to the definitions, limitations and exclusions in this brochure and are payable only when we determine they are medically necessary.
- The calendar year deductible is: $300 per person ($600 per family). The calendar year deductible applies to almost all benefits in this Section. We added "No deductible" to show when the calendar year deductible does not apply.
- Be sure to read Section 4, *Your costs for covered services* for valuable information about how cost sharing works, with special sections for members who are age 65 or over. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

IMPORTANT

- **Who can write your prescription.** A licensed physician must write the prescription
- **Where you can obtain them.** You may fill the prescription at a participating network pharmacy, a non-network pharmacy, or by mail. – To receive the Plan's maximum benefit, you must fill the prescription at a plan pharmacy, or by mail for a maintenance medication.
- **We use a formulary.** Our prescription drug program includes a "formulary" feature. A formulary is a list of commonly prescribed FDA approved medications that have been selected based on their effectiveness and cost savings. By asking your doctor to prescribe a formulary medication(s), you can help control rising costs while maintaining high-quality care. Use of a formulary drug is voluntary; there is no financial penalty if your physician does not prescribe a formulary drug.
- **These are the dispensing limitations.**

  •• You may purchase up to a 30-day supply of covered drugs or supplies through a Pequot Pharmaceutical Network (PRxN®)/PCS Health Systems, Inc. (PCS) pharmacy participating in the SAMBA program. Call toll-free 1-888/779-6638 to locate a Plan network pharmacy in your area. For each prescription drug, supply or refill purchased at the pharmacy there is a copayment of $15 generic, $20 name brand single source (no generic substitute) and $25 multisource name brand.

  •• You may purchase up to a 90-day supply of covered drugs or supplies through the mail order program. You order your prescription or refill by mail from the Pequot Pharmaceutical Network (PRxN). PRxN will fill your prescription. For each prescription drug, supply or refill purchased at the pharmacy there is a copayment of $15 generic, $20 name brand single source (no generic substitute) and $25 multisource name brand.

  Note: If your physician prescribes a medication that will be taken over an extended period of time, you should request two prescriptions – one to be used for the participating pharmacy and the other for the mail order program. You may obtain up to a 30-day supply right away through the prescription card program, and up to a 90-day supply from the mail order program.

Prescription drug benefits – Continued on next page

- **To claim benefits.**

  •• From a pharmacy – When you purchase medication from a network pharmacy use your SAMBA Health Insurance Identification Card, which serves as a PRxN/PCS Prescription Identification Card. In most cases, you simply present the card, together with the prescription, to the pharmacist; the claim is automatically filed through the PRxN/PCS system.

  If you do not use your identification card when purchasing your medication, or you use a non-network pharmacy, you must complete a direct reimbursement claim form to claim benefits. You may obtain these forms by calling PRxN toll-free at 1-888/779-6638. Service is available Monday through Friday 8:00 a.m. to 12:00 midnight, eastern time. Follow the instructions on the form and mail it to:

  Pequot Pharmaceutical Network
  Pharmacy Management Services
  P. O. Box 3560
  Mashantucket, CT 06339-3560

  Note: Reimbursement will be limited to SAMBA's cost had you used a participating pharmacy minus the copayments described above.

  •• By mail – The Plan will send you information on the PRxN Mail Service Program. To use the Program:

  1. ask your doctor to give you a new prescription for up to a 90-day supply of your regular medication plus refills, if appropriate;
  2. complete the patient profile questionnaire the first time you order under the program; and
  3. complete a mail order envelope, enclose your prescriptions, and mail them along with the required copayment - $15 generic, $20 name brand single source (no generic equivalent) and $25 multisource name brand – for each prescription or refill to:

  Pequot Pharmaceutical Network
  P. O. Box 49
  Ledyard, CT 06339-9987

  You must pay your share of the cost by check, money order, VISA, or MasterCard (complete the space provided on the order envelope to use your charge card).

  You will receive forms for refills and future prescription orders each time you receive drugs or supplies under the Program. In the meantime, if you have any questions about a particular drug or a prescription, and to request your first order forms, you may call 1-877/99SAMBA (1-877/997-2622) toll-free. Customer service is available Monday through Friday, 8:00 a.m. to 5:30 p.m. or Saturday, from 8:00 a.m. to 12:00 p.m., eastern time.

  Note: As at your local pharmacy, if you request a name brand prescription but your doctor has not required it, PRxN Services will charge you the difference in price between the name brand drug and its generic equivalent, and bill you for any balance due. This will be included with the delivery of your filled prescription.

