SAMBA
Health Benefit Plan

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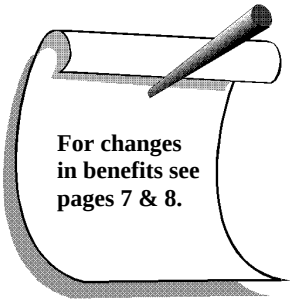
http://www.SambaPlans.com

2006

A fee-for-service plan (high and standard option) with a preferred provider organization



Sponsored and administered by: the Special Agents Mutual Benefit Association

Who may enroll in this Plan: Active and retired employees of all components of the United States Department of Justice (DOJ) including the Federal Bureau of Investigation (FBI), the Drug Enforcement Administration (DEA), the Bureau of Alcohol, Tobacco, Firearms, and Explosives (ATFE), the Federal Bureau of Prisons (BOP), and the United States Marshals Service (USMS); all divisions and agencies of the Department of Homeland Security (DHS) including the United States Secret Service (USSS) and the Transportation Security Administration (TSA); all offices of the Inspectors General (IGs); the Naval Criminal Investigative Service (NCIS); the Criminal Investigation Division of the Internal Revenue Service (IRS); Civilian Employees of the Office of Special Investigations of the Department of the Air Force (OSI); the Financial Crimes Enforcement Network (FinCEN); the Odometer Fraud Unit of the National Highway Traffic Safety Administration (NHTSA); the Office of Criminal Enforcement, Forensics and Training (OCEFT) of the Environmental Protection Agency (EPA); the Office of Criminal Investigations of the Food and Drug Administration (OCI); the Bureau of Industry and Security of the United States Department of Commerce (BIS); the United States Postal Inspection Service; and civilian employees of the United States Army Criminal Investigation Command (USACIDC). You must also be eligible to enroll in the Federal Employees Health Benefit Program (FEHB).

Membership dues: There are no membership dues.

Enrollment codes for this Plan:

- **441 High Option – Self Only**
- **442 High Option – Self and Family**
- **444 Standard Option – Self Only**
- **445 Standard Option – Self and Family**

URAC ACCREDITED HEALTH UTILIZATION MANAGEMENT

URAC ACCREDITED CASE MANAGEMENT

ENCOMPASS Health Management Systems is URAC accredited for Health Utilization Management (since 1992) and Case Management (since 1999). See the 2006 Guide for more information on accreditation.

FEHB Federal Employees Health Benefits Program

Authorized for distribution by the:

United States
Office of Personnel Management

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

RI 72-006

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

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

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

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

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

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

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

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

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

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

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

- See and get a copy of your personal medical information held by OPM.
- Amend any of your personal medical information created by OPM if you believe that it is wrong or if information is missing, and OPM agrees. If OPM disagrees, you may have a statement of your disagreement added to your personal medical information.
- Get a listing of those getting your personal medical information from OPM in the past 6 years. The listing will not cover your personal medical information that was given to you or your personal representative, any information that you authorized OPM to release, or that was given out for law enforcement purposes or to pay for your health care or a disputed claim.
- Ask OPM to communicate with you in a different manner or at a different place (for example, by sending materials to a P.O. Box instead of your home address).
- Ask OPM to limit how your personal medical information is used or given out. However, OPM may not be able to agree to your request if the information is used to conduct operations in the manner described above.
- Get a separate paper copy of this notice.

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

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

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

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

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

Important Notice from SAMBA About Our Prescription Drug Coverage and Medicare

OPM has determined that the SAMBA Health Benefit Plan prescription drug coverage is, on average, comparable to Medicare Part D prescription drug coverage; thus you do not need to enroll in Medicare Part D and pay extra for prescription drug benefits. If you decide to enroll in Medicare Part D later, you will not have to pay a penalty for late enrollment as long as you keep your FEHB coverage.

However, if you choose to enroll in Medicare Part D, you can keep your FEHB coverage and SAMBA will coordinate benefits with Medicare.

Remember: If you are an annuitant and you terminate your FEHB coverage, you may not re-enroll in the FEHB Program.

Please be advised

If you lose or drop your FEHB coverage, you will have to pay a higher Part D premium if you go without equivalent prescription drug coverage for a period of 63 days or longer. If you enroll in Medicare Part D at a later date, your premium will increase 1 percent per month for each month you did not have equivalent prescription drug coverage. For example, if you go 19 months without Medicare Part D prescription drug coverage, your premium will always be at least 19 percent higher than what most other people pay. You may also have to wait until the next open enrollment period to enroll in Medicare Part D.

Medicare's Low Income Benefits

For people with limited income and resources, extra help paying for a Medicare prescription drug plan is available. Information regarding this program is available through the Social Security Administration (SSA) online at www.socialsecurity.gov, or call the SSA at 1-800-772-1213 (TTY 1-800-325-0778).

You can get more information about Medicare prescription drug plans and the coverage offered in your area from these places:

- Visit www.medicare.gov for personalized help,
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

Table of Contents

Introduction

This brochure describes the benefits of the SAMBA Health Benefit Plan under our contract (CS 1074) with the United States Office of Personnel Management, as authorized by the Federal Employees Health Benefits law. The address for the SAMBA Health Benefit Plan administrative offices is:

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

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

If you are enrolled in this Plan, you are entitled to the benefits described in this brochure. If you are enrolled in Self and Family coverage, each eligible family member is also entitled to these benefits. You do not have a right to benefits that were available before January 1, 2006, unless those benefits are also shown in this brochure.

OPM negotiates benefits and rates with each plan annually. Benefit changes are effective January 1, 2006, and changes are summarized on pages 7 and 8. Rates are shown at the end of this brochure.

Plain Language

All FEHB brochures are written in plain language to make them responsive, accessible, and understandable to the public. For instance,

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

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

Stop Health Care Fraud!

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

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

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

- Be wary of giving your plan identification (ID) number over the telephone or to people you do not know, except to your doctor, other provider, or authorized plan or OPM representative.
- Let only the appropriate medical professionals review your medical record or recommend services.
- Avoid using health care providers who say that an item or service is not usually covered, but they know how to bill us to get it paid.
- Carefully review explanations of benefits (EOBs) that you receive from us.
- Do not ask your doctor to make false entries on certificates, bills or records in order to get us to pay for an item or service.
- If you suspect that a provider has charged you for services you did not receive, billed you twice for the same service, or misrepresented any information, do the following:

  Call the provider and ask for an explanation. There may be an error.

If the provider does not resolve the matter, call us at 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:
United States Office of Personnel Management
Office of the Inspector General Fraud Hotline
1900 E Street NW Room 6400
Washington, DC 20415-1100

- Do not maintain as a family member on your policy:

  Your former spouse after a divorce decree or annulment is final (even if a court order stipulates otherwise); or

  Your child over age 22 (unless he/she is disabled and incapable of self support).

- If you have any questions about the eligibility of a dependent, check with your personnel office if you are employed, with your retirement office (such as OPM) if you are retired, or with the National Finance Center if you are enrolled under Temporary Continuation of Coverage.

- You can be prosecuted for fraud and your agency may take action against you if you falsify a claim to obtain FEHB benefits or try to obtain services for someone who is not an eligible family member or who is no longer enrolled in the Plan.

Preventing medical mistakes

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

1. **Ask questions if you have doubts or concerns.**
   - Ask questions and make sure you understand the answers.
   - Choose a doctor with whom you feel comfortable talking.
   - Take a relative or friend with you to help you ask questions and understand answers.
2. **Keep and bring a list of all the medicines you take.**
   - Bring the actual medicines or give your doctor and pharmacist a list of all the medicines that you take, including non-prescription (over-the-counter) medicines.
   - Tell them about any drug allergies you have.
   - Ask about any risks or side effects of the medication and what to avoid while taking the medicine. Be sure to write down what your doctor or pharmacist says.
   - Make sure your medicine is what the doctor ordered. Ask the pharmacist about your medicine if it looks different than you expected.
   - Read the label and patient package insert when you get your medicine, including all warnings and instructions.
   - Know how to use your medicine. Especially note the times and conditions when your medicine should and should not be taken.

3. **Get the results of any test or procedure.**
   - Ask when and how you will get the results of tests or procedures.
   - Don't assume the results are fine if you do not get them when expected, be it in person, by phone, or by mail.
   - Call your doctor and ask for your results.
   - Ask what the results mean for your care.
4. **Talk to your doctor about which hospital is best for your health needs.**
   - Ask your doctor about which hospital has the best care and results for your condition if you have more than one hospital to choose from to get the health care you need.
   - Be sure you understand the instructions you get about follow-up care when you leave the hospital.
5. **Make sure you understand what will happen if you need surgery.**
   - Make sure you, your doctor, and your surgeon all agree on exactly what will be done during the operation.
   - Ask your doctor, "Who will manage my care when I am in the hospital?"
   - Ask your surgeon:

     Exactly what will you be doing?

     About how long will it take?

     What will happen after surgery?

     How can I expect to feel during recovery?
   - Tell the surgeon, anesthesiologist, and nurses about any allergies, bad reaction to anesthesia, and any medications you are taking.

Want more information on patient safety?

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

Section 1. Facts about this 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 give you a choice of enrollment in a High Option or a Standard Option.

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.

General features of our High and Standard Options

We have a Preferred Provider Organization (PPO)

Our fee-for-service plan offers services through PPO networks. When you use our network providers, you will receive covered services at reduced cost. SAMBA is solely responsible for the selection of PPO networks in your area. Contact us for the names of PPO providers. You can also go to our Web page, which you can reach through the FEHB Web site, www.opm.gov/insure. Contact SAMBA at 1-800/638-6589 or 301/984-1440 (for TDD, use 301/984-4155) to request a PPO directory.

We have entered into arrangements with CareFirst BlueCross BlueShield (CareFirst), Beech Street and CCN to offer PPO providers in all states. The doctors and hospitals participating in these networks have agreed to provide services to Plan members. You always have the right to choose a PPO provider or a non-PPO provider for medical treatment.

The non-PPO benefits are the regular benefits of this Plan. PPO benefits apply only when you use a PPO provider. 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. Provider networks may be more extensive in some areas than others. We cannot guarantee the availability of every specialty in all areas and continued participation of any specific provider cannot be guaranteed. If no PPO provider is available, or you do not use a PPO provider, the regular non-PPO benefits apply. You cannot change plans because of changes to the provider network.

