SAMBA
Health Benefit Plan

http://www.SambaPlans.com

SAMBA
ESTABLISHED 1948

2009

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

Sponsored and administered by: the Special Agents Mutual Benefit Association

For changes in benefits, see page 8.

Who may enroll in this Plan: All Federal employees and annuitants who are eligible to enroll in the Federal Employees Health Benefits Program (FEHB) may enroll in the SAMBA Health Benefit Plan.

To become a member: Employees and annuitants enrolling in the SAMBA Health Benefit Plan will automatically become members of the Special Agents Mutual Benefit Association.

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

CareAllies health and medical management programs are administered by International Rehabilitation Associates, Inc. d/b/a Intracorp. Intracorp holds accreditations in Health Utilization Management and Case Management. Medco Health Solutions, Inc. is JCAHO accredited. See the 2009 Guide for more information on accreditation.

Special Notice:
This is the first year that SAMBA is an "open" plan.
Membership is no longer restricted to specific groups

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

Important Notice from SAMBA About

Our Prescription Drug Coverage and Medicare

OPM has determined that the SAMBA Health Benefit Plan's prescription drug coverage is, on average, expected to pay out as much as the standard Medicare prescription drug coverage will pay for all plan participants and is considered Creditable Coverage. Thus you do not need to enroll in Medicare Part D and pay extra for prescription drug benefit coverage. 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 your FEHB plan will coordinate benefits with Medicare.

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

Please be advised

If you lose or drop your FEHB coverage and go 63 days or longer without prescription drug coverage that's at least as good as Medicare's prescription drug coverage, your monthly premium will go up at least 1% per month for every month that you did not have that 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 many other people pay. You'll have to pay this higher premium as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the next Annual Coordinated Election Period (November 15th through December 31st) 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, 2009, unless those benefits are also shown in this brochure.

OPM negotiates benefits and rates with each plan annually. Benefit changes are effective January 1, 2009, 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” or "us" 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:

- Do not give your plan identification (ID) number over the telephone or to people you do not know, except for your health care provider, authorized health benefits 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) statements 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, DC20415-1100

- 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); o
  - 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 it. 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.
- Contact your doctor or pharmacist if you have any questions.

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 reactions to anesthesia, and any medications you are taking.

Visit these Web sites for more information about patient safety.

Ø www.ahrq.gov/beactive.htm. 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.

Ø www.npsf.org. The National Patient Safety Foundation has information on how to ensure safer health care for you and your family.

Ø www.talkaboutrx.org. The National Council on Patient Information and Education is dedicated to improving communication about the safe, appropriate use of medicines.

Ø www.leapfroggroup.org. The Leapfrog Group is active in promoting safe practices in hospital care.

Ø www.ahqa.org. The American Health Quality Association represents organizations and health care professionals working to improve patient safety.

Ø 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 a PPO. This means that certain hospitals and other health care providers are "preferred providers." We have entered into an arrangement with CIGNA to offer the CIGNA Shared Administration PPO Network to SAMBA enrollees in all states. When you use our PPO providers, you will receive covered services at reduced cost. SAMBA is solely responsible for the selection of the PPO network in your area. Contact CareAllies (a CIGNA subsidiary) at 1-800/887-9735 for the names of PPO providers and to verify their continued participation. You can also go to our Web page, which you can reach through the FEHB Web site, www.opm.gov/insure. Contact SAMBA at 1-800/638-6589 or 301/984-1440 (for TDD, use 301/984-4155) to request a PPO directory.

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. When you phone for an appointment, please remember to verify that the health care provider or facility is still a PPO provider. The nature of the services (such as urgent or emergency situations) does not affect whether benefits are paid as PPO or non-PPO. If you reside in the PPO network area and no PPO provider is available, or you do not use a PPO provider, the regular non-PPO benefits apply.

You cannot change health plans out of Open Season 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 Ingenix, Inc. (Ingenix) 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 and our providers. 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.

Your medical and claims records are confidential

We will keep your medical and claims records confidential. Please note that we may disclose your medical and claims information (including your prescription drug utilization) to any of your treating physicians or dispensing pharmacies.

Section 2. How we change for 2009

Do not rely only 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**, Illinois has been added to the list of medically underserved areas for 2009.

Changes to both our High and Standard Options

- Coverage of routine mammograms for women age 65 and older has been increased from one every two consecutive calendar years to one every calendar year. See page 24.
- Benefits for skilled nursing care facilities are no longer available. See page 44.
- Benefits for foot orthotics and arch supports are no longer available. See page 30.
- Fertility drugs are no longer covered. See page 56.
- Coverage has been increased to 100% for routine adult immunizations endorsed by the Centers for Disease Control and Prevention (CDC). See page 24.
- The non-PPO benefits for *Orthopedic and prosthetic devices* has been reduced from 70% to 50% of the Plan allowance. See page 30.
- PPO benefits will be paid for services rendered by a non-PPO assistant surgeon when treatment is received in a PPO facility. See pages 35 and 43.

Changes to our High Option only

- Your share of the non-Postal premium will decrease for Self Only and Self and Family. See page 86.
- Benefits for home health aide services are no longer available. See page 32.
- Benefits are now provided for screenings, testing, diagnostic evaluations, and treatment by licensed hearing professionals (including hearing aids) for adults under the Plan's *Hearing services (testing, treatment, and supplies)* benefit. See page 28.
- The prescription drug copayment amounts under *Section 5(f). Prescription drug benefits* have increased as follows: Non-Medicare members at Retail – preferred drugs have increased from $25 to $30 per prescription and non-preferred drugs have increased from $40 to $45 per prescription; Non-Medicare members at Mail Order – preferred drugs have increased from $45 to $50 per prescription and non-preferred drugs have increased from $60 to $65 per prescription; Medicare members at Retail – all copays remain the same; Medicare members at Mail Order – generic drugs have increased from $5 to $10 per prescription, preferred drugs have increased from $20 to $30 per prescription and non-preferred drugs have increased from $35 to $50 per prescription. See page 55.

Changes to our Standard Option only

- Your share of the non-Postal premium will increase for Self Only and Self and Family. See page 86.
- PPO benefits for *Other inpatient hospital services and supplies* have been reduced from 100% to 85% of the Plan allowance. See page 43.
- The catastrophic protection out-of-pocket maximum will no longer include out-of-pocket expenses for deductibles and copayments. See page 15.
- Benefits for the diagnosis and treatment of infertility have been reduced from $5,000 per person, per lifetime to $2,500 per person, per lifetime. See page 26.
- The calendar year deductible has been increased from $250 to $300 per person and from $500 to $600 per family for all benefit categories.
- The calendar year deductible for mental health and substance abuse benefits has been increased from $250 to $300 per person and from $500 to $600 per family.

- Benefits for the first hearing aid and testing when necessitated by an accidental injury are no longer available. See page 29.
- A catastrophic out-of-pocket limit of $5,000 per person, per calendar year has been added to the Prescription drug benefits for both retail and mail order drugs combined. See page 16.
- The prescription drug copayment amounts under *Section 5(f). Prescription drug benefits* have changed as follows: Retail – preferred drugs have changed from $30 to 25% coinsurance ($30 minimum/$60 maximum) per prescription and non-preferred drugs have changed from $45 to 35% coinsurance ($45 minimum/$90 maximum) per prescription; Mail Order – preferred drugs have changed from 25% coinsurance ($45 minimum/$80 maximum) to 25% coinsurance ($50 minimum/$100 maximum) per prescription and non-preferred drugs have changed from 25% coinsurance ($60 minimum/$100 maximum) to 35% coinsurance ($65 minimum/$120 maximum) per prescription. The generic copayments will remain unchanged. See page 55.