Prescription drug benefits – Continued on next page

Section 5 (f). Prescription drug benefits *(continued)*

- **Coordinating with other drug coverage.**

  If you have prescription drug coverage through another insurance carrier, and SAMBA is secondary, follow the procedures outlined below.

  When another insurance carrier is primary you should use that carrier's prescription drug benefits.

  However, if you elect to use the mail order pharmacy, PRxN Services will bill you directly for the full discounted cost of the covered medication. Pay PRxN Services the amount billed and submit the bill to your primary insurance carrier. After their consideration submit the claim and the explanation of benefits (EOB) directly to the SAMBA office.

  Should you elect to use a retail pharmacy, pay the full cost of the covered medication (do not show your SAMBA Health Insurance Identification Card). Submit the bill to your primary insurance carrier. After their consideration, submit the claim and the explanation of benefits (EOB) directly to the SAMBA office.

Prescription drug benefits – Continued on next page

Benefit Description	You pay After the calendar year deductible…
NOTE: The calendar year deductible applies to almost all benefits in this Section. We say "No deductible" when it does not apply.	
Covered medications and supplies	
Each enrollee will receive a description of our prescription drug program, a combined prescription drug/Plan identification card, a mail order form/patient profile and a preaddressed reply envelope. Your SAMBA Health Insurance Identification Card serves as your drug program identification card. You may purchase the following medications and supplies prescribed by a physician from either a pharmacy or by mail: • Drugs that by Federal law of the United States require a doctor's written prescription for purchase • Insulin • Needles and syringes for the administration of covered medications, such as insulin • Contraceptive drugs and devices Here are some things to keep in mind about our prescription drug program: • 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. 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. For information about the formulary or to order a prescription drug brochure, call 1-877/997-2622.	• Network Retail: $15 generic/$20 name brand single source (no generic substitute)/$25 multisource name brand copayment (no deductible) • Non-Network Retail: $15 generic/ $20 name brand single source (no generic)/$25 multisource name brand copayment, plus the difference in cost had you used a participating pharmacy (no deductible) • Network Mail Order: $15 generic/ $20 name brand single source (no generic substitute)/$25 multisource name brand copayment (no deductible) Note: Medicare enrollees pay the same prescription drug copayments as listed above.
Not covered: • *Drugs and supplies for cosmetic purposes, e.g., Retin A, Minoxidil, Rogaine* • *Nutritional supplements and vitamins (except injectable B-12)* • *Nonprescription medicines (over-the-counter medication)* • *The difference in cost between the name brand drug and the generic substitute, if requested by you but not required by your doctor, when a generic equivalent is available.* • *Drugs for sexual dysfunction, e.g., Viagra, Muse, Caverject, etc.* *Note: Drugs to aid in smoking cessation are covered only under Educational classes and programs (Section 5(a)).*	*All Charges*

Section 5 (g). Special features

Special features	Description
Flexible benefits option	Under the flexible benefits option, we determine the most effective way to provide services. • 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. • Our decision to offer or withdraw alternative benefits is not subject to OPM review under the disputed claims process.
Managed Care Advisor (MCA) Program	Enrollees in the First Health service area lacking Network access may join the Plan's Managed Care Advisor (MCA) Program offered through First Health Group Corp. To determine eligibility and to join the MCA Program, call 1-800/346-6755 and speak with a Referral Management Coordinator. The coordinator will help you select a primary care physician who will manage all of your medical needs. If your primary care physician recommends specialty care, you or your provider must contact a First Health Referral Management Coordinator at 1-800/346-6755 for a referral. Enrollees who join and comply with the requirements of the MCA Program will receive the Plan's enhanced PPO benefits (subject to the Plan's definitions, limitations, and exclusions).
Worldwide Assistance Program	SAMBA has contracted with Worldwide Assistance Services, Inc. to provide medical assistance, medical evacuation and other covered services to our members and their eligible family members through the Worldwide Assistance Program. Each enrollee will receive a separate brochure describing this program. Note: Services provided under this benefit through Worldwide Assistance are not subject to the FEHB disputed claims process.
24-hour nurse line	Enrollees in the First Health service area (see page 7) may access Health Resource Line by calling First Health Group Corp. at 1-800/346-6755. Health Resource Line is a 24-hour, seven-day-a-week nurse advisor line that answers general medical questions, provides educational materials, assists you in making health care decisions, and assists in locating Network providers.
Services for deaf and hearing impaired	SAMBA has a TDD line for the hearing-impaired: 301/984-4155 (TDD equipment is needed).