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. When you use a non-PPO provider to perform the service or provide the supply, covered expenses will be considered at the 75th percentile factor of claims data and fee information gathered for specific geographic areas by Medical Data Research (MDR) and payable at the Plan's out-of-network (non-PPO) benefits. You are responsible for amounts over the Plan's 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.

Your Rights

OPM requires that all FEHB Plans provide certain information to their FEHB members. You may get information about us, our networks, providers, and facilities. OPM's FEHB Web site (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 Web site at www.SambaPlans.com.

Section 2. How we change for 2006

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

Program-wide changes

- In Section 3 under Covered providers, Arizona and West Virginia are designated as medically underserved areas in 2006. Texas is no longer designated as a medically underserved area in 2006.

Changes to both our High and Standard Options

- The Plan has contracted with CareFirst BlueCross BlueShield (CareFirst), Beech Street and CCN to offer PPO networks for our entire membership based on their geographic area. (See page 6.) Previously, Blue Cross and Blue Shield was the Plan's nationwide PPO network.
- The Plan has contracted with ENCOMPASS Health Management Systems (ENCOMPASS) to provide preauthorization and case management services. (See page 11.) Previously, these services were performed nationally by Blue Cross and Blue Shield.
- Rental or purchase of covered durable medical equipment (DME) no longer requires a preauthorization.
- The 20% penalty for failure to obtain preauthorization for covered private duty nursing services, hospice care and extended care/skilled nursing facility care no longer applies.
- The Plan allowance for non-PPO benefits will be based on the reasonable and customary charge which is established at the 75th percentile of claims and fee data compiled by Medical Data Research (MDR). (See page 70.) Previously, the average PPO negotiated rate was used.
- The Plan will now pay all anesthesia services by a non-PPO anesthesiologist at the PPO in-network benefit when a PPO facility is used. (See page 37.)
- The Plan will now consider out-of-network charges for covered services rendered outside the United States and Puerto Rico at the Plan's reasonable and customary charge established for the District of Columbia. (See page 53.)

Changes to our High Option only

- Your share of the non-Postal premium will increase by 24.9% for Self Only or 24.1% for Self and Family.
- The hospice care benefits have been combined for both inpatient and outpatient services and are now limited to $10,000 per calendar year under the High Option. (See page 41.) Previously, regular Plan benefits for the High Option had no maximum.

Changes to our Standard Option only

- Your share of the non-Postal premium will increase by 10% for Self Only or 6% for Self and Family.
- The Plan's hospice care benefits have been combined for both inpatient and outpatient services and are now limited to $5,000 per calendar year under the Standard Option. (See page 41.) Previously, benefits were limited to 60 days of care.
- Rental or purchase of covered durable medical equipment (DME) is limited to $25,000 per person, per lifetime under the Standard Option. (See page 29.) Previously, regular Plan benefits applied.

Other Changes

- Open enrollment in the SAMBA Health Benefit Plan has been extended to include civilian employees of the United States Army Criminal Investigation Command (USACIDC).

Clarifications

- The Plan's telephone number for claims services and/or questions has been changed to 1-800/638-6589 or 301/984-1440.
- Ambulance benefits in Section 5(c) have been updated to clarify our coverage of air ambulance services. Also, ambulance transportation for the patient's and/or the family's convenience is now specifically excluded.
- Osteoporosis screening is now specifically listed as covered under *Preventive care, adult* in Section 5(a).

- The Plan's precertification/prior approval requirements have been updated to included "certain prescription drugs." (See page 12.)
- Lifts, such as seat, chair or van lifts are now specifically excluded under *Durable medical equipment (DME)* benefits in Section 5(a).
- Colonoscopy is now listed under *Preventive care, adult* in Section 5(a).
- Telephone therapy and travel time to the patient's home to conduct therapy are now specifically excluded. (See page 47.)
- *Section 5(f). Prescription Drug Benefits* now specifically excludes over-the-counter nutritional supplements and medical foods.
- Refractions are now listed as "Not covered" under *Vision services (testing, treatment and supplies)* in Section 5(a).
- The Plan's definition of cosmetic surgery has been added to *Section 10. Definitions of terms we use in the brochure*.

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 electronic enrollment system (such as 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) or write to us at SAMBA, 11301 Old Georgetown Road, Rockville, MD 20852-2800. You may also request replacement cards through our Web site: www.SambaPlans.com.

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.

• 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: 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 2006, the states are: Alabama, Alaska, Arizona, Idaho, Kentucky, Louisiana, Mississippi, Missouri, Montana, New Mexico, North Dakota, South Carolina, South Dakota, West Virginia, 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 provider 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 drop out of the Federal Employees Health Benefits (FEHB) Program and you enroll in another FEHB Plan, or
- lose access to your PPO specialist because we terminate our contract with your specialist for other than for cause,

you may be able to continue seeing your specialist and receiving any PPO benefits 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 and any PPO benefits continue 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. If your plan terminates participation in the FEHB in whole or in part, or if OPM orders an enrollment change, this continuation of coverage provision does not apply. In such case, the hospitalized family member's benefits under the new plan begin on the effective date of enrollment.

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 benefits.

How to precertify an admission

- You, your representative, your doctor, or your hospital must call ENCOMPASS Health Management Systems (ENCOMPASS) at 1-888/249-2595 7 days (whenever possible) before admission. In Delaware, the District of Columbia, Maryland, and Virginia call CareFirst at 1-866/PRE-AUTH (773-2884) to precertify.
- 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 you, your representative, your physician, or the hospital must contact us for precertification of additional days. Further, if your baby stays after you are discharged, then you, your representative, 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, you, your representative, your doctor or the hospital must ask us to approve the additional days.

What happens when you do not follow the precertification rules

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.

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 pay only medical services and supplies otherwise payable on an outpatient basis and will not pay inpatient benefits.

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.

- Preauthorization is required for covered outpatient services for the treatment of mental conditions and substance abuse. Call ENCOMPASS at 1-888/249-2595 to obtain preauthorization. In Delaware, the District of Columbia, Maryland, and Virginia call CareFirst at 1-800/245-7013. Refer to pages 45 and 47 for additional information.

Warning:

We will reduce our Plan allowance by 20% 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 Medco Health at 1-800/753-2851 for preauthorization. If we determine GHT is not medically necessary, we will not cover the GHT or related services and supplies.
- Certain prescription drugs and supplies require prior approval. Contact Medco Health at 1-800/753-2851 for additional information.

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, facility, pharmacy, etc., when you receive services.

Example: When you see your PPO physician you pay a copayment of $20 per visit.

We also have a separate copayment for:

- Inpatient hospital confinement; PPO: $200 per confinement; non-PPO: $300 per confinement under both High Option and Standard Option
- High Option outpatient services facility charge; PPO: $100 per facility, per day; non-PPO: $150 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, any penalties, and prescription drug program charges do not count toward any deductible.

- The calendar year deductible is $250 per person under both High Option and Standard Option. 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 $500 under High Option and Standard Option.

We also have a separate deductible for certain covered expenses for the treatment of mental health and substance abuse. The calendar year deductible is $250 per person/$500 per family under both High Option and Standard Option.

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

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

Coinsurance

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

Example: You pay 10% of the Plan allowance for in-network laboratory services under High Option or 15% of the Plan allowance under Standard Option.

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% out-of-network 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 or copayment. Here is an example about coinsurance: 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, under High Option 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 under High Option for services from a PPO physician and 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	
Surgical 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 catastrophic protection 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 you and your covered family members for the deductibles, copayments and coinsurance in that calendar year exceed:

- PPO: $3,500 under High Option or $4,000 under Standard Option when PPO providers are used.
- Non-PPO: $5,000 under High Option or $6,000 under Standard Option. Eligible PPO expenses will also count toward this limit.

Out-of-pocket expenses for the purposes of this benefit are the:

- $250 calendar year deductible,
- $250 mental health deductible,
- $200 PPO and $300 non-PPO per inpatient hospital confinement copayment,
- $100 PPO and $150 non-PPO outpatient facility services copayment under the High Option,
- $20 office visit 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:

- expenses in excess of the Plan allowance or maximum benefit limitations;
- amounts you pay for non-compliance with this Plan's preauthorization requirements;
- copayments under prescription drug benefits; and
- the cost difference between a name brand drug and its generic equivalent.

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.

Note: If you change options in this Plan during the year, we will credit the amount of covered expenses already accumulated toward the catastrophic protection out-of-pocket limit of your old option to the catastrophic protection out-of-pocket limit of your new option.

When Government facilities bill us

Facilities of the Department of Veteran 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 do not have Medicare

Under the FEHB law, we must limit our payments for **inpatient hospital care** and **physician care** to 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. You and the FEHB benefit from these payment limits. Outpatient hospital and non-physician based care is not covered by this law; regular Plan benefits apply. 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 (EOB) form that we send you; 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 permitted to collect only 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 (Part A, Part B, or both)

We limit our payment to an amount that supplements the benefits that Medicare would pay under Medicare Part A (Hospital insurance) and Medicare 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 that 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 we waive some of your deductibles, copayment and coinsurance for covered charges.
- If your physician **does not accept** Medicare assignment, then you pay the difference between the "limiting charge" or the physician's charge (whichever is less) and our payment combined with Medicare's payment.

It is important to know that a 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 the physician to reduce the charges. If the physician does not, report the physician to your Medicare carrier who sent you the MSN form. Call us if you need further assistance.

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

High and Standard Option Benefits

See pages 7 and 8 for how our benefits changed this year. Page 82 and page 83 are a benefits summary of each option. Make sure that you review the benefits that are available under the option in which you are enrolled.

High and Standard Option Overview

This Plan offers both a High and Standard Option. Both benefit packages are described in Section 5. Make sure that you review the benefits that are available under the option in which you are enrolled.

The High and Standard Option Section 5 is divided into subsections. Please read the important things you should keep in mind at the beginning of the 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 High and Standard Option benefits, contact us at 1-800/638-6589 (TDD, use 301/984-4155) or at our Web site at www.SambaPlans.com.

Both options provide comprehensive coverage for a vast majority of your health care needs. Please review the easy-to-read benefit design lay-out in Section 5 for a comparison between the High and Standard Options. Call us at 1-800/638-6589 or 301/984-1440 (for TDD, use 301/984-4155) for answers to any benefit questions.

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

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: $250 per person ($500 per family) under both High Option and Standard Option. 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.
- The non-PPO benefits are the regular benefits of this Plan. PPO benefits apply only when you use a PPO provider. When no PPO provider is available, non-PPO benefits 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.