Other Changes

- Open enrollment in the SAMBA Health Benefit Plan has been extended to include all Federal employees and annuitants who are eligible to enroll in the Federal Employees Health Benefits Program (FEHB).
- Please note the SAMBA Health Benefit Plan brochure number has changed to RI 71-015

Clarifications

- A definition for sound natural tooth has been added to this brochure. See *Section 10. Definitions of terms we use in this brochure* on page 75.
- Dental implants are now specifically excluded under *Section 5(g). Dental benefits*. See page 58.
- The Plan's extended prescription drug dispensing limitations have been updated to indicate that the Plan will authorize up to a 90-day supply of medication(s) if you should be called to active military duty and a 30-day supply in the event of a national emergency. See *Section 5(f). Prescription drug benefits* on page 53.
- Diagnostic tests and medication management are now specifically listed as covered expenses under Out-of-Network benefits in *Section 5(e). Mental health and substance abuse benefits*. See page 50.
- Emergency room physician care is now specifically listed as a covered expense under "Diagnostic and treatment services" in *Section 5(a). Medical services and supplies provided by physicians and other health care professionals*. See page 22.
- The three benefit levels for prescription drugs purchased through the retail pharmacy and mail order programs under *Section 5(f). Prescription drug benefits* have been further defined as follows. Level I: generic drugs; Level II: formulary or preferred name brand drugs; and Level III: non-formulary or non-preferred name brand drugs. See page 52.
- Telephone and on-line medical consultations are now specifically excluded. See *Section 6. General exclusions – things we don't cover* on page 62.

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
- licensed acupuncturist (LAC)
- 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 the states OPM determines are "medically underserved." For 2009, the states are: Alabama, Arizona, Idaho, Illinois, Kentucky, Louisiana, Mississippi, Missouri, Montana, New Mexico, North Dakota, South Carolina, South Dakota, 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.
- 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.

In no event shall the term "hospital" include a skilled nursing facility, a convalescent nursing home, or any institution or part thereof which: a) is used principally as a convalescent facility, nursing facility, or facility for the aged; b) furnishes primarily domiciliary or custodial care, including training in the routines of daily living; or c) is operated as a school or residential treatment facility.

- 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.

What you must do to get covered care

It depends on the type 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 reasons 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 your PPO benefits continue until the end of your postpartum care, even if it is beyond the 90 days.

- **If you are hospitalized when your enrollment begins**

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 are new to the FEHB Program, we will reimburse you for your covered services while you are in the hospital beginning on the effective date of your coverage.

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

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

These provisions apply only to the benefits of the hospitalized person. If your plan terminates participation in the FEHB Program in whole or in part, or if OPM orders an enrollment change, this continuation of coverage provision does not apply. In such cases, 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 your care is precertified, 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 CIGNA/CareAllies at 1-800/887-9735 7 days (whenever possible) before admission.

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 admission for a vaginal delivery or 96 hours after admission for a cesarean section, then your physician or the hospital must contact us for precertification of additional days. Further, if your baby stays after you are discharged, then your physician or the hospital must contact us for precertification of additional days for your baby

If your hospital stay needs to be extended:

If your hospital stay – including for maternity care – needs to be extended, 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 contacts 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.
- 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**

Certain services require prior authorization from us. You must obtain prior authorization for:

- Covered outpatient services for the treatment of mental conditions and substance abuse. Your provider must submit a treatment plan to CIGNA/CareAllies prior to your 9th outpatient visit. In determining when your treatment plan must be submitted, we count all outpatient psychotherapy visits, even if you use different providers. If you change providers, a new treatment plan must be submitted. Call CIGNA/CareAllies at 1-800/887-9735. Refer to pages 49 and 51 for additional information.
- Certain prescription drugs and supplies. Contact Medco Health at 1-800/753-2851 for additional information.
- Growth hormone therapy (GHT) drugs (see Section 5(f)). 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.
- Surgical treatment of morbid obesity (bariatric surgery). Contact CIGNA/CareAllies at 1-800/887-9735.

Note: The prior authorization process for organ/tissue transplants is more extensive than the normal authorization process. See Section 5(b) on page 40.

Warning:

We will reduce our Plan allowance by 20% if no one contacts us for prior authorization. In addition, if the services are not medically necessary, we will not pay any benefits.

Section 4. Your costs for covered services

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

Copayment

A copayment is a fixed amount of money you pay to the provider, facility, pharmacy, etc., when you receive certain services.

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

Note: If the billed amount (or the Plan allowance that providers we contract with have agreed to accept as payment in full) is less than your copayment, you pay the lower amount.

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

Cost-sharing

Cost-sharing is the general term used to refer to your out-of-pocket costs (e.g., deductible, coinsurance, and copayments) for the covered care you receive.

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 and coinsurance amounts do not count toward any deductible. When a covered service or supply is subject to a deductible, only the Plan allowance for the service or supply counts toward the deductible.

- The calendar year deductible is $250 per person under the High Option and $300 per person under the 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 the High Option and $600 under the 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 the High Option and $300 per person/$600 per family under the Standard Option.

If the billed amount (or Plan allowance that providers we contract with have agreed to accept as payment in full) is less than the remaining portion of your deductible, you pay the lower amount.

Example: If the billed amount if $100, the provider has an agreement with us to accept $80, and you have not paid any amount toward meeting your calendar year deductible, you must pay $80. We will apply $80 to your deductible. We will begin paying benefits once the remaining portion of your calendar year deductible ($170) has been satisfied.

Note: If you change plans during open season and the effective date of your new plan is after January 1 of the next year, 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.

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.

If your provider routinely waives your cost

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).

Waivers

In some instances, a provider may ask you to sign a "waiver" prior to receiving care. This waiver may state that you accept responsibility for the total charge for any care that is not covered by your health plan. If you sign such a waiver, whether you are responsible for the total charge depends on the contracts that the Plan has with its providers. If you are asked to sign this type of waiver, please be aware that, if benefits are denied for the services, you could be legally liable for the related expenses. If you would like more information about waivers, please contact us at 1-800/638-6589 or 301/984-1440 (for TDD, use 301/984-4155).

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 surgeon 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/her 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, the physician can bill you for the $50 difference between our allowance and his/her 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 expenses listed below 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.

High Option:

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

- $250 calendar year deductible ($500 family);
- $250 mental health deductible ($500 family);
- $200 PPO and $300 non-PPO per inpatient hospital confinement copayment;
- $100 PPO and $150 non-PPO outpatient facility services copayment;
- $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 High Option 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.

Standard Option:

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

- 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 Standard Option out-of-pocket expenses:

- the $300 per person ($600 family) calendar year deductible
- the $300 per person ($600 family) mental health deductible;
- the $200 PPO and $300 non-PPO per inpatient hospital confinement copayment;
- the $20 office visit copayment under PPO benefits;
- expenses in excess of the Plan allowance or maximum benefit limitations;

- amounts you pay for non-compliance with the Plan's preauthorization requirements; and
- the cost difference between a name brand drug and its generic equivalent.

Standard Option (only) prescription drugs: Copayments and coinsurance expenses for prescription drugs obtained from a Network retail pharmacy or through our Mail Order program will count toward a separate $5,000 per person, per calendar year prescription out-of-pocket limit. Note: expenses you pay for non-covered drugs and the difference in cost between a name brand drug and its generic equivalent do not count toward this out-of-pocket limit.

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 received in January before your effective date of coverage in this Plan. If you have already met your old plan's catastrophic protection benefit level in full, it will continue to apply until the effective date of your coverage in this Plan. 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 of your coverage in this Plan. Your 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 out-of-pocket limit of your old option to the catastrophic protection limit of your new option.