Special features – Continued on next page

Special features	Description
High risk pregnancies	The precertification program will provide maternity patients and their attending doctors with information that will assist in effective management of prenatal care. This service includes monitoring of prenatal care by a nurse, identifying potential risk factors and providing literature about important prenatal topics. To obtain this service, call the precertification number for your area when your pregnancy is confirmed. (This portion of the program is not available to maternity patients in the CareFirst Service Area.)
National Transplant Program and Centers of Excellence for organ/tissue transplants	The First Health National Transplant Program and the CareFirst Centers of Excellence are available to patients for the treatment of organ/tissue transplants. See page 30, Section 5(b).
Travel benefit/services overseas	For covered services rendered by a hospital or by a doctor outside the United States and Puerto Rico, the Plan will pay eligible charges at PPO benefit levels, limited to the Plan's allowance established for the Washington, DC Metropolitan area. The member is responsible for the difference between the Plan's allowance and the provider's charge. See page 54, Section 7 *Filing a claim for covered services.*

Section 5 (h). Dental benefits

IMPORTANT

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.
- The calendar year deductible is: $300 per person ($600 per family). The calendar year deductible applies to almost all benefits in this Section. We added "(No deductible)" to show when the calendar year deductible does not apply. In addition to the calendar year deductible, there is a $100 per accident deductible, which applies to dental accidental injury benefits.
- Be sure to read Section 4, *Your costs for covered services* for valuable information about how cost sharing works, with special sections for members who are age 65 or over. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- Note: We cover hospitalization for dental procedures only when a non-dental physical impairment exists which makes hospitalization necessary to safeguard the health of the patient. We do not cover the dental procedure.

IMPORTANT

Benefit Description	You pay
Accidental injury benefit	
We cover surgical and dental treatment of accidental injury to repair sound natural teeth. Treatment must be rendered within 24 months of the accident. Definition: A sound, natural tooth is a tooth that is whole or properly restored and is without impairment, periodontal or other conditions and is not in need of the treatment provided for any reason other than an accidental injury. Note: An injury to the teeth while chewing and/or eating is not considered to be an accidental injury.	PPO: $100 per accident deductible and 10% of the Plan allowance Non-PPO: $100 per accident deductible and 25% of the Plan allowance and any difference between our allowance and the billed amount
Dental benefits	
Orthodontic treatment • We cover charges of an orthodontist for treatment after surgery for closure of a cleft palate or cleft lip, or for correction of prognathism or micrognathism. Lifetime benefits per person are: • Cleft palate or cleft palate with cleft lip limited to $2,500 • Cleft lip, prognathism or micrognathism limited to $1,000	PPO: 10% of the Plan allowance Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount Note: You pay charges above the Plan's limit.

Dental benefits – Continued on next page

Dental benefits *(continued)*	**You pay**
Dental prosthetic appliances • We will pay covered charges for dental prosthetic appliances to treat conditions due to a congenital anomaly or defect up to a maximum lifetime benefit of $3,000 per person.	PPO: 10% of the Plan allowance Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount Note: You pay charges above the Plan's limit.
Not covered: Dental appliances, study models, splints and other devices or services associated with the treatment of temporomandibular joint (TMJ) dysfunction.	*All charges*

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

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

Terrorism Coverage

SAMBA provides all its members, without charge, a $100,000 accident policy payable upon death caused by an act of terrorism within the United States and $50,000 if overseas.

SAMBA Supplemental Insurance Plans

Below is a brief description of supplemental insurance plans available through SAMBA Plan provisions, certain exclusions, eligibility requirements and underwriting guidelines apply for each plan. For more details, contact SAMBA.

Group Term Life

Group Term Life Insurance is available for all active SAMBA members, their spouses, and dependent children. The basic Plan for members is based upon the member's GS classification. Premiums are based strictly on the member's grade classification rather than age. The benefit doubles in the event of a covered accidental death plus an additional 50% of the original amount if the member is killed in the line of duty.

Supplementary Group Term Life

SAMBA offers up to $240,000 of additional protection at attractive group rates to members and spouses enrolled in the basic Group Term Life Plan.

Disability Income Protection

For active members, the Disability Income Protection Plan, specially designed to fill in the gaps that exist in both the CSRS and FERS, provides the following four types of coverage:

Hospital Income Protection for each covered day hospitalized up to 60 days. The member or spouse will receive 70% of the member's insured daily earnings, 35% of the members insured daily earnings is paid for dependent children.

Long-Term Disability for members becoming totally disabled and unable to work for more than 60 days. The Plan will pay up to 65% of the insured monthly salary until age 62 (if covered under FERS) or age 65 (if covered under CSRS), in combination with any disability awards from certain other sources.

Pension Supplement offers a unique benefit that replaces the pension credits lost because of disability. This benefit credit is equal to 2% of the insured salary for each year disabled.