Benefits 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	**High Option**	**Standard Option**
Professional services of physicians • Office visits and consultations, including second surgical opinion Note: We cover one routine physical exam and one routine gynecologic exam for women age 18 and older, per calendar year.	PPO: $20 copayment per office visit (No deductible) Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount	PPO: $20 copayment per office visit (No deductible) Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount
• Same day services performed and billed by the doctor in conjunction with the office visit	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	PPO: 15% of the Plan allowance (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	PPO: 15% 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	
	High Option	**Standard Option**
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 (also see *Preventive care, adult*) related to one routine physical exam and one routine gynecologic exam for women age 18 and older, per calendar year. Non-routine or more extensive tests as determined by the Plan are not covered under this benefit.	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 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.	PPO: 15% of the Plan allowance (No deductible) 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 over • Routine 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	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 • Colonoscopy – every 10 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	PPO: 15% of the Plan allowance Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount
Routine screenings, limited to: • Total blood cholesterol • Chlamydial infection • Osteoporosis screenings, once every two years, for women age 65 and older	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	PPO: 15% of the Plan allowance (No deductible) Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount

Preventive care, adult – continued on next page

Preventive care, adult *(continued)*	**You pay**	
	High Option	**Standard Option**
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	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	PPO: 15% 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.*	*All charges.*
Preventive care, children		
• Childhood immunizations recommended by the American Academy of Pediatrics for dependent children to age 22	PPO: Nothing (No deductible) Non-PPO: Nothing (No deductible)	PPO: Nothing (No deductible) Non-PPO: Nothing (No deductible)
• The office visit for routine well-child care examinations (to age 22) • Same day services performed and billed by the doctor in conjunction with the office visit	PPO: Nothing (No deductible) Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount	PPO: Nothing (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 (No deductible) Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount	PPO: 15% of the Plan allowance (No deductible) Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount

Maternity care	You pay	
	High Option	**Standard Option**
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 12 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 cesarean delivery. We will cover an extended stay if medically necessary, but you, your representative, your doctor, or your hospital must precertify. • 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 and newborn circumcision) the same as for illness and injury. See Hospital benefits (Section 5(c)) and Surgery benefits (Section 5(b)).	PPO: 10% of the Plan allowance Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount	PPO: 15% of the Plan allowance Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount
Not covered: • *Routine sonograms to determine fetal age, size or sex* • *Stand-by doctor for cesarean section* • *Services before enrollment in the Plan begins or after enrollment ends*	*All charges.*	*All charges.*
Family planning		
A range of voluntary family planning services, limited to: • Voluntary sterilization (See Surgical procedures Section 5(b)) • Surgically implanted contraceptives • Injectable contraceptive drugs (such as Depo provera) • Intrauterine devices (IUDs) • Diaphragms Note: We cover oral contraceptives under the prescription drug benefit.	PPO: 10% of the Plan allowance Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount	PPO: 15% of the Plan allowance Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount

Family planning – continued on next page

Family planning *(continued)*	**You pay**	
	High Option	**Standard Option**
Not covered: • *Reversal of voluntary surgical sterilization* • *Genetic counseling*	*All charges.*	*All charges.*
Infertility services		
Diagnosis and treatment of infertility, except as shown in *Not covered.* • Benefits are limited to $5,000 per person, per lifetime. Note: Fertility drugs are covered in Section 5(f) and are limited to $5,000 per person, per lifetime.	PPO: 10% of the Plan allowance and all charges after the Plan has paid $5,000 Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount and all charges after the Plan has paid $5,000	PPO: 15% of the Plan allowance and all charges after the Plan has paid $5,000 Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount and all charges after the Plan has paid $5,000
Not covered: • *Infertility services after voluntary sterilization* • *Any charges in excess of the $5,000 plan limitation for covered infertility services or the separate $5,000 plan limitation for covered fertility drugs* • *Assisted reproductive technology (ART) procedures, such as:* – *artificial insemination* – *in vitro fertilization* – *embryo transfer and gamete intra-fallopian transfer (GIFT)* – *intravaginal insemination (IVI)* – *intracervical insemination (ICI)* – *intrauterine insemination (IUI)* • *Services and supplies related to ART procedures* • *Cost of donor sperm* • *Cost of donor egg*	*All charges.*	*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	PPO: 15% 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	
	High Option	**Standard Option**
• Chemotherapy and radiation therapy • Dialysis – Renal dialysis, hemodialysis and peritoneal dialysis • Intravenous (IV)/Infusion Therapy – Home IV and antibiotic therapy • Transparenteral nutrition (TPN) • Medical foods and nutritional supplements when administered by catheter or nasogastric tubes • Growth hormone therapy (GHT) Note: Growth hormone is covered under the prescription drug benefit. Note: We only cover GHT when we preauthorize the treatment. Call Medco Health at 1-800/753-2851 for preauthorization. We will ask you to submit information that establishes that the GHT is medically necessary. See *Other services* under *How to get approval for …* in Section 3. • Respiratory and inhalation therapies • Cardiac rehabilitation	PPO: 10% of the Plan allowance Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount	PPO: 15% of the Plan allowance Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount
Physical and occupational therapies		
Services of a qualified physical therapist, occupational therapist, doctor of osteopathy (D.O.), or physician for the following: • Physical therapy • Occupational therapy Benefits are limited to $3,000 per person per calendar year under **High Option** and $2,000 per person per calendar year under **Standard Option**.	PPO: 10% of the Plan allowance and all charges after the Plan has paid $3,000 Non-PPO: 50% of the Plan allowance and any difference between our allowance and the billed amount and all charges after the Plan has paid $3,000	PPO: 15% of the Plan allowance and all charges after the Plan has paid $2,000 Non-PPO: 50% of the Plan allowance and any difference between our allowance and the billed amount and all charges after the Plan has paid $2,000
Not covered: • *Long-term rehabilitative therapy* • *Exercise programs*	*All charges.*	*All charges.*
Speech therapy		
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.	PPO: 10% of the Plan allowance Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount.	PPO: 15% of the Plan allowance Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount.

Hearing services (testing, treatment, and supplies)	You pay	
	High Option	**Standard Option**
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	PPO: 15% 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.*	*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	PPO: 15% 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* • *Refractions* • *Radial keratotomy, lasik and other refractive surgery*	*All charges.*	*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 Note: See *Orthopedic and prosthetic devices* for information on podiatric shoe inserts.	PPO: $20 copayment for the office visit (No deductible) plus 10% of the Plan allowance for other services Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount	PPO: $20 copayment for the office visit (No deductible) plus 15% of the Plan allowance for other services 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.*	*All charges.*

Orthopedic and prosthetic devices	You pay	
	High Option	**Standard Option**
• 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: We will pay only for the cost of the standard item. Coverage for specialty items such as bionics is limited to the cost of the standard item. Dental prosthetic appliances are covered under High Option 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	PPO: 15% of the Plan allowance Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount
Not covered: • *Penile prosthetics* • *Wigs*	*All charges.*	*All charges.*

Durable medical equipment (DME)	You pay	
	High Option	**Standard Option**
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 (up to the purchase price) or purchase, at our option, including necessary repair and adjustment, of durable medical equipment, such as: • Oxygen equipment and oxygen • Hospital beds; • Wheelchairs; • Walkers. Benefits are limited to $25,000 per person, per lifetime under the **Standard Option**. Note: We will pay only for the cost of the standard item. Coverage for specialty equipment such as all-terrain wheelchairs is limited to the cost of the standard equipment.	PPO: 10% of the Plan allowance Non-PPO: 50% of the Plan allowance and any difference between our allowance and the billed amount	PPO: 15% of the Plan allowance and all charges after the Plan has paid $25,000 (lifetime) Non-PPO: 50% of the Plan allowance and any difference between our allowance and the billed amount and all charges after the Plan has paid $25,000 (lifetime)
Not covered: • *Equipment replacements provided less than 3 years after the last one we covered* • *Air conditioners, humidifiers, dehumidifiers, purifiers* • *Safety, hygiene, convenience, and exercise equipment and supplies* • *Lifts, such as seat, chair or van lifts* • *Any charges in excess of the $25,000 Standard Option limitation for covered durable medical equipment* • *Other items that do not meet the definition of durable medical equipment*	*All charges.*	*All charges.*

Home health services	You pay	
	High Option	**Standard Option**
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 69. 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% of the Plan allowance and all charges after 100 visits Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount and all charges after 100 visits	PPO: All charges Non-PPO: All charges
Private duty nursing care 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. Benefits are limited to $10,000 per person per calendar year under **High Option** and $5,000 per person per calendar year under **Standard Option**.	PPO: 10% of the Plan allowance and all charges after the Plan has paid $10,000 Non-PPO: 50% of the Plan allowance and any difference between our allowance and the billed amount and all charges after the Plan has paid $10,000	PPO: 15% of the Plan allowance and all charges after the Plan has paid $5,000 Non-PPO: 50% of the Plan allowance and any difference between our allowance and the billed amount and all charges after the Plan has paid $5,000
Not covered: • *Nursing care requested by, or for the convenience of, the patient or the patient's family* • *Services primarily for hygiene, feeding, exercising, moving the patient, homemaking, companionship or giving oral medication* • *Any charges in excess of the $10,000 (High Option) or $5,000 (Standard Option) plan limitation for covered private duty nursing care*	*All charges.*	*All charges.*
Chiropractic		
• Services of a chiropractor, such as manipulation and X-rays Benefits are limited to $500 per person, per calendar year.	PPO: 10% of the Plan allowance and all charges after the Plan has paid $500 Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount and all charges after the Plan has paid $500	PPO: 15% of the Plan allowance and all charges after the Plan has paid $500 Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount and all charges after the Plan has paid $500
Alternative treatments		
• Acupuncture by a doctor of medicine or osteopathy for pain relief Benefits are limited to $500 per person, per calendar year	PPO: 10% of the Plan allowance and all charges after the Plan has paid $500 Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount and all charges after the Plan has paid $500	PPO: 15% of the Plan allowance and all charges after the Plan has paid $500 Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount and all charges after the Plan has paid $500

Alternative treatments – continued on next page

Alternative treatments *(continued)*	**You pay**	
	High Option	**Standard Option**
Not covered: • *Naturopathic practitioner* • *Massage therapist* • *Any charges in excess of the $500 plan limitation for covered acupuncture services* *(Note: Benefits of certain alternative treatment providers may be covered in medically underserved areas; see page 9.)*	*All charges.*	*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 and all charges after the Plan has paid $100 Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount and all charges after the Plan has paid $100	PPO: 15% of the Plan allowance and all charges after the Plan has paid $100 Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount and all charges after the Plan has paid $100