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 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.

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 payments you would be entitled to if you had Medicare. 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 care and non-physician based care are 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 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 "equivalent Medicare amount."

And, for your physician care,the law requires us to base our payment and your coinsurance or copayment 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.

We use the Department of Veterans Affairs (VA) Medicare-equivalent Remittance Advice (MRA) when the statement is submitted to determine our payment for covered services provided to you if Medicare is primary, when Medicare does not pay the VA facility.

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 the Medicare carrier that 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 84 and page 85 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 *Important things you should keep in mind* at the beginning of the subsections. Also read the *General exclusions* in Section 6, they apply to the benefits in the following subsections. To obtain claim forms, claims filling 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

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 the High Option and $300 per person ($600 per family) under the 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.

Benefit Description	You Pay	
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 • Emergency room physician care	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

Benefit Description	You Pay	
Lab, X-ray and other diagnostic tests	**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 If your PPO provider uses a non-PPO lab or radiologist, we will pay non-PPO benefits for any lab and X-ray charges.
Quest Lab Program — You can use this voluntary program for covered lab services. Testing must be performed by Quest Diagnostics. Ask your doctor to use Quest for lab processing. To find a location near you, visit our Web site at www.SambaPlans.com.	Nothing for services obtained through the Quest Lab Program (No deductible)	Nothing for services obtained through the Quest Lab Program (No deductible)
Preventive care, adult	**High Option**	**Standard Option**
Cancer screenings, including: • Fecal occult blood test • 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 • Double contrast barium enema – every five years starting at age 50	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
Routine screenings, limited to: • Total blood cholesterol • Chlamydial infections • Osteoporosis screenings, once every two years, for women age 65 or 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
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 and older, one every calendar year	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

Preventive care, adult - continued on next page

Benefit Description	You Pay	
Preventive care, adult (cont.)	**High Option**	**Standard Option**
Adult routine immunizations endorsed by the Centers for Disease Control and Prevention (CDC)	PPO: Nothing (No deductible) Non-PPO: Any difference between our allowance and the billed amount (No deductible)	PPO: Nothing (No deductible) Non-PPO: Any difference between our allowance and the billed amount (No deductible)
Not covered • *Routine immunizations not endorsed by the Centers for Disease Control and Prevention (CDC)*	*All charges*	*All charges*
Preventive care, children	**High Option**	**Standard Option**
• Childhood immunizations recommended by the American Academy of Pediatrics for dependent children to age 22	PPO: Nothing (No deductible) Non-PPO: Any difference between our allowance and the billed amount (No deductible)	PPO: Nothing (No deductible) Non-PPO: Any difference between our allowance and the billed amount (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 the 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 Note: see *Lab, X-ray and other diagnostic tests* on page 23 for information regarding services obtained through the Quest Lab Program.	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	**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 11 for other circumstances, such as extended stays for you or your baby. • You may remain in the hospital up to 48 hours after admission for a regular delivery and 96 hours after admission for 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.	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

Maternity care - continued on next page

Benefit Description	You Pay	
Maternity care (cont.)	**High Option**	**Standard Option**
• 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	**High Option**	**Standard Option**
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
Not covered: • *Reversal of voluntary surgical sterilization* • *Genetic counseling* • *Genetic testing* • *Expenses for sperm collection and storage*	*All charges*	*All charges*
Infertility services	**High Option**	**Standard Option**
Diagnosis and treatment of infertility, except as shown in *Not covered.* Note: Benefits are limited to $5,000 per person, per lifetime under the **High Option** and $2,500 per person, per lifetime under the **Standard Option**.	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 $2,500 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 $2,500
Not covered: • *Infertility services after voluntary sterilization* • *Any charges in excess of the $5,000 (High Option) and $2,500 (Standard Option) plan limitation for covered infertility services* • *Fertility drugs* • *Assisted reproductive technology (ART) procedures, such as:*	*All charges*	*All charges*

Infertility services - continued on next page

Benefit Description	You Pay	
Infertility services (cont.)	**High Option**	**Standard Option**
• *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 or egg* • *Expenses for sperm collection and storage* • *Surrogacy (host uterus/gestational carrier)*	*All charges*	*All charges*
Allergy care	**High Option**	**Standard Option**
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
Not covered: • *Provocative food testing and sublingual allergy desensitization* • *Clinical ecology and environmental medicine*	*All charges*	*All charges*
Treatment therapies	**High Option**	**Standard Option**
• Chemotherapy and radiation therapy Note: High dose chemotherapy in association with autologous bone marrow transplants is limited to those transplants listed on pages 38 and 39. • 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.	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 - continued on next page

Benefit Description	You Pay	
Treatment therapies (cont.)	**High Option**	**Standard Option**
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. Ask us to authorize GHT before you begin treatment; otherwise, we will only cover GHT services from the date you submit the information. If you do not ask or if we determine GHT is not medically necessary, we will not cover the GHT or related services and supplies. See *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	**High Option**	**Standard Option**
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	**High Option**	**Standard Option**
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)	**High Option**	**Standard Option**
Hearing screenings, testing, diagnostic evaluation, and treatment by a licensed hearing professional for dependent children up to age 22. Note: Benefits for hearing aids are limited to $1,000 per newborn/child, per lifetime.	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 screenings, testing, diagnostic evaluation, and treatment by a licensed hearing professional for adults. Note: Benefits for hearing aids are limited to $500 per person/adult, per lifetime.	PPO: 10% of the Plan allowance Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount	All charges
Not covered:	*All charges*	*All charges*

Hearing services (testing, treatment, and supplies) - continued on next page

Benefit Description	You Pay	
Hearing services (testing, treatment, and supplies) (cont.)	**High Option**	**Standard Option**
• *Hearing testing, except as stated on page 28* • *Hearing aids, testing and examinations for them, except as stated on page 28* • *Any charges in excess of the $1,000 per newborn/child, per lifetime Plan limitation for hearing aids* • *Any charges in excess of the $500 per person/adult, per lifetime Plan limitation for hearing aids* • *Replacement batteries for hearing aids*	*All charges*	*All charges*
Vision services (testing, treatment, and supplies)	**High Option**	**Standard Option**
• 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	**High Option**	**Standard Option**
• 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*

Benefit Description	You Pay	
Orthopedic and prosthetic devices	**High Option**	**Standard Option**
• Artificial limbs and eyes; stump hose • Orthopedic and corrective shoes • Externally worn breast prostheses and surgical bras, including necessary replacements following a mastectomy • Lumbosacral supports • Crutches, surgical dressings, splings, 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: 50% of the Plan allowance and any difference between our allowance and the billed amount	PPO: 15% of the Plan allowance Non-PPO: 50% of the Plan allowance and any difference between our allowance and the billed amount
Not covered: • *Penile prosthetics* • *Wigs* • *Arch supports and foot orthotics* • *Heel pads and heel cups*	*All charges*	*All charges*
Durable medical equipment (DME)	**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 of durable medical equipment, at our option, including repair and adjustment. Covered items include: • Oxygen equipment and oxygen; • Hospital beds; • Wheelchairs; and • Walkers.	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)

Durable medical equipment (DME) - continued on next page

Benefit Description	You Pay	
Durable medical equipment (DME) (cont.)	**High Option**	**Standard Option**
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 lifetime limitation for covered durable medical equipment* • *Computer devices to assist with communications* • *Computer programs of any type* • *Other items that do not meet the definition of durable medical equipment*	*All charges*	*All charges*
Home health services	**High Option**	**Standard Option**
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 when: • prescribed by the attending physician; • the physician indicates the length of time the services are needed; and • the physician identifies the specific professional skills required by the patient and the medical necessity for the services. 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: • *Home health aide services* • *Inpatient private duty nursing* • *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*	*All charges*	*All charges*

Home health services - continued on next page

Benefit Description	You Pay	
Home health services (cont.)	**High Option**	**Standard Option**
• *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	**High Option**	**Standard Option**
• 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	**High Option**	**Standard Option**
• Acupuncture by a doctor of medicine, doctor of osteopathy or licensed acupuncturist for pain relief Benefits are limited to $500 per person, per calendar year for all covered services and supplies.	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
Not covered: • *Naturopathic practitioner* • *Massage therapist* • *Any charges in excess of the $500 plan limitation for covered acupuncture and chiropractic 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	**High Option**	**Standard Option**
• Smoking Cessation – Up to $100 for one smoking cessation program per member per lifetime, including all related expenses such as drugs.	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
• Diabetes self management	PPO: 10% of the Plan allowance Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount	PPO: 15% of the Plan allowance Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount

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

Important 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 the High Option and $300 per person ($600 per family) under the 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 FOR SOME SURGICAL PROCEDURES.** Please refer to page 40 for information regarding *Organ/tissue transplants*.