Survivor's Benefit in the event of the member's death while receiving disability benefits, the beneficiary will receive a payment for a minimum of 15 years or age 65 (unless spouse remarries) whichever is later. This benefit is equal to 60% of the member's adjusted disability payment under the plan.

Personal Accident Insurance

The Personal Accident Insurance Plan allows members the opportunity to increase their protection for covered accidents up to $250,000 at low group rates. Coverage is also available for family members.

Long Term Care

Is a program to provide long term care coverage for members, spouses, parents, and parents-in-law. Benefits are payable for nursing homes, home health care, adult day care, and respite care.

Professional Liability and Legal Services

SAMBA offers its members a comprehensive Professional Liability Plan and a Personal Legal Services Plan giving the member instant access to experienced legal counsel throughout the United States.

Dental/Vision

SAMBA offers a very comprehensive Dental/Vision Care Plan.

Dependent Children Health Benefit Plan

For unmarried, wholly dependent children from age 22 to age 27, SAMBA offers its members the same health coverage for their dependent children that the children enjoyed before they reached age 22 and became ineligible for coverage under the FEHB Program.

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 we determine it is medically necessary to prevent, diagnose, or treat your illness, disease, injury, or condition.** The fact that one of our covered providers has prescribed, recommended, or approved a service or supply does not make it medically necessary or eligible for coverage under this Plan.

We do not cover the following:

- 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 in the United States;
- 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;
- Procedures, services, drugs, and supplies related to sex transformations, sexual dysfunction or sexual inadequacy;
- Services, drugs, or supplies you receive from a provider or facility barred from the FEHB Program;
- Services when no charge would be made if the covered individual had no health insurance coverage;
- Services furnished without charge (except as described on page 62); while in active military service; or required for illness or injury sustained on or after the effective date of enrollment (1) as a result of an act of war within the United States, its territories, or possessions or (2) during combat;
- Services and supplies furnished by immediate relatives or household members, such as your parents, your spouse, and your own and your spouse's children, brothers and sisters by blood, marriage or adoption;
- Noncovered facilities, except that medically necessary prescription drugs are covered;
- Services and supplies not specifically listed as covered;
- Any portion of a provider's fee or charge ordinarily due from the enrollee but that has been waived. If a provider routinely waives (does not require the enrollee to pay) a deductible, copayment or coinsurance, the Carrier will calculate the actual provider fee or charge by reducing the fee or charge by the amount waived;
- Charges the enrollee or Plan has no legal obligation to pay, such as: excess charges for an annuitant age 65 or older who is not covered by Medicare Parts A and/or B (see page 16), doctor charges exceeding the amount specified by the Department of Health and Human Services when benefits are payable under Medicare (limiting charge) (see page 17), or State premium taxes however applied;
- Dental treatment, including X-rays and treatment by a dentist or oral surgeon except to the extent shown on page 49, Section 5(h);
- Dental appliances, study models, splints and other devices or services associated with the treatment of temporomandibular joint (TMJ) dysfunction;
- Eyeglasses or hearing aids, or examinations for them, except as shown in Section 5(a);
- Treatment of learning disabilities;
- Marital counseling;
- Practitioners who do not meet the definition of covered provider on page 8, Section 3;
- Charges for services and supplies that exceed the Plan allowance;
- Services in connection with custodial care as defined on page 64;
- Services in connection with: corns; calluses; toenails; weak, strained, or flat feet; any instability or imbalance of the foot; or any metatarsalgia or bunion, including related orthotic devices, except as listed on page 25, Section 5(a);

General exclusions – things we don't cover *(continued)*

- Services by a massage therapist;
- Services by a naturopathic practitioner;
- Services and supplies for cosmetic purposes, e.g., Retin A, Minoxidil, Rogaine;
- Services and supplies for sexual dysfunction, e.g., Viagra, Muse, Caverject; and
- Fees for medical records not requested by the Plan.

Section 7. Filing a claim for covered services

How to claim benefits

To obtain claim forms or other claims filing advice or answers about our benefits, contact us at 1-800/638-6589 or 301/984-1440 (for TDD, use 301/984-4155), or at our website at www.samba-insurance.com.

In most cases, providers and facilities file claims for you. Your physician 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 1-800/638-6589 or 301/984-1440 (for TDD, use 301/984-4155).

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

- Name of patient and relationship to enrollee;
- Plan identification number of the enrollee;
- Name and address of person or firm providing the service or supply;
- Dates that services or supplies were furnished;
- Diagnosis;
- Type of each service or supply; and
- The charge for each service or supply.

Note: Canceled checks, cash register receipts, or balance due statements are not acceptable substitutes for itemized bills.