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

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: $250 per person ($500 per family) under both High Option and Standard Option. 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.
- The non-PPO benefits are the regular benefits of this Plan. PPO benefits apply only when you use a PPO provider. When no PPO provider is available, non-PPO benefits 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.).
- **YOU MUST GET PRECERTIFICATION OF SOME SURGICAL PROCEDURES. Please refer to page 36 for information regarding *Organ/tissue transplants*.**

Benefits 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	**High Option**	**Standard Option**
A comprehensive range of services, such as: • Operative procedures • Treatment of fractures, including casting • Normal pre- and post-operative care by the surgeon • Correction of amblyopia and strabismus • Endoscopy procedures • Biopsy procedures • Removal of tumors and cysts • Correction of congenital anomalies (see *Reconstructive surgery*) • Insertion of internal prosthetic devices. See 5(a) – *Orthopedic and prosthetic devices* for device coverage information • Voluntary sterilization (e.g., Tubal ligation, Vasectomy). • Surgically implanted contraceptives • Intrauterine devices (IUDs)	PPO: 10% of the Plan allowance Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount	PPO: 15% 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**	
	High Option	**Standard Option**
• Surgical treatment of morbid obesity (bariatric surgery) — Preauthorization of this procedure is required. Contact ENCOMPASS at 1-888/249-2595 or in Delaware, the District of Columbia, Maryland, and Virginia, contact CareFirst at 1-866/773-2884. The Plan's criteria includes the following: – Eligible patients must be age 18 or over – The patient has a documented body mass index (BMI) of 40 or greater and documented failure to sustain weight loss with medically supervised dietary and conservative treatment for a total of 12 months or a 6 month multidisciplinary approach (physician, dietician and physical therapy) within the two years preceding surgery – The patient has a BMI over 40 and at least one co-morbidity such as hypertension, type 2 diabetes, cardiovascular disease, respiratory compromise related to obesity, or other medical conditions that have a morbid effect on the clinical course and are related to or accentuated by obesity • 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 payment and the billed amount	PPO: 15% of the Plan allowance Non-PPO: 30% of the Plan allowance and any difference between our payment and the billed amount
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: – Full Plan allowance • For the secondary procedure(s): – 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	PPO: 15% of the Plan allowance for the primary procedure and 15% 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

Surgical procedures – continued on next page

Surgical procedures *(continued)*	**You pay**	
	High Option	**Standard Option**
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.*	*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 of breasts; – treatment of any physical complications, such as lymphedemas; – breast prostheses; and surgical bras and replacements (see *Orthopedic and prosthetic devices* for coverage) 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.	PPO: 10% of the Plan allowance Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount	PPO: 15% 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**	
	High Option	**Standard Option**
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.*	*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	PPO: 15% 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.*	*All charges.*
Organ/tissue transplants		
Limited to: • Cornea • Heart • Heart/lung • Kidney • Liver • Pancreas • Kidney/Pancreas • Single lung • Double lung	PPO: 10% of the Plan allowance. Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount and all charges after the Plan pays $100,000 per transplant	PPO: 15% of the Plan allowance. Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount and all charges after the Plan pays $100,000 per transplant

Organ/tissue transplants – continued on next page

Organ/tissue transplants *(continued)*	**You pay**	
	High Option	**Standard Option**
• Intestinal transplants (small intestine) and the small intestine with the liver or small intestine with multiple organs such as the liver, stomach, and pancreas • Allogeneic (donor) bone marrow transplants for chronic myelogenous leukemia, acute leukemia, aplastic anemia, severe combined immuno-deficiency disease, Wiscott-Aldrich syndrome, advanced Hodgkin's lymphoma, advanced non-Hodgkin's lymphomas, and myelodysplastic syndrome (in advanced form) • Autologous (self) bone marrow transplants (autologous stem cell and peripheral stem cell support) for chronic or acute lymphocytic or non-lymphocytic leukemia; advanced Hodgkin's lymphoma; advanced non-Hodgkin's lymphomas; resistant or recurrent neuroblastoma; testicular, mediastinal, retroperitoneal, and ovarian germ cell tumors; breast cancer; multiple myeloma; and epithelial ovarian cancer • Autologous tandem bone marrow transplants for testicular and other germ cell tumors and multiple myeloma Covered expenses for the purpose of this benefit are: • The pretransplant evaluation; • Organ procurement; • 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. As a potential candidate for an organ transplant procedure, you or your doctor must contact ENCOMPASS at 1-888/249-2595 to obtain transplant approval. In Delaware, the District of Columbia, Maryland, and Virginia contact CareFirst at 1-866/PRE-AUTH (773-2884). The clinical results of the evaluation will be reviewed to determine if the proposed procedure meets the Plan's definition of medically necessary. The Plan has the right to restrict authorization to a Preferred transplant facility.	PPO: 10% of the Plan allowance Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount and all charges after the Plan pays $100,000 per transplant	PPO: 15% of the Plan allowance Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount and all charges after the Plan pays $100,000 per transplant

Organ/tissue transplants – continued on next page

Organ/tissue transplants *(continued)*	**You pay**	
	High Option	**Standard Option**
Limited Benefits – If you do not use a Preferred PPO provider, regular 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 immonosuppressant and other transplant-related medication will be limited to a maximum payment of $100,000 per transplant. Note: We cover related medical and hospital expenses of the actual donor for the initial transplant confinement when we cover the recipient, if these expenses are not covered by any other health plan.		
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.*	*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.	PPO: 15% 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.
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 you use a PPO facility, we pay PPO benefits if you receive treatment from an anesthesiologist who is not a PPO provider.	PPO: 15% of the Plan allowance Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount Note: If you use a PPO facility, we pay PPO benefits if you receive treatment from an anesthesiologist who is not a PPO provider.

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

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.
- In this Section, unlike Sections 5(a) and 5(b), the calendar year deductible applies to only a few benefits. In that case, we added "(calendar year deductible applies)". The calendar year deductible is: $250 per person ($500 per family) under both High Option and Standard Option.
- The non-PPO benefits are the regular benefits of this Plan. PPO benefits apply only when you use a PPO provider. When no PPO provider is available, non-PPO benefits 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 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 Sections 5(a) or (b).
- **YOU MUST GET PRECERTIFICATION OF HOSPITAL STAYS; FAILURE TO DO SO WILL RESULT IN A MINIMUM $500 PENALTY.** Please refer to the precertification information shown in Section 3 to be sure which services require precertification.

Benefits Description	You pay	
Note: The calendar year deductible applies ONLY when we say below:-"(calendar year deductible applies)".		
Inpatient hospital	**High Option**	**Standard Option**
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: Nothing after a $200 copayment per confinement Non-PPO: $300 copayment per confinement and 30% of the Plan allowance Note: A confinement is defined in Section 10, page 68.	PPO: Nothing after a $200 copayment per confinement Non-PPO: $300 copayment per confinement and 30% of the Plan allowance Note: A confinement is defined in Section 10, page 68.

Inpatient hospital – continued on next page.

Inpatient hospital *(continued)*	**You pay**	
	High Option	**Standard Option**
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 anesthetics 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.	PPO: Nothing 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.*	*All charges.*

Outpatient hospital or ambulatory surgical center	You pay	
	High Option	**Standard Option**
• Operating, recovery, and other treatment rooms • Prescribed drugs and medicines • Diagnostic laboratory test, 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: $150 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 copayment per facility per occurrence.	PPO: 15% of the Plan allowance (calendar year deductible applies) Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount (calendar year deductible applies)
Extended care benefits/Skilled nursing care facility benefits		
Skilled nursing facility (SNF)/Convalescent nursing home (CNH): We cover services and supplies in a SNF/CNH 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 an SNF/CNH in lieu of continued hospitalization Benefits are limited to 60 days per confinement under **High Option** and 30 days per confinement under **Standard Option**.	PPO: Nothing until benefits stop at 60 days Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount until benefits stop at 60 days	PPO: Nothing until benefits stop at 30 days Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount until benefits stop at 30 days
Not covered: • *Custodial care* • *Personal comfort services such as beauty and barber services*	*All charges.*	*All charges.*

Hospice care	You pay	
	High Option	**Standard Option**
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.	See below	See below
Benefits are limited to $10,000 under **High Option** and $5,000 under **Standard Option** per person, per calendar year for a combination of inpatient and outpatient services.	PPO: 10% of the Plan allowance and all charges after the Plan has paid $10,000 Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount and all charges after the Plan has paid $10,000	PPO: 15% of the Plan allowance and all charges after the Plan has paid $5,000 Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount and all charges after the Plan has paid $5,000
Not covered: • *Any charges in excess of the $10,000 High Option or $5,000 Standard Option plan limitation for covered hospice care* • *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.*	*All charges.*
Ambulance		
• Local professional ambulance service only to and from a hospital, when medically appropriate	PPO: 10% of the Plan allowance Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount	PPO: 15% of the Plan allowance Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount
• All other local ambulance service when medically appropriate. • Air ambulance to nearest facility where necessary treatment is available if no emergency ground transportation is available or suitable and the patient's condition warrants immediate evacuation.	PPO: 10% of the Plan allowance (calendar year deductible applies) Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount (calendar year deductible applies)	PPO: 15% of the Plan allowance (calendar year deductible applies) Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount (calendar year deductible applies)

Ambulance – continued on next page.

Ambulance *(continued)*	**You pay**	
	High Option	**Standard Option**
Not covered: • *Ambulance transport for you or your family's convenience* • *Air ambulance if transport is beyond the nearest available suitable facility, but is requested by the patient or physician for continuity of care or other reasons*		
Blood and plasma		
Blood and plasma to the extent not donated or replaced when not otherwise payable under *Inpatient hospital benefits*.	Nothing	Nothing

Section 5(d) Emergency services/accidents

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: $250 per person ($500 per family) under both High Option and Standard Option. 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.
- The non-PPO benefits are the regular benefits of this Plan. PPO benefits apply only when you use a PPO provider. When no PPO provider is available, non-PPO benefits 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.

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.

Benefits 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	**High Option**	**Standard Option**
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 regular Plan benefits will apply.	PPO: Nothing (No deductible) Non-PPO: Only the difference between our allowance and the billed amount (No deductible)	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 regular Plan benefits apply.	Regular Plan benefits apply	Regular Plan benefits apply
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)	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

You may choose to get care In-Network or Out-of-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.
- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- We have a separate $250 per person ($500 per family) calendar year deductible under both High Option and Standard Option, 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 regular 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 46.