Benefit Description	You Pay After the calendar year deductible…	
Note: The calendar year deductible applies ONLY when we say below: "(calendar year deductible applies)".		
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 • Electroconvulsive therapy • 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 treatment of morbid obesity (bariatric surgery) – Preauthorization of this procedure is required. Contact CIGNA/CareAllies at 1-800/887-9735. The Plan's criteria includes the following: - Eligible patients must be age 18 or over	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

Benefit Description	You Pay After the calendar year deductible…	
Surgical procedures (cont.)	**High Option**	**Standard Option**
- 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 - A repeat or revised bariatric surgical procedure is covered only when deemed medically necessary or a complication has occurred. • Treatment of burns • Assistant surgeons- we cover up to 20% of our allowance for the surgeon's charge	PPO: 10% of the Plan allowance Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount Note: If you use a PPO facility, we pay PPO benefits if you receive treatment from an assistant surgeon 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 assistant surgeon who is not a PPO provider.
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 allowance and the billed amount
Not covered: • *Reversal of voluntary sterilization* • *Services of a standby surgeon, except during angioplasty or other high risk procedures when we determine standbys are medically necessary* • *Routine treatment of conditions of the foot; see Foot care* • *Eye surgery, such as radial keratotomy, lasik and laser surgery when the primary purpose is to correct myopia (nearsightedness), hyperopia (farsightedness) or astigmatism (blurring)*	*All charges*	*All charges*

Benefit Description	You Pay After the calendar year deductible…	
Reconstructive surgery	**High Option**	**Standard Option**
• 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 admission.	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: • *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	**High Option**	**Standard Option**
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	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

Oral and maxillofacial surgery - continued on next page

Benefit Description	You Pay After the calendar year deductible…	
Oral and maxillofacial surgery (cont.)	**High Option**	**Standard Option**
• 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	**High Option**	**Standard Option**
Solid organ transplants are limited to: • Cornea • Heart • Heart/lung • Kidney • Liver • Pancreas • Single, double or lobar lung • Intestinal transplants - Small intestine - Small intestine with the liver - Small intestine with multiple organs, such as the liver, stomach, and pancreas	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
Blood or marrow stem cell transplants limited to the stages of the following diagnoses (the medical necessity limitation is considered satisfied if the patient meets the staging description): • Allogeneic transplants for: - Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia - Chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL) - Advanced Hodgkin’s lymphoma - Advanced non-Hodgkin’s lymphoma - Chronic myleogenous leukemia - Hemoglobinopathy (i.e., Fanconi's, Thalessemia major) - Myelodysplasia/Myelodysplastic syndromes - Severe combined immunodeficiency - Severe or very severe aplastic anemia - Amyloidosis	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

Benefit Description	You Pay After the calendar year deductible…	
Organ/tissue transplants (cont.)	**High Option**	**Standard Option**
• Autologous transplants for: - Acute lymphocytic or nonlymphocytic (i.e., myelogenous) leukemia - Advanced Hodgkin's lymphoma - Advanced non-Hodgkin's lymphoma - Advanced Neuroblastoma - Amyloidosis • Autologous tandem transplants for - Recurrent germ cell tumors (including testicular cancer) - Multiple myeloma - De-novo myeloma	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
Blood or marrow stem cell transplants for: • Allogeneic transplants for: - Phagocytic/Hemophagocytic deficiency diseases (e.g., Wiskott-Aldrich syndrome) - Leukocyte adhesion deficiencies - Mucolipidosis (e.g., Gaucher's disease, metachromatic leukodystrophy, adrenoleukodystrophy) - Mucopolysaccharidosis (e.g., Hurler's syndrome, Maroteaux-Lamy syndrome variants) - X-linked lymphoproliferative syndrome • Autologous transplants for: - Multiple myeloma - Testicular, mediastinal, retroperitoneal, and ovarian germ cell tumors - Breast cancer - Epithelial ovarian cancer - Pineoblastoma - Waldenstrom's macroglobulinemia	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
Blood or marrow stem cell transplants covered only in a National Cancer Institute or National Institutes of Health approved clinical trial for: • Allogeneic transplants for: - Chronic lymphocytic leukemia - Chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL) - Early stage (indolent or non-advanced) small cell lymphocytic lymphoma - Myelodysplasia/Myelodysplastic syndromes - Multiple myeloma	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

Benefit Description	You Pay After the calendar year deductible…	
Organ/tissue transplants (cont.)	**High Option**	**Standard Option**
• Nonmyeloablative allogeneic transplants for: - Chronic lymphocytic leukemia - Chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL) - Early stage (indolent or non-advanced) small cell lymphocytic lymphoma - Multiple myeloma	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
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 from the date the transplant procedure is performed; and • Pharmacy costs for immunosuppressant and other transplant-related medication. The Plan uses specific Plan-designated organ/tissue transplant facilities. Before your initial evaluation as a potential candidate for a transplant procedure, you or your doctor must contact the CareAllies CIGNA LIFESOURCE Transplant Unit at 1-800/668-9682 to initiate the pretransplant evaluation. The clinical results of the evaluation will be reviewed to determine if the proposed procedure meets the Plan's definition of medically necessary. A case manager will assist the patient in accessing the appropriate transplant facility. If you choose a Plan-designated transplant facility, the Plan will provide an allowance for preapproved reasonable travel and lodging costs (see Travel/Lodging Benefit below). 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.		
Travel/Lodging Benefit – If the recipient lives more than 50 miles from a Plan-designated transplant facility, the Plan will provide an allowance for preapproved travel and lodging expenses up to $10,000 per transplant. The allowance will provide coverage of reasonable travel and temporary lodging expenses for the recipient and one companion (two companions if the recipient is a minor) and the actual organ donor, if applicable.		

Organ/tissue transplants - continued on next page

Benefit Description	You Pay After the calendar year deductible…	
Organ/tissue transplants (cont.)	**High Option**	**Standard Option**
Limited Benefits – If you do not use a Plan-designated transplant facility total benefit payments, including donor expenses, the transplant procedure itself (hospital and doctor fees), transplant-related follow-up care for one year from the date the transplant procedure is performed, and pharmacy costs for immonosuppressant and other transplant-related medication will be limited to a maximum payment of $100,000 per transplant. The travel and lodging allowance will not be available.		
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	**High Option**	**Standard Option**
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

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. We added "(calendar year deductible applies)". The calendar year deductible is: $250 per person ($500 per family) under the High Option and $300 per person ($600 per family) under the 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 FOR 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.