In addition:

- You must send a copy of the explanation of benefits (EOB) from any primary payer (such as the Medicare Summary Notice (MSN)) with your claim.
- Bills for private duty nursing must show that the nurse is a registered or licensed practical nurse.
- Claims for rental or purchase of durable medical equipment; private duty nursing; and physical, occupational, and speech therapy require a written statement from the physician specifying the medical necessity for the service or supply and the length of time needed. Rental or purchase of durable medical equipment costing in excess of $1,000 and private duty nursing care must be preauthorized by SAMBA. See page 12, Section 3.

Note: Claims for prescription drugs and supplies are addressed in Section 5(f), page 43.

Records

Keep a separate record of the medical expenses of each covered family member as deductibles and maximum allowances apply separately to each person. Save copies of all medical bills, including those you accumulate to satisfy a deductible. In most instances they will serve as evidence of your claim. We will not provide duplicate or year-end statements.

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. Once we pay benefits, there is a three-year limitation on the reissuance of uncashed checks.

Overseas claims

Claims for overseas (foreign) services should include an English translation. Charges should be converted to U.S. dollars using the exchange rate applicable at the time the expense was incurred. Send itemized bills for covered services provided by hospitals or doctors outside the United States to SAMBA, 11301 Old Georgetown Road, Rockville, MD 20852-2800.

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/prior approval:

Step	Description
1	Ask us in writing to reconsider our initial decision. You must: (a) Write to us within 6 months from the date of our decision; and (b) Send your request to us at: SAMBA, 11301 Old Georgetown Road, Rockville, MD 20852-2800; and (c) Include a statement about why you believe our initial decision was wrong, based on specific benefit provisions in this brochure; and (d) Include copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms.
2	We have 30 days from the date we receive your request to: (a) Pay the claim or approve your request for coverage; or (b) Write to you and maintain our denial -- go to step 4; or (c) Ask you or your provider for more information. If we ask your provider, we will send you a copy of our request—go to step 3.
3	You or your provider must send the information so that we receive it within 60 days of our request. We will then decide within 30 more days. If we do not receive the information within 60 days, we will decide within 30 days of the date the information was due. We will base our decision on the information we already have. We will write to you with our decision.
4	If you do not agree with our decision, you may ask OPM to review it. You must write to OPM within: • 90 days after the date of our letter upholding our initial decision; or • 120 days after you first wrote to us -- if we did not answer that request in some way within 30 days; or • 120 days after we asked for additional information. Write to OPM at: Office of Personnel Management, Office of Insurance Programs, Contracts Division II, P.O. Box 436, Washington, D.C. 20044-0436.

The disputed claims process *(continued)*

Send OPM the following information:

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

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

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

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

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

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

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

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

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

(a) We haven't responded yet to your initial request for care or preauthorization/prior approval, then call us at 1-800/638-6589 or 301/984-1440 (for TDD, use 301/984-4155) and we will expedite our review; or

(b) We denied your initial request for care or preauthorization/prior approval, then:

- If we expedite our review and maintain our denial, we will inform OPM so that they can give your claim expedited treatment too, or
- You can call OPM's Health Benefits Contracts Division II at 202/606-3818 between 8 a.m. and 5 p.m. eastern time.

Section 9. Coordinating benefits with other coverage

When you have other health coverage

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

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

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

When we are the secondary payer, we will determine our allowance. After the primary plan pays, we will pay either what is left of our allowance or up to our regular benefit, whichever is less. We will not pay more than our allowance. The combined payments from both plans may not equal the entire amount billed by the provider.

- **What is Medicare?**

Medicare is a Health Insurance Program for:

•• People 65 years of age and older.

•• Some people with disabilities, under 65 years of age.

•• People with End-Stage Renal Disease (permanent kidney failure requiring dialysis or a transplant).

Medicare has two parts:

•• Part A (Hospital Insurance). Most people do not have to pay for Part A.

•• Part B (Medical Insurance). Most people pay monthly for Part B.

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

- **The Original Medicare Plan**

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

When you are enrolled in this Plan and Original Medicare, you still need to follow the rules in this brochure for us to cover your care.

Claims process -- You probably will never have to file a claim form when you have both our Plan and Medicare. We have contracted with most Medicare Part B claims processors (also known as carriers) to receive electronic copies of your claims after Medicare has paid their benefits.

- When Original Medicare is the primary payer, Medicare processes your claim first. In most cases, your claims will be coordinated automatically and we will pay the balance of covered charges. You will not need to do anything. To find out if you need to do something about filing your claims, call us at 1-800/638-6589 or 301/984-1440 (for TDD, use 301/984-4155) or at our website at www.samba-insurance.com.