Benefits 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	**High Option**	**Standard Option**
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 illnesses or conditions.	Your cost sharing responsibilities are no greater than for other illnesses or conditions.
• 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 45.	$20 copayment per visit (No deductible)	$20 copayment per visit (No deductible)

In-Network benefits – continued on next page.

In-Network benefits *(continued)*	**You pay**	
	High Option	**Standard Option**
Other outpatient care including: • Day or after care (partial hospitalization) in a hospital Note: Preauthorization is required; see below.	10% of the Plan allowance	15% of the Plan allowance
• Diagnostic tests	10% of the Plan allowance	15% 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 below. A confinement is defined in Section 10, page 68.	$200 copayment per confinement, nothing for room and board and 10% of Plan allowance for other hospital services (No deductible)	Nothing after a $200 copayment per confinement (No deductible)
• Services of a doctor for inpatient hospital visits	10% of the Plan allowance	15% 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.*	*All charges.*

Preauthorization

To be eligible to receive these enhanced mental health and substance abuse benefits you must obtain a treatment plan and follow all of the 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 after care treatment (partial hospitalization). If preauthorization is not obtained, we will reduce our Plan allowance by 20%.

Note: To obtain preauthorization call 1-888/249-2595. In Delaware, the District of Columbia, Maryland, and Virginia, call 1-800/245-7013.

Network limitation

If you do not obtain an approved treatment plan, we will provide only Out-of-Network benefits.

Out-of-Network benefits	You pay	
	High Option	**Standard Option**
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 Benefits are based on a maximum allowance of $100 per visit and 50 visits per person per calendar year under **High Option** and 25 visits per person per calendar year under **Standard Option** – 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 47. 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 until benefits stop at 50 visits	50% of the Plan allowance and any difference between our allowance and the billed amount until benefits stop at 25 visits
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 47.	$300 copayment per confinement 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.	$300 copayment per confinement 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	30% of the Plan allowance and any difference between our allowance and the billed amount

Out-of-Network benefits – continued on next page.

Out-of-Network benefits *(continued)*	**You pay**	
	High Option	**Standard Option**
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* • *Telephone therapy* • *Travel time to the patient's home to conduct therapy*	*All charges.*	*All charges.*

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 after care treatment (partial hospitalization). If preauthorization is not obtained, we will reduce our Plan allowance by 20%.

To obtain preauthorization, call 1-888/249-2595. In Delaware, the District of Columbia, Maryland, and Virginia, call 1-800/245-7013.

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

- Section 3, *How you get care*, for information about out-of-pocket maximums 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

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 page 51.
- 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 does not apply to prescription drugs.**
- The non-PPO benefits are the regular benefits of this Plan. PPO benefits apply only when you use a PPO provider. When no PPO provider is available, non-PPO benefits apply.
- Certain prescription drugs and supplies require prior approval by SAMBA and/or Medco before providing 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.

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

- **Who can write your prescription.** A licensed physician or other covered provider acting within the scope of their license must write the prescription
- **Where you can obtain them.** You may fill the prescription at a participating Plan 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.** The formulary identifies preferred name brand drugs that have been selected for their clinical effectiveness and opportunities to help contain your and SAMBA's costs. Our formulary applies to drugs received from a network retail pharmacy or our mail order program. Your copayment is less for drugs listed on the formulary than those that are not. You may obtain a list of formulary medications online at http://www.medcohealth.com or call 1-800/283-3478.
- **These are the dispensing limitations.**
  - **High Option Retail:** You may purchase up to a 30-day supply with unlimited refills of covered drugs or supplies through the Medco Health system available at most pharmacies. Call toll-free 1-800/283-3478 to locate a Plan network pharmacy in your area.
  - **Standard Option Retail:** You may only obtain a 30-day supply and one refill at a Plan network pharmacy. Call 1-800/283-3478 to locate a network pharmacy in your area.
  - **High Option and Standard Option Mail Order:** 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 Medco Health Home Delivery Pharmacy service. The Home Delivery Pharmacy service will fill your prescription.

  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 Plan network pharmacy and the other for the Home Delivery Pharmacy service. 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 Home Delivery Pharmacy service.

  If you should be called to active military duty or require an extended supply of medication(s) to meet your needs in time of national or other emergency, contact the Plan immediately.

  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, you have to pay the difference in cost between the name brand drug and the generic.

Prescription drug benefits – continued on next page

Prescription drugs *(continued)*

- **Why use generic drugs?** Generic drugs are lower-priced drugs that are the therapeutic equivalent to more expensive name brand drugs. They must contain the same active ingredients and must be equivalent in strength and dosage to the original name brand product. Generics cost less than the equivalent name brand product. The U.S. Food and Drug Administration sets quality standards for generic drugs to ensure that these drugs meet the same standards of quality and strength as name brand drugs.

  You and your doctor have the option to request a name brand drug even if a generic equivalent is available. However, you will be responsible for the difference in cost between the name brand drug and the generic even when the physician indicates "dispense as written" (DAW). Using the most cost effective medication saves money.

- **Patient Safety**

  SAMBA has several programs to promote patient safety. These programs work to ensure that safe and appropriate quantities of medication are being dispensed. The result is improved care and safety for our members. Patient safety programs include:

  – **Pharmacy utilization:** Used to identify and restrict over-utilization or inappropriate use of medications that treat certain conditions.

  – **Prior authorization:** Prior authorization must be obtained for certain prescription drugs and supplies to assess medical necessity and drug dosage before providing benefits.

  Contact Medco Health at 1-800/753-2851 for additional information regarding the Patient Safety programs.

- **To claim benefits.**

  – From a pharmacy – When you purchase medication from a network pharmacy use your SAMBA/ Medco Health Identification Card. In most cases, you simply present the card, together with the prescription, to the pharmacist; the claim is automatically filed through the Medco Health 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 Medco Health toll-free at 1-800/283-3478. Service is available 7 days a week, 24 hours a day. Follow the instructions on the form and mail it to:

  Medco Health Solutions, Inc.
  P. O. Box 2187
  Lee's Summit, MO 64063-2187

  Note: Reimbursement will be limited to SAMBA's cost had you used a participating pharmacy minus the copayments described on page 51.

  – By mail – The Plan will send you information on the Medco Health Home Delivery Service:

  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 for each prescription or refill to:

     Medco Health Home Delivery Pharmacy Service
     P. O. Box 2201
     Pittsburgh, PA 15230-2201

  You must pay your share of the cost by check, money order, VISA, Discover, 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 1-800/283-3478 toll-free. Customer service is available 7 days a week, 24 hours a day.

  Under the **High Option**, if Medicare Part B is your primary payer, the Plan will reduce the required copayment amount for purchases made through the Medco Health Home Delivery Service. See page 51 for copayment amounts.

  Note: As at your local pharmacy, if you request a name brand prescription when a generic equivalent is available, you will be responsible for the difference in price between the name brand drug and its generic equivalent.

Prescription drug benefits – continued on next page

Prescription drugs *(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 Home Delivery Pharmacy service, you will be billed directly for the full discounted cost of the covered medication. Pay the Home Delivery Pharmacy service 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 Medco Health office at:

  Medco Health Solutions, Inc.
  P. O. Box 2187
  Lee's Summit, MO 64063-2187

  Should you elect to use a retail pharmacy, follow your primary insurance carrier's instructions on how to file a claim. After their consideration, submit the claim and the explanation of benefits (EOB) directly to the Medco Health office at:

  Medco Health Solutions, Inc.
  P. O. Box 2187
  Lee's Summit, MO 64063-2187

Prescription drug benefits – continued on next page

Benefits Description	You pay	
Covered medications and supplies	**High Option**	**Standard Option**
Each enrollee will receive a description of our prescription drug program, a prescription drug identification card, a mail order form/patient profile, and a preaddressed reply envelope. 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 prescription for purchase • Insulin • Needles and syringes for the administration of covered medications, such as insulin • Contraceptive drugs and devices • Growth hormone therapy (GHT), if preauthorized • Fertility drugs (coverage is limited to $5,000 per person, per lifetime) Note: The Medicare level of benefits applies only when Medicare Part B is your primary payer.	Copayments per prescription or refill are: Network Retail: • $10 generic • $25 formulary name brand • $40 non-formulary name brand Non-Network Retail: • $10 generic • $25 formulary name brand • $40 non-formulary name brand plus the difference in cost had you used a participating Plan network pharmacy **Note:** Medicare enrollees pay the same prescription drug copayments for retail as listed above. Network Mail Order: • $10 generic • $45 formulary name brand • $60 non-formulary name brand Network Mail Order Medicare: • $5 generic • $20 formulary name brand • $35 non-formulary name brand Note: For generic and name brand drug purchases, if the cost of your prescription is less than your cost-sharing amount listed above, you pay only the cost of your prescription. If there is no generic equivalent available, you will have to pay the name brand copayment.	Copayments per prescription or refill are: Network Retail: • $10 generic • $30 formulary name brand • $45 non-formulary name brand Non-Network Retail: • $10 generic • $30 formulary name brand • $45 non-formulary name brand plus the difference in cost had you used a participating Plan network pharmacy Retail purchases are limited to the initial fill (not to exceed a 30-day supply) and one refill. Network Mail Order: • $20 generic • 25% of the Plan allowance ($45 minimum/$80 maximum for each purchase) formulary name brand • 25% of the Plan allowance ($60 minimum/$100 maximum for each purchase) non-formulary name brand **Note:** Medicare enrollees pay the same prescription drug copayments as listed above. Note: For generic and name brand drug purchases, if the cost of your prescription is less than your cost-sharing amount listed above, you pay only the cost of your prescription. If there is no generic equivalent available, you will have to pay the name brand copayment.