Benefit 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 72.	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 72.
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	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, anesthesiologist, or assistant surgeon who is not a PPO provider.	PPO: 15% 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, anesthesiologist, or assistant surgeon who is not a PPO provider.

Inpatient hospital - continued on next page

Benefit Description	You Pay	
Inpatient hospital (cont.)	**High Option**	**Standard Option**
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, anesthesiologist, or assistant surgeon who is not a PPO provider.	PPO: 15% 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, anesthesiologist, or assistant surgeon 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	**High Option**	**Standard Option**
• Operating, recovery, and other treatment rooms • Prescribed drugs and medicines • Diagnostic laboratory tests, X-rays , and pathology services • Administration of blood, blood plasma, and other biologicals • Blood and blood plasma , if not donated or replaced • Pre-surgical testing • Dressings, casts, and sterile tray services • Medical supplies, including oxygen • Anesthetics and anesthesia service Note: We cover hospital services and supplies related to dental procedures when necessitated by a non-dental physical impairment.	PPO: $100 copayment per outpatient facility charge and 10% of the Plan allowance 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 Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount (calendar year deductible applies)

Benefit Description	You Pay	
Extended care benefits/Skilled nursing care facility benefits	**High Option**	**Standard Option**
No benefit	All charges	All charges
Hospice care	**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	**High Option**	**Standard Option**
• Local professional ambulance service only to and from a hospital, when medically appropriate	PPO: 10% of the Plan allowance Non-PPO: 30% of thePlan 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)
Not covered:	*All Charges*	*All Charges*

Ambulance - continued on next page

Benefit Description	You Pay	
Ambulance (cont.)	**High Option**	**Standard Option**
• *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*	*All Charges*	*All Charges*

Section 5(d). Emergency services/accidents

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 the High Option and $300 per person ($600 per family) under the 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(g) for dental care for accidental injury.

Benefit Description	You pay After the calendar year deductible…	
Note: The calendar year deductible applies to almost all benefits in this Section. We say "(No deductible)" when it does not apply.		
Accidental injury	**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	**High Option**	**Standard Option**
Medical emergencies are considered the same as any other illness and regular Plan benefits apply.	Regular Plan benefits apply	Regular Plan benefits apply
Ambulance	**High Option**	**Standard Option**
For accidental injury only - 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.

Important things you should keep in mind about these benefits:

- Services must be provided by a PPO provider to receive In-Network 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 calendar year deductible of $250 per person ($500 per family) under the High Option and $300 per person ($600 per family) under the 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 FOR 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 50.

Benefit Description	You Pay After the calendar year deductible…	
Note: The calendar year deductible applies to almost all benefits in this Section. We say "(No deductible)" when it does not apply.		
In-Network benefits	**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 49.	$20 copayment per visit (No deductible)	$20 copayment per visit (No deductible)
Other outpatient care including: • Day or after care (partial hospitalization) in a hospital	10% of the Plan allowance	15% of the Plan allowance

In-Network benefits - continued on next page

Benefit Description	You Pay After the calendar year deductible…	
In-Network benefits (cont.)	**High Option**	**Standard Option**
Note: Preauthorization is required; see page 49.	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 page 49. A confinement is defined in Section 10, page 72.	$200 copayment per confinement, nothing for room and board and 10% of the Plan allowance for other hospital services (No deductible)	$200 copayment per confinement, nothing for room and board and 15% of the Plan allowance for other hospital services (No deductible)
• Services of a doctor for inpatient hospital visits	10% of the Plan allowance	15% of the Plan allowance
Not covered: • *Marital counseling* • *Treatment for learning disabilities* • *Telephone consultations and/or therapy* • *On-line consultations* • *Travel time to the patient's home to conduct therapy* • *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 following network authorization processes:

- The medical necessity of your admission to a hospital or other covered facility must be preauthorized prior to admission. Emergency admissions must be reported within two business days following the day of admission even if you have been discharged. Otherwise, benefits will be reduced by $500.
- Prior authorization is required for outpatient treatment and day or after care treatment (partial hospitalization). In order to maximize your benefits, your provider must submit a treatment plan to CIGNA/CareAllies prior to your 9th outpatient visit. In determining when your treatment plan must be submitted, we count all outpatient psychotherapy visits, even if you use different providers. When we approve the treatment plan, we will give your provider authorization for additional visits. If you change providers, a new treatment plan must be submitted. If preauthorization is not obtained, we will reduce our Plan allowance by 20%.

Note: To obtain preauthorization call CIGNA/CareAllies at 1-800/887-9735

Network limitation

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

Benefits Description	You pay After the calendar year deductible…	
The calendar year deductible applies to almost all benefits in this Section. We say ""(No deductible)" when it does not apply		
Out-of-Network benefits	**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 • Medication management 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 51. 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
• Diagnostic tests	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
Covered inpatient hospital and rehabilitation facility charges include: • Room and board including general nursing care, in semiprivate accomodations • 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 51.	$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
Not covered out-of-network:	*All charges*	*All charges*

Out-of-Network benefits - continued on next page

Benefits Description	You pay After the calendar year deductible…	
Out-of-Network benefits (cont.)	**High Option**	**Standard Option**
• *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 gnerally not order us to pay or provide one clinically appropriate treatment plan in favor of another.* • *Any charges in excess of the stated limitations* • *Marital counseling* • *Treatment for learning disabilities* • *Telephone consultations and/or therapy* • *On-line consultations* • *Travel time to the patient's home to conduct therapy* • *Any charges in excess of the stated limitations*	*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 authorizations processes. These include obtaining prior authorization 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, benefits will be reduced by $500. See Section 3 for details.
- Outpatient treatment and day or after care treatment (partial hospitalization). In order to maximize your benefits, your provider must submit a treatment plan to CIGNA/CareAllies prior to your 9th outpatient visit. In determining when your treatment plan must be submitted, we count all outpatient psychotherapy visits, even if you use different providers. When we approve the treatment plan, we will give your provider authorization for additional visits. If you change providers, a new treatment plan must be submitted. If prior authorization is not obtained, we will reduce our Plan allowance by 20%.

To obtain preauthorization call CIGNA/CareAllies 1-800/887-9735.

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

- Section 4, *Your cost for covered services*, for information about catastrophic protection for these benefits.
- Section 7, *Filing a claim for covered services*, for information about submitting out-of-network claims.

Section 5(f). Prescription drug benefits

Important things you should keep in mind about these benefits:

- We cover prescribed drugs and medications, as described in the chart beginning on page 55.
- Please remeber 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 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.
- 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 lecense 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 or coinsurance amounts are less for drugs listed on the formulary than those that are not.

Our payment levels are categorized as:

Level I: generic drugs

Level II: formulary or preferred name brand drugs

Level III: non-formulary or non-preferred name brand drugs

You may look up the formulary status of medications online at www.medco.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 or 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. This limit does not apply to medications not available through the mail order program. 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 Medco By Mail. Medco By Mail will fill your precription.

Note: Not all drugs may be available through the mail order program. Any drugs which cannot be dispensed in accordance with Medco By Mail pharmacy's dispensing protocols or which requires special record-keeping procedures may be excluded. However, these excluded drugs are covered under the retail prescription drug program.

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 Medco By Mail. You may obtain up to a 30-day supply right away through the prescription card program, and up to a 90-day supply from Medco By Mail. In most cases, refills cannot be obtained until 75% of the prescription has been used. Call us or visit our web site if you have any questions about dispensing limits.

The Plan will authorize up to a 90-day supply of medication(s) if you should be called to active military duty or a 30-day supply to meet your needs in time of a national emergency.

Benefits for all prescription drugs will be determined based on the fill date of the prescription.

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.

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 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 appropriate therapy and drug dosage before providing benefits.