- When we are the primary payer, we process the claim first.

We waive some costs when you have Medicare -- When Medicare is the primary payer, we will waive some out-of-pocket costs, as follows:

- If you are enrolled in Medicare Part B, we will waive the deductibles, copayments and coinsurances for:
  - •• Surgery and anesthesia services
  - •• Mental health and substance abuse benefits
  - •• Medical services and supplies provided by physicians and other health care professionals
  - •• Services by a hospital and other facilities and ambulance services
  - •• Dental benefits

Note: The prescription drug copayment is not waived.

- If you are enrolled in Medicare Part A, we will waive the following:
  - •• the $200 per confinement copayment for inpatient hospital confinements
  - •• the coinsurance for inpatient hospital benefits

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

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

- **Medicare managed care plan**

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

This Plan and another Plan's Medicare managed care plan: You may enroll in another plan's Medicare managed care plan and also remain enrolled in our FEHB plan. We will still provide benefits if you receive services from providers who do not participate in the Medicare managed care plan, but we will not waive any of our copayments, coinsurance, or deductibles.

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

- **Private Contract**

A physician may ask you to sign a private contract agreeing that you can be billed directly for service ordinarily covered by Original Medicare. Should you sign an agreement, Medicare will not pay any portion of the charges, and we will not increase our payment. We will still limit our payment to the amount we would have paid after Original Medicare's payment.

- **Enrollment in Medicare Part B**

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

TRICARE

TRICARE is the health care program for eligible dependents of military persons, and retirees of the military. TRICARE includes the CHAMPUS program. If both TRICARE and this Plan cover you, we pay first. See your TRICARE Health Benefits Advisor if you have questions about TRICARE coverage.

Workers' Compensation

We do not cover services that:

- You need because of a workplace-related disease or injury that the Office of Workers' Compensation Programs (OWCP) or a similar Federal or State agency determines they must provide; or

- OWCP or a similar agency pays for through a third party injury settlement or other similar proceeding that is based on a claim you filed under OWCP or similar laws.

Once OWCP or similar agency pays its maximum benefits for your treatment, we will cover your benefits.

Medicaid

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

DVA facilities, DoD facilities and Indian Health Service

Facilities of the Department of Veterans Affairs, the Department of Defense, and the Indian Health Service are entitled to seek reimbursement from the Plan for certain services and supplies provided to you or a family member to the extent that reimbursement is required under the Federal statutes governing such facilities.

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

Liability insurance and third party actions – Subrogation applies when you are sick or injured as a result of the act or omission of another person or party. If damages are payable to you or any member of your family as a result of injury or illness for which a claim is made against a third party, the Plan, where cost effective, will take an assignment of the proceeds of the claim and will assert a lien against such proceeds to reimburse the Plan for the full amount of Plan benefits paid or payable to you or any member of your family. The Plan's lien will apply to any and all recoveries for such claim whether by court order, out-of-court settlement, or otherwise. The Plan will provide the necessary forms and may insist on the assignment before paying any benefits on account of the injury or illness. Failure to notify the Plan promptly of a third party claim for damages on which the Plan has paid or may pay benefits may result in an overpayment by the Plan subject to recoupment. If you need more information about subrogation, the Plan will provide you with its subrogation procedures.

Section 10. Definitions of terms we use in this brochure

Admission

The period from entry (admission) into a hospital or other covered facility until discharge. In counting days of inpatient care, the date of entry and the date of discharge are counted as the same day.

Assignment

An authorization by an enrollee or spouse for us to issue payment of benefits directly to the provider. We reserve the right to pay the member directly for all covered services.

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.

Confinement

An admission (or series of admissions separated by less than 60 days) to a hospital as an inpatient, for which a full day's room and board charge is made, for any one illness or injury. There is a new confinement when an admission is:

1) for a cause entirely unrelated to the cause for the previous admission; or
2) for an enrolled employee who returns to work for at least one day before the next admission; or
3) for a dependent or annuitant when admissions are separated by at least 60 days.

Congenital anomaly

A condition existing at or from birth, which is a significant deviation from the common form or norm. For purposes of this Plan, congenital anomalies include protruding ear deformities, cleft lips, cleft palates, birthmarks, webbed fingers or toes, and other conditions that the Carrier may determine to be congenital anomalies. In no event will the term congenital anomaly include conditions relating to teeth or intra-oral structures supporting the teeth except for the Dental prosthetic appliances benefit and Orthodontic treatment covered under Section 5(h); Dental benefits.