Prescription drug benefits – continued on next page

Covered medications and supplies *(continued)*	**You pay**	
	High Option	**Standard Option**
Not covered: • *Drugs and supplies for cosmetic purposes, e.g., Retin A, Minoxidil, Rogaine* • *Vitamins (except injectable B-12)* • *Over-the-counter nutritional supplements and medical foods* • *Nonprescription medicines (over-the-counter medication)* • *The difference in cost between the name brand drug and the generic substitute when a generic equivalent is available.* • *Drugs for sexual dysfunction, e.g., Viagra, Muse, Caverject, etc.* • *Cost of fertility drugs which exceed the $5,000 plan limitation.* *Note: Drugs to aid in smoking cessation are covered only under Educational classes and programs (Section 5(a)).*	*All charges.*	*All charges.*

Section 5(g) Special features

Special feature	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. If we identify a less costly alternative, we may ask you to sign an alternative benefits agreement that will include all of the following terms. Until you sign and return the agreement, regular contract benefits will continue. • Alternative benefits will be made available for a limited time period and are subject to our ongoing review. You must cooperate with the review process. • 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 except as expressly provided in the agreement, we may withdraw it at any time and resume regular contract benefits. • If you sign an agreement, we will provide the agreed-upon alternative benefits for the stated time period (unless circumstances change). You may request an extension of the time period, but regular benefits will resume if we do not approve your request. • Our decision to offer or withdraw alternative benefits is not subject to OPM review under the disputed claims process.
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, D.C. Metropolitan area. The member is responsible for the difference between the Plan's allowance and the provider's charge. See page 59, *Section 7 Filing a claim for covered services*. Note: For those members residing in Delaware, the District of Columbia, Maryland, and Virginia, the Plan offers BlueCard Worldwide® which enables Plan members traveling abroad to receive inpatient, outpatient and professional services from healthcare providers worldwide. If you or a covered family member is traveling outside the United States and requires medical attention, call the BlueCard *Access* line at 1-800/810-BLUE (2583). A medical assistance coordinator will be available to assist you.
Services for deaf and hearing impaired	SAMBA has a TDD line for the hearing-impaired: 301/984-4155 (TDD equipment is needed).
BlueCard® Program	For those members residing in Delaware, the District of Columbia, Maryland, and Virginia, the Plan offers the BlueCard® Program. The independent BlueCross and BlueShield licensees throughout the country are working together in a cooperative arrangement called the BlueCard® Program. Under this program, if an eligible enrollee receives services outside the CareFirst BlueCross BlueShield service area from a health care provider that participates with another BlueCross and/or BlueShield licensee ("Host Plan"), the member is responsible only for the coinsurance, copayment, and/or deductible. The calculation of the member's liability for covered services for claims incurred will be processed through the BlueCard Program. To find names and addresses of nearby doctors and hospitals, visit the BlueCard® Doctor and Hospital Finder or call BlueCard *Access*® at 1-800-810-BLUE (2583). When you arrive at the participating doctor's office or hospital, simply present your Plan ID card.

Section 5(h) Dental benefits

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: $250 per person ($500 per family) under both High Option and Standard Option. 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.
- 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. See Section 5(c) for inpatient hospital benefits.

Benefits Description	You pay	
Accidental injury benefit	**High Option**	**Standard Option**
We cover surgical and dental treatment of an accidental injury to 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: 10% of the Plan allowance Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount	PPO: 15% of the Plan allowance Non-PPO: 30% 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.	All charges
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.	All charges

Dental benefits – continued on next page

Dental benefits *(continued)*	**You pay**	
	High Option	**Standard Option**
Other Dental Services • Routine cleaning including scaling and polishing • Two oral examinations per person, per calendar year • Two topical fluoride applications per calendar year (children up to the age of 16) • Regular X-rays • Palliative emergency services • Space maintainers (for deciduous teeth only) • Pulp vitality tests • Consultation by a dental consultant • Panoramic X-rays (1 every 3 years) Note: Benefits are limited to $1,000 per person per calendar year.	All charges	PPO: Nothing until benefits stop at $1,000 (No deductible) Non-PPO: Any difference between our allowance and the billed amount and all charges after the Plan has paid $1,000 (No deductible)
Not covered: • *Dental appliances, study models, splints and other devices or services associated with the treatment of temporomandibular joint (TMJ) dysfunction.*	*All charges*	*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 catastrophic protection out-of-pocket maximums.

Terrorism Coverage

Without charge, SAMBA provides its members a $100,000 accident policy payable upon death or dismemberment caused by an act of terrorism within the United States – $50,000 if on official assignment overseas – provided they are enrolled under the SAMBA Health Benefit Plan, Group Term Life Insurance or Disability Income Protection Program.

SAMBA's Other Group Insurance Plans

Below is a brief description of other group insurance plans available through SAMBA. Plan provisions, certain exclusions, eligibility requirements and underwriting guidelines apply for each plan. For more details, contact SAMBA toll-free at 1-800/638-6589 or visit our website at www.SambaPlans.com.

Group Term Life

This low-cost plan allows you to provide financial protection for your family in the event of your untimely death. Plus, the plan includes free accidental death and dismemberment coverage. 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.

Dependents Group Term Life

To help ease economic consequences of the loss of a spouse or child, SAMBA offers this plan, which protects your whole family for one low-cost premium.

Supplemental Group Term Life

SAMBA offers you additional protection at attractive group rates to members and spouses enrolled in the basic Group Term Life Plan.

Disability Income Protection

In the event of a long-term illness or disability, this plan provides much-needed income for you and your family. The plan pays up to 65% of your insured salary, tax-free. In addition, the plan pays 70% of your insured salary for each day you or your spouse are hospitalized and 35% for hospitalized children.

Long-Term Care

Our customized plans help you cover the high cost of long-term care. Members, spouses, parents, parents-in-law and children qualify for benefits that help pay for nursing home care, home health care, adult day care and respite care.

Dental and Vision Care Plan

SAMBA offers you and your family a choice of two comprehensive Dental and Vision Care Programs: 1) **The DMO Dental Plan**, for which you select a Primary Care dentist and receive a broad range of coverage and savings, or 2) **The Alternate Dental Plan**, which provides flexibility to receive coverage for care from any licensed dentist. Both plans provide coverage for a wide range of dental procedures from basic dental care to oral surgery and dentures, and include the same vision care benefits for eye examinations, frames, and lenses (or contact lenses).

Dependent Children Health Benefit Plan

Your child's coverage under your Federal Employees Health Benefits Program (FEHBP) plan generally terminates 31 days after your child turns 22, even if your child is a full-time student. Available only to members who are enrolled in the SAMBA Health Benefit Plan, SAMBA offers you an affordable health plan for your unmarried children ages 22 to 27. Your child does not have to be a student to be eligible, just wholly dependent upon you for support and maintenance.

LegalRx® Plan

SAMBA offers the LegalRx® Plan to help protect you from expenses and worries that life's unexpected legal situations can trigger. The Plan includes personal wills for you and your spouse. In addition, you have access to unlimited, toll-free consultations with network attorneys who can answer questions and review or draft basic legal documents. The legal fees are either discounted or paid for you in full by the plan.

The above is a brief description of the non-FEHB plans available. All Plan benefits are subject to the definitions, limitations and exclusions set forth in the official Plan documents.

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 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, e.g., Viagra, Muse, Caverject, penile prosthesis;
- 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, drugs, or supplies you receive without charge while in active military service;
- 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 in 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 9, Section 3;
- Charges for services and supplies that exceed the Plan allowance;
- Services in connection with custodial care as defined on page 68;
- 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 28, Section 5(a);
- Services by a massage therapist;
- Services by a naturopathic practitioner;

General exclusions *(continued)*

- Services and supplies for cosmetic purposes, e.g., Retin A, Minoxidil, Rogaine;
- Treatment of obesity or weight reduction, except for treatment of morbid obesity as listed on page 33, Section 5(b);
- Safety, hygiene, convenience, and exercise equipment and supplies;
- Fees for medical records not requested by the Plan; or
- Handling charges/administrative charges or late charges, missed appointment fees, including interest, billed by providers of care.

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 Web site at www.SambaPlans.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 – such as for services you receive overseas or when another group health plan is primary – 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.

Note: Claims for prescription drugs and supplies are addressed in Section 5(f), page 48.

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 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. You are responsible to make certain that your claims are filed within the timely filing deadline. Once we pay benefits, there is a three-year limitation on the re-issuance 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 to the date the service was rendered. For inpatient hospital services, the exchange rate will be based on the date of admission. 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: United States Office of Personnel Management, Insurance Services Programs, Health Insurance Group II, 1900 E Street, NW, Washington, DC 20415-3620.

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.

The disputed claims process *(continued)*

Note: If you want OPM to review more than one claim, you must clearly identify which documents apply to which claim.

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

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

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

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

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

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

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

a) We haven't responded yet to your initial request for care or preauthorization/prior approval, then call us at 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 may call OPM's Health Insurance Group 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 or a covered family member have coverage under another group health plan or have automobile insurance that pays health care expenses without regard to fault. This is called "double coverage."

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

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

When we are the secondary payer, we will determine our allowance. After the primary plan pays, we will pay what is left of our allowance 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 or older.
- Some people with disabilities under 65 years of age.
- People with End-Stage Renal Disease (permanent kidney failure requiring dialysis or a transplant).

Medicare has four parts:

- Part A (Hospital Insurance). Most people do not have to pay for Part A. If you or your spouse worked for at least 10 years in Medicare-covered employment, you should be able to qualify for premium-free Part A insurance. (Someone who was a Federal employee on January 1, 1983, or since automatically qualifies.) Otherwise, if you are age 65 or older, you may be able to buy it. Contact 1-800-MEDICARE for more information.
- Part B (Medical Insurance). Most people pay monthly for Part B. Generally, Part B premiums are withheld from your monthly Social Security check or your retirement check.
- Part C (Medicare Advantage). You can enroll in a Medicare Advantage plan to get your Medicare benefits. We do not offer a Medicare Advantage plan. Please review the information on coordinating benefits with Medicare Advantage plans on page 65.
- Part D (Medicare prescription drug coverage). There is a monthly premium for Part D. If you have limited savings and a low income, you may be eligible for Medicare's Low-Income Benefits. For people with limited income and resources, extra help in paying for a Medicare prescription drug plan is available. Information regarding this program is available through the Social Security Administration (SSA). For more information about this extra help, visit SSA online at www. socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778). Before enrolling in Medicare Part D, please review the important disclosure notice from us about our prescription drug coverage and Medicare. The notice is on the first inside page of this brochure. The notice will give you guidance on enrolling in Medicare Part D.

• Should I enroll in Medicare?

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

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

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

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

- **The Original Medicare Plan (Part A or Part B)**

The Original Medicare Plan (Original Medicare) is available everywhere in the United States. It is the way everyone used to get Medicare benefits and is the way most people get their Medicare Part A and Part B benefits now. You may go to any doctor, specialist, or hospital that accepts Medicare. The Original Medicare Plan pays its share and you pay your share.