Contact Medco Health at 1-800/753-2851 for additional information regarding 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. Services 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 14711

Lexington, KY 40512

Note: Reimbursement will be limited to SAMBA's cost had you used a participating pharmacy minus the copayments discribed on page 55.

- By mail - The Plan will send you information on Medco By Mail:

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

P. O. Box 650022

Dallas, TX 75265-0022

Your 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 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 (except Thanksgiving and Christmas). You may also download order forms from www.medco.com.

Under the **High Option**, if Medicare Part B or Part D is your primary payer, the Plan will reduce the required copayment amount for purchases made through Medco By Mail. See page 55 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.

- **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 Medco By Mail, you will be billed directly for the full discounted cost of the covered medication. Pay Medco By Mail 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 office at:

Medco Health Solutions, Inc.

P. O. Box 14711

Lexington, KY 40512

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 office at:

Medco Health Solutions, Inc.

P. O. Box 14711

Lexington, KY 40512

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.		
Covered medications and supplies	**High Option**	**Standard Option**
Each new 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	Copayments per prescription or refill are: Retail: • $10 generic • $30 preferred name brand • $45 non-preferred name brand Retail Medicare: • $10 generic • $25 preferred name brand • $40 non-preferred name brand	Copayments per prescription or refill are: Retail: • $10 generic • 25% ($30 minimum/$60 maximum for each purchase) preferred name brand • 35% ($45 minimum/$90 maximum for each purchase) non-preferred name brand

Covered medications and supplies - continued on next page

<table>
<tr><th rowspan="2">Benefits Description</th><th colspan="2">You Pay
After the calendar year deductible...</th></tr>
<tr><th>High Option</th><th>Standard Option</th></tr>
<tr><td>Covered medications and supplies (cont.)</td><td></td><td></td></tr>
<tr><td>• Contraceptive drugs and devices
• Growth hormone therapy (GHT), if preauthorized

Note: The Medicare level of benefits applies only when Medicare Part B or Part D is your primary payer.

Note: Retail copayments will apply to prescription drugs billed by a skilled nursing facility, nursing home or extended care facility.

Note: Under the Standard Option there is a $5,000 per person, per calendar year catastrophic protection limit on your out-of-pocket copayment and coinsurance expenses for prescription medications obtained from a Network retail pharmacy or through our Mail Order program. This limit does not apply to drugs obtained from any other source.</td><td>Copayments per prescription or refill are:

Retail:

Retail Medicare:

Note: For retail purchases made at a non-Network pharmacy, you pay the same per prescription copayment listed above, plus the difference in cost had you used a participating Plan network pharmacy.

Network Mail Order:
• $10 generic
• $50 preferred name brand
• $65 non-preferred name brand

Network Mail Order Medicare:
• $10 generic
• $30 preferred name brand
• $50 non-preferred 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.</td><td>Copayments per prescription or refill are:

Retail:

Note: For retail purchases made at a non-Network pharmacy, you pay the same per prescription copayments as listed above, 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 ($50 minimum/$100 maximum for each purchase) preferred name brand
• 35% of the Plan allowance ($65 minimum/$120 maximum for each purchase) non-preferred 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.</td></tr>
<tr><td>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)</td><td>All Charges</td><td>All charges</td></tr>
</table>

Covered medications and supplies - continued on next page

Benefits Description	You Pay After the calendar year deductible...	
Covered medications and supplies (cont.)	**High Option**	**Standard Option**
• *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* *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). Dental benefits

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.
- If you are enrolled in a Federal Employees Dental/Vision Insurance Program (FEDVIP) Dental Plan, your FEHB Plan will be First/Primary payer of any Benefit payments and your FEDVIP Plan is secondary to your FEHB Plan. See Section 9. Coordinating benefits with other coverage.
- The calendar year deductible is: $250 per person ($500 per family) under the High Option and $300 per person ($600 per family) under the 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.

Accidental injury benefit	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 accidential injury. For purposes of this Plan, a tooth previously restored with a crown, inlay, onlay, or porcelain restoration or treated by endodontics is not considered a sound natural tooth. 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	**High Option**	**Standard Option**
Orthodontic treatment • We cover charges for 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	PPO: 10% of the Plan allowance	All charges

Dental benefits - continued on next page

Accidental injury benefit	You Pay	
Dental benefits (cont.)	**High Option**	**Standard Option**
• 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
The diagnostic and preventive services listed below: • two examinations per person, per calendar year, and • two prophylaxis (cleanings) per person, per calendar year. • X-rays Note: Benefits are limited to $400 per person, per calendar year.	All charges	Any difference between our allowance and the billed amount and all charges after the Plan has paid $400 (No deductible)
Not covered: • *Dental appliances, study models, splints and other devices or services associated with the treatment of temporomandibular joint (TMJ) dysfunction* • *Charges in excess of the $400 plan limitation for diagnostic and preventive services* • *Dental implants*	*All charges*	*All charges*

Section 5(h). Special features

<table>
<tr><th>Special feature</th><th>Description</th></tr>
<tr><td>Flexible benefits option</td><td>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 the 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.</td></tr>
<tr><td>Travel benefit/services overseas</td><td>For covered services rendered by a hospital or by a doctor outside of 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 63, Section 7 Filing a claim for covered services.</td></tr>
<tr><td>Services for deaf and hearing impaired</td><td>SAMBA has a TDD line for the hearing-impaired: 301/984-4155 (TDD equipment is needed).</td></tr>
<tr><td>Online Resources</td><td>Visit our web site at www.SambaPlans.com to view your claim history, order prescription refills and have access to many health resources, such as:
a Hospital Quality Ratings Guide and Treatment Cost Estimator tool,
an electronic Health Library to obtain information about a specific disease or medical condition,
a Health Assessment to help you determine what medical conditions you are at risk for due to personal habits, family history, etc. and what to do to reduce the chances of getting these conditions,
preventive care tips, and
tools to quit smoking, lose weight and live a healthier life.</td></tr>
<tr><td>Healthy Rewards Program</td><td>SAMBA members can participate in the CIGNA/CareAllies Healthy Rewards Program. This Program provides access to discounts on treatments and items not covered under the Plan. For example, you could obtain discounts as high as 25% - 50% on services such as LASIK surgery, cosmetic items, massage therapy, and fitness memberships.

Visit www.SambaPlans.com for more information.</td></tr>
</table>

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. These programs and materials are the responsibility of the Plan, and all appeals must follow their guidelines. For additional information contact the Plan at 1-800/638-6589 or 301/984-1440 (for TDD, use 301/984-4155) or visit their website at www.SambaPlans.com.

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.

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 plan allows you to provide financial protection for you and your family in the event of an untimely death. Insurance protection is available for you and your spouse with coverage amounts ranging from **$25,000** up to **$600,000**. You can even elect to enroll your child (children) for $10,000 in coverage. Plus, the plan includes an accidental death benefit thata doubles your coverage amount in the event the covered death was caused by an accident. *And, you may continue your enrollment even if you should no longer be employed by a federal agency.*

Want even more coverage - SAMBA offers Personal Accident Insurance with coverage up to $500,000. This low-cost coverage provides around-the-clock protection that will pay a lump-sum benefit in the event you or your dependents experience an accidental bodily injury that results in death or the loss of hands, feet, or eyesight. In addition to the base benefit that is paid, there are additional benefits provided for mortgage payments, tuition reimbursement for your spouse and dependent children, plus many others.

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, dentures and orthodontia, and include vision care benefits for eye examinations, frames, and lenses (or contact lenses).

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 covered salary, tax-free. In addition, the plan pays 70% of your covered 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.