Copayment

A copayment is a fixed amount of money you pay when you receive covered services. See page 13

Coinsurance

Coinsurance is the percentage of our allowance that you must pay for your care. You may also be responsible for additional amounts. See page 13.

Covered services

Services we provide benefits for, as described in this brochure.

Custodial care

Treatment or services, regardless of who recommends them or where they are provided, that could be rendered safely and reasonably by a person not medically skilled, or that are designed mainly to help the patient with daily living activities. These activities include but are not limited to:

1) personal care such as help in: walking; getting in and out of bed; bathing; eating by spoon, tube or gastrostomy; exercising; dressing;
2) homemaking, such as preparing meals or specials diets;
3) moving the patient;
4) acting as companion or sitter;
5) supervising medication that can usually be self administered; or
6) treatment or services that any person may be able to perform with minimal instruction, including but not limited to recording temperature, pulse, and respirations, or administration and monitoring of feeding systems.

The Plan determines which services are custodial care.

Deductible

A deductible is a fixed amount of covered expenses you must incur for certain covered services and supplies before we start paying benefits for those services. See page 13.

Experimental or investigational services

A drug, device, or biological product is experimental or investigational if the drug, device, or biological product cannot be lawfully marketed without approval of the U.S. Food and Drug Administration (FDA) and approval for marketing has not been given at the time it is furnished. Approval means all forms of acceptance by the FDA.

A medical treatment or procedure, or a drug, device, or biological product is experimental or investigation if 1) reliable evidence shows that it is the subject of ongoing phase I, II, or III clinical trials or under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with the standard means of treatment or diagnosis; or 2) reliable evidence shows that the consensus of opinion among experts regarding the drug, device, or biological product or medical treatment or procedure is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with the standard means of treatment or diagnosis.

Reliable evidence shall mean only published reports and articles in the authoritative medical and scientific literature; the written protocol or protocols used by the treating facility or the protocol(s) of another facility studying substantially the same drug, device or medical treatment or procedure; or the written informed consent used by the treating facility or by another facility studying substantially the same drug, device or medical treatment or procedure.

Group health coverage

Health care coverage that a member is eligible for because of employment by, membership in, or connection with, a particular organization or group that provides payment for hospital, medical, or other health care services or supplies, or that pays a specific amount for each day or period of hospitalization if the specified amount exceeds $200 per day, including extension of any of these benefits through COBRA.

Home Health Care Plan

A home health care program, prescribed in writing by a person's doctor, for the care and treatment of the person's illness or injury in the person's home. In the plan, the doctor must certify that an inpatient stay (for which a room and board charge would be made) in a hospital, convalescent nursing home or skilled nursing facility would be required by that person if there were no home health care. The home health care plan must be established in writing no later than 14 days after the start of the home health care. After each sixty days the written plan must be renewed.

Medical necessity

Services, drugs, supplies or equipment provided by a hospital or covered provider of health care services that we determine:

1) are appropriate to diagnose or treat the patient's condition, illness or injury;
2) are consistent with standards of good medical practice in the United States;
3) are not primarily for the personal comfort or convenience of the patient, the family, or the provider;
4) are not a part of or associated with the scholastic education or vocational training of the patient; and
5) in the case of inpatient care, cannot be provided safely on an outpatient basis.

The fact that a covered provider has prescribed, recommended, or approved a service, supply, drug or equipment does not, in itself, make it medically necessary.

Plan allowance

Our Plan allowance is the amount we use to determine our payment and your coinsurance for covered services. Fee-for-service plans determine their allowances in different ways. We determine our allowance as follows:

- PPO benefits: For services rendered by a covered provider who participates in the Plan's PPO network, our allowance is based on a negotiated rate agreed to under the providers' network agreement.

  Note: You will not be responsible for any amount above the provider's negotiated rate; PPO providers accept the Plan's allowance as payment in full.

- Non-PPO benefits: When you do not use a PPO provider to perform the service or provide the supply, there are two methods we use to determine the Plan allowance; 1) the Plan uses the 75^{th} percentile factor of claims data and fee information gathered for specific geographic areas by Medical Data Research (MDR) or 2) in geographic areas where access to a PPO provider was available but the patient did not use a PPO provider, our allowance is based on the average PPO negotiated rate for that region.

Note: We will not consider any fee charged above the Plan's allowance. You will be responsible for the difference between our allowance and the bill.

For more information, see *Differences between our allowance and the bill* in Section 4.

Us/We

Us and we refer to SAMBA.

You

You refers to the enrollee and each covered family member.