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

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

- When we are the primary payer, we process the claim first.
- When Original Medicare is the primary payer, Medicare processes your claim first. In most cases, your claims will be coordinated automatically and we will then provide secondary benefits for covered charges. You will not need to do anything. To find out if you need to do something to file your claim, call us at 1-800/638-6589 or 301/984-1440 (for TDD, use 301/984-4155) or see our Web site at www.SambaPlans.com.

We waive some costs if the Original Medicare Plan is your 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
  - Outpatient 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 per confinement copayment for inpatient hospital confinements
  - the coinsurance for inpatient hospital benefits

In cases where we cover a service that is not covered by Medicare, we are the primary payer. In these cases, we do not waive any out-of-pocket costs.

- **Private Contract with your physician**

A physician may ask you to sign a private contract agreeing that you can be billed directly for services 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.

- **Medicare Advantage (Part C)**

If you are eligible for Medicare, you may choose to enroll in and get your Medicare benefits from a Medicare Advantage plan. These are private health care choices (like HMOs and regional PPOs) in some areas of the country. To learn more about Medicare Advantage plans, contact Medicare at 1-800-MEDICARE (1-800-633-4227) or at www.medicare.gov.

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

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

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

- **Medicare prescription drug coverage (Part D)**

When we are the primary payer, we process the claim first. If you enroll in Medicare Part D and we are the secondary payer, we will review claims for your prescription drug costs that are not covered by Medicare Part D and consider them for payment under the FEHB plan.

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

Primary Payer Chart		
A. When you - or your covered spouse - are age 65 or over and have Medicare and you…	**The primary payer for the individual with Medicare is…**	
	Medicare	**This Plan**
1) Have FEHB coverage on your own as an active employee or through your spouse who is an active employee		✓
2) Have FEHB coverage on your own as an annuitant or through your spouse who is an annuitant	✓	
3) Are a reemployed annuitant with the Federal government and your position is excluded from the FEHB (your employing office will know if this is the case) and you are not covered under FEHB through your spouse under #1 above	✓	
4) Are a reemployed annuitant with the Federal government and your position is not excluded from the FEHB (your employing office will know if this is the case) and… You have FEHB coverage on your own or through your spouse who is also an active employee		✓
You have FEHB coverage through your spouse who is an annuitant	✓	
5) Are a Federal judge who retired under title 28, U.S.C., or a Tax Court judge who retired under Section 7447 of title 26, U.S.C. (or if your covered spouse is this type of judge) and you are not covered under FEHB through your spouse under #1 above	✓	
6) Are enrolled in Part B only, regardless of your employment status	✓ for Part B services	✓ for other services
7) Are a former Federal employee receiving Workers' Compensation and the Office of Workers' Compensation Programs has determined that you are unable to return to duty	✓*	
B. When you or a covered family member…		
1) Have Medicare solely based on end stage renal disease (ESRD) and… • It is within the first 30 months of eligibility for or entitlement to Medicare due to ESRD (30-month coordination period)		✓
• It is beyond the 30-month coordination period and you or a family member are still entitled to Medicare due to ESRD	✓	
2) Become eligible for Medicare due to ESRD while already a Medicare beneficiary and… • This Plan was the primary payer before eligibility due to ESRD		✓ for 30-month coordination period
• Medicare was the primary payer before eligibility due to ESRD	✓	
C. When either you or a covered family member are eligible for Medicare solely due to disability and you…		
1) Have FEHB coverage on your own as an active employee or through a family member who is an active employee		✓
2) Have FEHB coverage on your own as an annuitant or through a family member who is an annuitant	✓	
D. When you are covered under the FEHB Spouse Equity provision as a former spouse	✓	

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

TRICARE and CHAMPVA

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

Suspended FEHB coverage to enroll in TRICARE or CHAMPVA: If you are an annuitant or former spouse, you can suspend your FEHB coverage to enroll in one of these programs, eliminating your FEHB premium. (OPM does not contribute to any applicable plan premiums.) For information on suspending your FEHB enrollment, contact your retirement office. If you later want to re-enroll in the FEHB Program, generally you may do so only at the next Open Season unless you involuntarily lose coverage under the program.

Workers' Compensation

We do not cover services that:

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

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

Medicaid

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

Suspended FEHB coverage to enroll in Medicaid or a similar State-sponsored program of medical assistance: If you are an annuitant or former spouse, you can suspend your FEHB coverage to enroll in one of these State programs, eliminating your FEHB premium. For information on suspending your FEHB enrollment, contact your retirement office. If you later want to re-enroll in the FEHB Program, generally you may do so only at the next Open Season unless you involuntarily lose coverage under the State program.

When other Government agencies are responsible for your care

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

When others are responsible for injuries

If you or any covered member of your family suffer injuries in an accident or become ill because of the actions of another person and you, thereafter, receive compensation, either from that person or from your own or other insurance, for the injuries or illness you will be required to reimburse the Plan for any services and supplies the Plan paid for out of the compensation you receive. This is known as the Plan's right of reimbursement and is also referred to as subrogation. You will have this obligation to reimburse the Plan even if the compensation you receive is not sufficient to compensate you fully for all of the damages which resulted from the accident or illness. In other words, the Plan is entitled to be reimbursed for all expenditures it has made on your behalf even if you are not "made whole" for all of your damages by the compensation you receive. The Plan's right to reimbursement is also not subject to reduction for attorney's fees under the "common fund" doctrine without the Plan's written consent. The Plan enforces this right of reimbursement by asserting a lien against any and all compensation you receive, whether by court order or out-of-court settlement. You must cooperate with the Plan in its enforcement of this right of reimbursement by telling the Plan whenever you or a covered member of your family has filed a claim for compensation resulting from an accident or illness. You must also accept the Plan's lien for the full amount of the benefits it has paid. You must agree to assign any proceeds from third party claims or your own insurance to the Plan when asked to do so and you must sign a Reimbursement Agreement for this purpose when asked by the Plan to do so. We will not pay benefits until this agreement is signed. The Plan's right to full reimbursement applies even if the Plan has paid benefits before we know of the accident or illness and before we have asked you to sign a Reimbursement Agreement. Unless the Plan agrees in writing to accept less than 100% of the Plan's lien amount, the Plan is entitled to be reimbursed for all the benefits it has paid on account of the accident or illness. If you would like more information about the subrogation process and how it works, please contact the Plan.

Section 10. Definitions of terms we use in this brochure

Accidental injury

A bodily injury sustained solely through violent, external and accidental means such as broken bones, animal bites and poisonings. Note: An injury to teeth while chewing and/or eating is not considered to be an accidental injury.

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.

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.

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.

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.

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.

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.

Custodial care that lasts 90 days or more is sometimes known as long term care. 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.

Durable medical equipment

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.

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 patient's doctor, for the care and treatment of the patient's illness or injury in the patient'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 patient 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.

Morbid obesity

A diagnosed condition in which the body mass index is 40 or greater or 35 or greater with co-morbidities such as diabetes, coronary artery disease, hypertension, hyperlipidemia, obstructive sleep apnea, pulmonary hypertension, weight related degenerative joint disease, or lower extremity venous or lymphatic obstruction. Eligible members must be age 18 or over.

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 providers: 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 providers' negotiated rate; PPO providers accept the Plan's allowance as payment in full.

- Non-PPO/non-participating providers: When you do not use a PPO provider to perform the service or provide the supply, our allowance is based on the 75th percentile factor of claims data and fee information gathered for specific geographic areas by Medical Data Research (MDR).

  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

Coverage information

- **No pre-existing condition limitation**

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

- **Where you can get information about enrolling in the FEHB Program**

See www.opm.gov/insure/health for enrollment information as well as:

- Information on the FEHB Program and plans available to you
- A health plan comparison tool
- A list of agencies who participate in Employee Express
- A link to Employee Express
- Information on and links to other electronic enrollment systems

Also, your employing or retirement office can answer your questions, and give you a *Guide to Federal Employees Health Benefits Plans*, brochures for other plans, and other materials you need to make an informed decision about your FEHB coverage. These materials tell you:

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

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

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

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

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

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

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

- **Children's Equity Act**

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

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

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

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

- **When benefits and premiums start**

The benefits in this brochure are effective January 1. If you joined this Plan during Open Season, your coverage begins on the first day of your first pay period that starts on or after January 1. If you changed plans or plan options during Open Season and you receive care between January 1 and the effective date of coverage under your new plan or option, your claims will be paid according to the 2006 benefits of your old plan or option. However, if your old plan left the FEHB Program at the end of the year, you are covered under that plan's 2005 benefits until the effective date of your coverage with your new plan. Annuitants' coverage and premiums begin on January 1. If you joined at any other time during the year, your employing office will tell you the effective date of coverage.

- **When you retire**

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

When you lose benefits

- **When FEHB coverage ends**

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

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

You may be eligible for spouse equity coverage or Temporary Continuation of Coverage (TCC), or a conversion policy (a non-FEHB individual policy.)

- **Spouse equity coverage**

If you are divorced from a Federal employee or annuitant, you may not continue to get benefits under your former spouse's enrollment. This is the case even when the court has ordered your former spouse to provide health coverage to you. But, you may be eligible for your own FEHB coverage under the spouse equity law or Temporary Continuation of Coverage (TCC). If you are recently divorced or are anticipating a divorce, contact your ex-spouse's employing or retirement office to get RI 70-5, the *Guide To Federal Employees Health Benefits Plans for Temporary Continuation of Coverage and Former Spouse Enrollees*, or other information about your coverage choices. You can also download the guide from OPM's Web site, www.opm.gov/insure.

- **Temporary Continuation of Coverage (TCC)**

If you leave Federal service, or if you lose coverage because you no longer qualify as a family member, you may be eligible for Temporary Continuation of Coverage (TCC). For example, you can receive TCC if you are not able to continue your FEHB enrollment after you retire, if you lose your Federal job, if you are a covered dependent child and you turn 22 or marry, etc.

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

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

- **Converting to individual coverage**

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

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

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

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

- **Getting a Certificate of Group Health Plan Coverage**

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is a Federal law that offers limited Federal protections for health coverage availability and continuity to people who lose employer group coverage. If you leave the FEHB Program, we will give you a Certificate of Group Health Plan Coverage that indicates how long you have been enrolled with us. You can use this certificate when getting health insurance or other health care coverage. Your new plan must reduce or eliminate waiting periods, limitations, or exclusions for health related conditions based on the information in the certificate, as long as you enroll within 63 days of losing coverage under this Plan. If you have been enrolled with us for less than 12 months, but were previously enrolled in other FEHB plans, you may also request a certificate from those plans.