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. There may be other exclusions and limitations listed in Section 5 of this brochure. **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 17), doctor charges exceeding the amount specified by the Department of Health and Human Services when benefits are payable under Medicare (limiting charge) (see page 18), 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(g);
- 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 72;
- 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 29, Section 5(a);
- Services by a massage therapist;

- Services by a naturopathic practitioner;
- 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 35, Section 5(b);
- Safety, hygiene, convenience, and exercise equipment and supplies;
- Fees for medical records not requested by the Plan;
- Handling charges/administrative charges or late charges, missed appointment fees, including interest, billed by providers of care;
- Telephone and on-line medical consultations; or
- "Never Events" - Are errors in patient care that can and should be prevented. We will follow the policy of the Centers for Medicare and Medicaid Services (CMS). The Plan will not cover care that falls under these policies. For additional information, please visit www.cms.gov, enter Never Events into SEARCH.

Section 7. Filing a claim for covered services

How to claim benefits

To obtain claim forms, 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.

When you must file a claim – such as for services you received 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) form you received 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 52.

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 benefits for 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 required by Section 3.

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, if applicable, arrange for the health care provider to give you the care); or

b) Write to you and maintain our denial - go to step 4; or

c) Ask you or your provider for more information. If we ask your provider, we will send you a copy of our request—go to step 3.

3 You or your provider must send the information so that we receive it within 60 days of 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.

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 has coverage under any other health plan or has automobile insurance that pays health care expenses without regard to fault. This is called "double coverage."

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

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

When we are the secondary payer, we will determine our allowance. After the primary plan pays, we will pay either what is left of our allowance or up to our regular benefit, whichever is less. We will not pay more than our allowance. The combined payments from both plans may not equal the entire amount billed by the provider. In certain circumstances, when there is no adverse effect on you (that is, you do not pay any more), we may also take advantage of any provider discount arrangements your primary plan may have and pay only the difference between the primary plan's payment and the amount the provider has agreed to accept as payment in full from the primary plan.

Please see Section 4, *Your costs for covered services*, for more information about how we pay claims.

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; and
- 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. (If you were a Federal employee at any time both before and during January 1983, you will receive credit for your Federal employment before January 1983.) 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 68.
- Part D (Medicare prescription drug coverage). There is a monthly premium for Part D coverage. 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 the FEHB 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.

(Please refer to page 17 for information about how we provide benefits when you are age 65 or older and do not have Medicare.)

- **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 will probably not need to file a claim form when you have both our Plan and the Original Medicare Plan.

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

When Original Medicare is the primary payer, Medicare processes your claim first. In most cases, your claim will be coordinated automatically and we will then provide secondary benefits for covered charges. 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. You may be responsible for paying the difference between the billed amount and the amount we paid.

- **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 (if you use our Plan providers), but we will not waive any of our copayments, coinsurance, or deductibles. If you enroll in a Medicare Advantage plan, tell us. We will need to know whether you are in the Original Medicare Plan or in a Medicare Advantage plan so we can correctly coordinate benefits with Medicare.

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

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

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. **(Having coverage under more than two health plans may change the order of benefits determined on this chart.)**

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		✓
2) Have FEHB coverage on your own as an annuitant or through your spouse who is an annuitant	✓	
3) Have FEHB through your spouse who is an active employee		✓
4) 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 #3 above	✓	
5) 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	✓	
6) 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 #3 above	✓	
7) Are enrolled in Part B only, regardless of your employment status	✓ for Part B services	✓ for other services
8) Are a Federal employee receiving Workers' Compensation disability benefits for six months or more	✓ *	
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	✓	
3) Have Temporary Continuation of Coverage (TCC) and...		
• Medicare based on age and disability	✓	
• Medicare based on ESRD **(for the 30 month coordination period)**		✓
• Medicare based on ESRD **(after the 30 month coordination period)**	✓	
C. When either you or a covered family member are eligible for Medicare solely due to disability and you...		
1) Have FEHB coverage on your own as an active employee or through a family member who is an active employee		✓
2) Have FEHB coverage on your own as an annuitant or through a family member who is an annuitant	✓	
D. When you are covered under the FEHB Spouse Equity provision as a former spouse	✓	

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

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 TRICARE or CHAMPVA.

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 another person's act or omission, and you later receive compensation for the injuries or illness from that person or your own or other insurance, you are required to reimburse us out of that compensation for any benefits we paid on your behalf or, if applicable, to you, your heirs, estate, administrators, successors, or assignees. This is known as our right of reimbursement, and is also sometimes referred to as subrogation.

You will have this obligation to reimburse us even if the compensation you receive is not sufficient to compensate you fully for all of the damages which resulted from the injuries or illness. In other words, we are entitled to be reimbursed for those benefit payments even if you are not "made whole" for all of your damages by the compensation you receive. Our right of reimbursement is also not subject to reduction for attorney's fees under the "common fund" doctrine without our written consent. In short, we are entitled to be reimbursed for 100% of the benefits we pay on account of the injuries or illness unless we agree in writing to accept a lesser amount.

We enforce this right of reimbursement by asserting a priority lien against any and all compensation you receive by court order or out-of-court settlement, without regard to how it is characterized, for example as "pain and suffering." You must cooperate with the our enforcement of our right of reimbursement by:

- telling us promptly whenever you have filed a claim for compensation resulting from an accident or illness;

- accepting our lien for the full amount of the benefits we have paid;
- agreeing to assign any proceeds from third party claims or your own insurance to us if we ask you to do so;
- keeping us advised of the claim's status;
- advising us of any settlement or court order;
- and promptly reimbursing us out of any recovery received to the full extent of our right of reimbursement.

You must also sign a Reimbursement Agreement for this purpose when asked to do so. We will not pay benefits until this Agreement is signed. Our right to full reimbursement applies even to benefits we paid before learning of a potential recovery, and before asking you to sign a Reimbursement Agreement; it also applies to any benefits payable on covered expenses incurred but not submitted for payment to us or processed by us before the date of a settlement or court order. Failure to cooperate with these obligations may result in the temporary suspension of your benefits and/or offsetting of future benefits.

If you would like more information about the subrogation process and how it works, please call our Third Party Recovery Services unit at 202/683-9140.

When you have Federal Employees Dental and Vision Insurance Plan (FEDVIP)

Some FEHB plans already cover some dental and vision services. When you are covered by more than one vision/dental plan, coverage provided under your FEHB plan remains as your primary coverage. FEDVIP coverage pays secondary to that coverage. When you enroll in a dental and/or vision plan on BENEFEDS.com, you will be asked to provide information on your FEHB plan so that your plans can coordinate benefits. Providing your FEHB information may reduce your out-of-pocket cost.

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.

Cost-sharing

Cost-sharing is the general term used to refer to your out-of-pocket costs (e.g., deductible, coinsurance, and copayments) for the covered care you receive.

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 investigational 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.

Hospice Care Hospice is a coordinated program of maintenance and supportive care for the terminally ill provided by a medically supervised team under the direction of a Plan-approved independent hospice administration.

Note: A terminally ill person is a covered family member whose life expectancy is six months or less, as certified by the primary doctor.

Incurred An expense is incurred on the date a service or supply is rendered or received unless otherwise noted in this brochure.

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.

Mental conditions/substance abuse

Conditions and diseases listed in the most recent edition of the International Classification of Diseases (ICD) as psychosis, neurotic disorders, or personality disorders; other nonpsychotic mental disorders listed in the ICD; or disorders listed in the ICD requiring treatment for abuse of, or dependence upon, substances such as alcohol, narcotics, or hallucinogens.

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.

Orthopedic device

Any custom fitted external device used to support, align, prevent, or correct deformities or to restore or improve function.

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 Ingenix.