Section 11. FEHB facts

No pre-existing condition limitation

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

Where you can get information about enrolling in the FEHB Program

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

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

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

Types of coverage available for you and your family

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

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

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

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

When benefits and premiums start

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

Your medical and claims records are confidential

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

- OPM, this Plan, and subcontractors when they administer this contract;
- This Plan, and appropriate third parties, such as other insurance plans and the Office of Workers' Compensation Programs (OWCP), when coordinating benefit payments and subrogating claims;
- Law enforcement officials when investigating and/or prosecuting alleged civil or criminal actions;
- OPM and the General Accounting Office when conducting audits;
- Individuals involved in bona fide medical research or education that does not disclose your identity;
- OPM, when reviewing a disputed claim or defending litigation about a claim.;
- As part of its administration of the prescription drug benefits, the Plan may disclose information about a member's prescription drug utilization, including the names of prescribing physicians, to any treating physicians or dispensing pharmacies.

When you retire

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

When you lose benefits

• When FEHB coverage ends

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

•• Your enrollment ends, unless you cancel your enrollment, or

•• You are a family member no longer eligible for coverage.

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

• Spouse equity coverage

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

• TCC

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

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

Get the RI 79-27, which describes TCC, and the RI 70-5, the *Guide to Federal Employees Health Benefits Plans for Temporary Continuation of Coverage and Former Spouse Enrollees*, from your employing or retirement office or from www.opm.gov/insure.

• Converting to individual coverage

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

•• Your coverage under TCC or the spouse equity law ends. If you canceled your coverage or did not pay your premium, you cannot convert;

•• You decided not to receive coverage under TCC or the spouse equity law; or

•• You are not eligible for coverage under TCC or the spouse equity law.

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

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

Getting a Certificate of Group Health Plan Coverage

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

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

Inspector General Advisory

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

- Call the provider and ask for an explanation. There may be an error.
- If the provider does not resolve the matter, call us at 1-800/638-6589 or 301/984-1440 (for TDD, use 301/984-4155) and explain the situation.
- If we do not resolve the issue, call **THE HEALTH CARE FRAUD HOTLINE--202/418-3300** or write to: The United States Office of Personnel Management, Office of the Inspector General Fraud Hotline, 1900 E Street, NW, Room 6400, Washington, DC 20415.

• Penalties for Fraud

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

Index

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

Notes

Summary of benefits for the SAMBA Health Benefit Plan - 2001

- **Do not rely on this chart alone.** All benefits 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.
- Below, an asterisk (*) means the item is subject to the $300 calendar year deductible. And, after we pay, you generally pay any difference between our allowance and the billed amount if you use a Non-PPO physician or other health care professional.

Benefits	You Pay	Page
Medical services provided by physicians:	PPO: $15 copayment per office visit	
• Diagnostic and treatment services provided in the office	Non-PPO: 30%* of the Plan allowance	19
Services provided by a hospital:		
• Inpatient.....	PPO: $200 copayment per confinement, nothing for room & board and 10% for other hospital services Non-PPO: $200 copayment per confinement and 30% of the Plan allowance	33
• Outpatient	PPO: $100 per facility charge and 10%* of the Plan allowance Non-PPO: $100 per facility charge and 30%* of the Plan allowance	34
Emergency benefits:		
• Accidental injury	Nothing within 72 hours	37
• Medical emergency.....	Regular benefits	37
Mental health and substance abuse treatment	In-Network: Regular cost sharing. Out-of-Network: Benefits are limited.	38 41
Prescription drugs	$15 generic, $20 name brand single source (no generic substitute) or $25 name brand copayment	43
Dental Care	PPO: 10%* of the Plan allowance (dental accident; $100 deductible and 10%) Non-PPO: 30%* of the Plan allowance (dental accident; $100 deductible and 25%)	49
Special features: Flexible benefits option; Managed care Advisor (MCA) Program; Worldwide Assistance Program; 24-hour nurse line; Services for deaf and hearing impaired; High risk pregnancies; National Transplant and Centers of Excellence for organ/tissue transplants; Travel benefit/services overseas		47
Protection against catastrophic costs (your out-of-pocket maximum).....	Nothing after $2,500/Self Only or $3,500/Family enrollment per year Some costs do not count toward this protection	15

2001 Rate Information for
SAMBA Health Benefit Plan

FEHB Benefits of the Plan are described in this brochure.

The 2001 rates for this Plan follow. If you are in a special enrollment category, refer to an FEHB Guide or contact the agency that maintains your health benefits enrollment.

		Biweekly Premium		Monthly Premium	
Type of Enrollment	Code	Gov't Share	Your Share	Gov't Share	Your Share
Self Only	441	$86.59	$56.74	$187.61	$122.94
Self and Family	442	$195.82	$141.72	$424.28	$307.06