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

Section 12. Two Federal Programs complement FEHB benefits

Important information

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

The Federal Flexible Spending Account Program – *FSAFEDS*

• What is an FSA?

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

There are two types of FSAs offered by FSAFEDS:

Health Care Flexible Spending Account (HCFSA)

- Covers eligible health care expenses not reimbursed by this Plan, or any other medical, dental, or vision care plan you or your dependents may have.
- Eligible dependents for this account include anyone you claim on your Federal Income Tax return as a qualified dependent under the U.S. Internal Revenue Service (IRS) definition and/or with whom you jointly file your Federal Income Tax return, even if you don't have self and family health benefits coverage. *Note:* The IRS has a broader definition of a "family member" than is used under the FEHB Program to provide benefits by your FEHB Plan.
- The maximum annual amount that can be allotted for the HCFSA is $5,000. *Note:* The Federal workforce includes a number of employees married to each other. If each spouse/employee is eligible for FEHB coverage, both may enroll for a HCFSA up to the maximum of $5,000 each ($10,000 total). Both are covered under each other's HCFSA. The minimum annual amount is $250.

Dependent Care Flexible Spending Account (DCFSA)

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

• Enroll during Open Season

You **must make an election** to enroll in an FSA during the 2006 FEHB Open Season. Even if you enrolled during 2005, you must make a new election to continue participating in 2006. Enrollment is easy!

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

What is SHPS?

SHPS is a Third-Party administrator hired by OPM to manage the FSAFEDS Program. SHPS is responsible for the enrollment, claims processing, customer service, and day-to-day operations of FSAFEDS.

- **Who is eligible to enroll?**

If you are a Federal employee eligible for FEHB – even if you're not enrolled in FEHB – you can choose to participate in either, or both, of the FSAFEDs accounts. *However, if you enroll in an FSA and enroll in a High Deductible Health Plan (HDHP), you are not eligible for a Health Savings Account (HSA) under your HDHP and will be enrolled in a Health Reimbursement Arrangement (HRA) instead.*

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

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

- **How much should I contribute to my FSA?**

Plan carefully when deciding how much to contribute to an FSA. Because of the tax benefits an FSA provides, the IRS requires that you forfeit any money for which you did not incur an eligible expense under your FSA account(s). This is known as the "Use-it-or-Lose-it" rule. FSAFEDS has adopted the "grace period" permitted by the IRS. You now have an additional 2½ months to incur eligible expenses and reduce any potential forfeitures. In addition, you will have until May 31, following the end of the Plan Year, to submit claims for your eligible expenses incurred from January 1 through March 15. For example, if you enroll in FSAFEDS for the 2006 Plan Year, you will have until May 31, 2007, to submit claims for eligible expenses. [And if your 2006 balance is not sufficient to reimburse you in full for eligible expenses incurred from January 1, 2007 through March 15, 2007, the unpaid balance will be paid out of your 2007 account if you re-enroll during Open Season. If you do not re-enroll, you cannot be reimbursed in full for these expenses.]

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

- **What can my HCFSA pay for?**

Every FEHB plan includes cost sharing features, such as deductibles you must meet before the Plan provides benefits, coinsurance or copayments that you pay when you and the Plan share costs, and medical services and supplies that are not covered by the Plan and for which you must pay. These out-of-pocket costs are summarized on pages 82 and 83 and detailed throughout this brochure. Your HCFSA will reimburse you when those costs are for qualified medical care that you, your spouse and/or your dependents receive that is NOT covered or reimbursed by this FEHB Plan or any other coverage that you have.

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

- the $20 per office visit PPO copayment
- the prescription drug copayments
- out-of-network mental health and substance abuse out-of-pocket expenses
- dental expenses not covered by this Plan
- expenses for lasik or other refractive surgery
- expenses for physical and occupational therapy services that exceed the $3,000 (High Option) or $2,000 (Standard Option) Plan limitation

The IRS governs expenses reimbursable by a HCFSA. See Publication 502 for a comprehensive list of tax-deductible medical expenses. Since Publication 502 is primarily meant to help on preparing your Federal income tax return, there are two important differences to note. ***Note:*** **While you will see insurance premiums listed in Publication 502, they are NOT a reimbursable expense for FSA purposes. In addition, over-the-counter medicines and products ARE an eligible expense under your HCFSA, and this is not included in Publication 502.** Publication 502 can be found on the IRS Web site at www.irs.gov/pub/irs-pdf/p502.pdf. The FSAFEDS Web site also has a comprehensive list of eligible expenses at https://www.FSAFEDS.com/fsafeds/eligibleexpenses.asp. If you do not see your service or expense listed, please call an FSAFEDS Benefits Counselor at 1-877-FSAFEDS (372-3337), who will be able to answer your specific questions.

• Tax savings with an FSA

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

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

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

• Tax credits and deductions

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

Health care expenses

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

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

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

Dependent care expenses

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

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

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

No. Section 1127 of the National Defense Authorization Act (Public Law 108-136) requires agencies that offer FSAFEDS to employees to cover the administrative fee(s) on behalf of their employees. However, remember that participating in FSAFEDS can cost you money if you don't spend your entire account balance during your period of coverage for the Plan Year plus 2½ months grace period, resulting in the forfeiture of funds remaining in your account (the IRS "Use-it-or-Lose-it" rule).

- **Contact us**

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

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

The Federal Long Term Care Insurance Program

- **It's important protection**

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

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

- **Qualified relatives are also eligible to apply.** Qualified relatives include spouses and adult children of employees and annuitants, and parents, parents-in-law, and stepparents of employees.

- **To request an Information Kit and application**

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

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

Notes

Notes

Summary of benefits for the High Option of the SAMBA Health Benefit Plan – 2006

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 $250 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.

High Option Benefits	You pay	Page
Medical services provided by physicians: • Diagnostic and treatment services provided in the office	PPO: $20 copayment per office visit Non-PPO: 30%* of the Plan allowance	21
Services provided by a hospital: • Inpatient	PPO: $200 copayment per confinement, nothing for room & board and 10% for other hospital services Non-PPO: $300 copayment per confinement and 30% of the Plan allowance	38
• Outpatient	PPO: $100 per facility charge and 10%* of the Plan allowance Non-PPO: $150 per facility charge and 30%* of the Plan allowance	40
Emergency benefits • Accidental injury	Nothing within 72 hours	43
• Medical emergency	Regular benefits apply	43
Mental health and substance abuse treatment	In-Network: Regular cost sharing Out-of-Network: Benefits are limited	44 46
Prescription drugs • Retail pharmacy	$10 generic, $25 formulary name brand or $40 non-formulary name brand copayment	51
• Mail order	$10 generic, $45 formulary name brand or $60 non-formulary name brand copayment Medicare Mail Order: $5 generic, $20 formulary name brand or $35 non-formulary name brand copayment	51
Dental care	PPO: 10%* of the Plan allowance for certain covered services Non-PPO: 30%* of the Plan allowance for certain covered services	54
Special features: Flexible benefits option; Travel benefit/services overseas; BlueCard® Program; Services for deaf and hearing impaired		53
Protection against catastrophic costs (out-of-pocket maximum)	PPO: Nothing after $3,500 for you and your covered family members per year Non-PPO: Nothing after $5,000 for you and your covered family members per year Some costs do not count toward this protection	14

Summary of benefits for the Standard Option of the SAMBA Health Benefit Plan – 2006

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 $250 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.

Standard Option Benefits	You pay	Page
Medical services provided by physicians: • Diagnostic and treatment services provided in the office	PPO: $20 copayment per office visit Non-PPO: 30%* of the Plan allowance	21
Services provided by a hospital: • Inpatient	PPO: $200 copayment per confinement Non-PPO: $300 copayment per confinement and 30% of the Plan allowance	38
• Outpatient	PPO: 15%* of the Plan allowance Non-PPO: 30%* of the Plan allowance	40
Emergency benefit • Accidental injury	Nothing within 72 hours	43
• Medical emergency	Regular benefits apply	43
Mental health and substance abuse treatment	In-Network: Regular cost sharing Out-of-Network: Benefits are limited	44 46
Prescription drugs • Retail pharmacy	$10 generic, $30 formulary name brand or $45 non-formulary name brand copayment; limited to the initial fill (not to exceed a 30-day supply) and one refill	51
• Mail order	$20 generic, 25% of the Plan allowance ($45 minimum/$80 maximum for each purchase) formulary name brand or 25% of the Plan allowance ($60 minimum/$100 maximum for each purchase) non-formulary name brand	51
Dental care	PPO: Nothing for routine dental services until benefits stop at $1,000 Non-PPO: The difference between the Plan allowance and the billed amount for routine dental services and all charges after the Plan pays $1,000	54
Special features: Flexible benefits option; Travel benefit/services overseas; BlueCard® Program; Services for deaf and hearing impaired		53
Protection against catastrophic costs (out-of-pocket maximum)	PPO: Nothing after $4,000 for you and your covered family members per year Non-PPO: Nothing after $6,000 for you and your covered family members per year Some costs do not count toward this protection	14

2006 Rate Information for the SAMBA Health Benefit Plan

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

Postal rates apply to career Postal Service employees. Most employees should refer to the FEHB Guide for United States Postal Service Employees, RI 70-2. Different postal rates apply and a special FEHB guide is published for Postal Service Inspectors and Office of Inspector General (OIG) employees (see RI 70-2IN).

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

Type of Enrollment	Enrollment Code	*Non-Postal Premium* Biweekly Government Share	*Non-Postal Premium* Biweekly Your Share	*Non-Postal Premium* Monthly Government Share	*Non-Postal Premium Monthly* Your Share	*Postal Premium* Biweekly USPS Share	Postal Premium *Biweekly Your Share*
High Option Self Only	**441**	**$139.18**	**$94.19**	**$301.56**	**$204.08**	**$164.31**	***$69.06***
High Option Self and Family	**442**	**$316.08**	**$233.50**	**$684.84**	**$505.92**	**$373.15**	***$176.43***
Standard Option Self Only	**444**	**$137.73**	**$45.91**	**$298.42**	**$99.47**	**$162.98**	***$20.66***
Standard Option Self and Family	***445***	***$314.57***	***$104.85***	***$681.56***	***$227.18***	***$372.24***	***$47.18***