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 covered services rendered by a hospital or by a doctor outside the United States and Puerto Rico, our allowance is based on the Plan's allowance established for the Washington, D.C. Metropolitan area.

Note: The member is responsible for the difference between the Plan's allowance and the provider's charge.

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

Prosthetic device

An artificial substitute for a missing body part such as an arm, eye, or leg. This device may be used for a functional or cosmetic reason or both.

Remission

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.

Routine services

Services that are not related to any specific illness, injury, set of symptoms, or maternity care.

Sound natural tooth

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. For purposes of this Plan, a tooth previously restored with a crown, inlay, onlay, or porcelain restoration or treated by endodontics is not considered a sound natural tooth.

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 Benefits,* 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;
- What happens 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 family members are added or lose coverage for any reason, including your marriage, divorce, annulment, or when your child under age 22 turns 22, or when your child under age 22 marries, or has a change in marital status (divorce or annulment).

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 2009 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 2008 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.

Any person covered under the 31 day extension of coverage who is confined in a hospital or other institution for care or treatment on the 31st day of the temporary extension is entitled to continuation of the benefits of the Plan during the continuance of the confinement but not beyond the 60th day after the end of the 31 day temporary extension.

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

Upon divorce

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. However, you may be eligible for your own FEHB coverage under either 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 Benefits 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 Benefits 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. Three Federal Programs complement FEHB benefits

Important information

OPM wants to be sure you are aware of three Federal programs that complement the FEHB Program.

First, the **Federal Flexible Spending Account Program**, also known as **FSAFEDS**, lets you set aside pre-tax money from your salary to reimburse you for eligible dependent care and/or health care expenses. You pay less in taxes so you save money. The result can be a discount of 20% to more than 40% on services/products you routinely pay for out-of-pocket.

Second, the **Federal Employees Dental and Vision Insurance Program (FEDVIP)** provides comprehensive dental and vision insurance at competitve group rates. There are several plans from which to choose. Under **FEDVIP** you may choose self only, self plus one, or self and family coverage for yourself and any eligible dependents.

Third, the **Federal Long Term Care Insurance Program (FLTCIP)** can help cover long term care costs, which are not covered under the FEHB Program.

The Federal Flexible Spending Account Program – *FSAFEDS*

What is an FSA?

It is an account where you contribute money from your salary **BEFORE** taxes are withheld, then incur eligible expenses and get reimbursed. You pay less in taxes so you save money. **Annuitants are not eligible to enroll.**

There are three types of FSAs offered by FSAFEDS. Each type has a minimum annual election of $250 and a maximum annual election of $5,000.

- **Health Care FSA (HCFSA)** – Reimburses you for eligible health care expenses (such as copayments, deductibles, over-the-counter medications and products, vision and dental expenses, and much more) for you and your dependents which are not covered or reimbursed by FEHBP or FEDVIP coverage or other insurance.
- **Limited Expense Health Care FSA (LEX HCFSA**) – Designed for employees enrolled in or covered by a High Deductible Health Plan with a Health Savings Account. Eligible expenses are limited to dental and vision care expenses for you and your dependents which are not covered or reimbursed by FEHBP or FEDVIP coverage or any other insurance.
- **Dependent Care FSA (DCFSA)** – Reimburses you for eligible non-medical day care expenses for your child(ren) under age 13 and/or for any person you claim as a dependent on your Federal Income Tax return who is mentally or physically incapable of self-care. You (and your spouse if married) must be working, looking for work (income must be earned during the year), or attending school full-time to be eligible for a DCFSA.

Where can I get more information about FSAFEDS?

Visit www.FSAFEDS.com or call an FSAFEDS Benefits Counselor toll-free at 1-877-FSAFEDS (1-877-372-3337), Monday through Friday, 9 a.m. until 9 p.m., Eastern Time. TTY: 1-800-952-0450.

The Federal Empolyees Dental and Vision Insurance Program – *FEDVIP*

Important Information

The Federal Employees Dental and Vision Insurance Program (FEDVIP) is a program, separate and different from the FEHB Program, established by the Federal Employee Dental and Vision Benefits Enhancement Act of 2004. This Program provides comprehensive dental and vision insurance at competitive group rates with no pre-existing condition limitations.

FEDVIP is available to eligible Federal and Postal Service employees, retirees, and their eligible family members on an enrollee-pay-all basis. Employee premiums are withheld from salary on a pre-tax basis.

Dental Insurance

Dental plans provide a comprehensive range of services, including the following:

- Class A (Basic) services, which include oral examinations, prophylaxis, diagnostic evaluations, sealants and x-rays.
- Class B (Intermediate) services, which include restorative procedures such as fillings, prefabricated stainless steel crowns, periodontal scaling, tooth extractions, and denture adjustments.
- Class C (Major) services, which include endodontic services such as root canals, periodontal services such as gingivectomy, major restorative services such as crowns, oral surgery, bridges and prosthodontic services such as complete dentures.
- Class D (Orthodontic) services with up to a 24-month waiting period.

Vision Insurance

Vision plans provide comprehensive eye examinations and coverage for lenses, frames and contact lenses. Other benefits such as discounts on LASIK surgery may also be available.

Additional Information

You can find a comparison of the plans available and their premiums on the OPM website at www.opm.gov/insure/dentalvision. This site also provides links to each plan's website, where you can view detailed information about benefits and preferred providers.

How do I enroll?

You enroll on the Internet at www.BENEFEDS.com. For those without access to a computer, call 1-877-888- 3337 (TTY number, 1-877-889-5680).

The Federal Long Term Care Insurance Program – *FLTCIP*

It's important protection

The Federal Long Term Care Insurance Program (FLTCIP) can help you pay for the potentially high cost of long term care services, which are not covered by FEHB plans. 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. 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. You must apply to know if you will be approved for enrollment. 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.

Summary of benefits for the High Option of the SAMBA Health Benefit Plan - 2009

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	22
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	42
• Outpatient	PPO: $100 per facility charge and 10% of the Plan allowance Non-PPO: $150 per facility charge and 30%* of the Plan allowance	44
Emergency benefits:		
• Accidental injury	Nothing within 72 hours	46
• Medical emergency	Regular benefits apply	46
Mental health and substance abuse treatment	In-Network: Regular cost sharing Out-of-Network: Benefits are limited	47 50
Prescription drugs:		
• Retail pharmacy	$10 generic, $30 preferred name brand or $45 non-preferred name brand copayment Medicare Retail: $10 generic, $25 preferred name brand or $40 non-preferred name brand copayment	55
• Mail order	$10 generic, $50 preferred name brand or $65 non-preferred name brand copayment Medicare Mail Order: $10 generic, $30 preferred name brand or $50 non-preferred name brand copayment	55
Dental care:	PPO: 10%* of the Plan allowance for certain covered services Non-PPO: 30%* of the Plan allowance for certain covered services	57
Special features:	Flexible benefits option; Travel benefit/services overseas; Services for deaf and hearing impaired; Online Resources; Healthy Rewards Program	59

High Option Benefits	You pay	Page
Protection against catastrophic costs (out-of-pocket maximum)**:**	PPO: Nothing after $3,500 per calendar year Non-PPO: Nothing after $5,000 per calendar year Some costs do not count toward this protection	15

Summary of benefits for the Standard Option of the SAMBA Health Benefit Plan - 2009

Do not rely on this chart alone. All benefits are subject to the definitions, limitations, and exclusions in this brochure. On this page we summarize specific expenses we cover; for more detail, look inside. If you want to enroll or change your enrollment in this Plan, be sure to put the correct enrollment code from the cover on your enrollment form.

Below, an asterisk (*) means the item is subject to the $300 calendar year deductible. And, after we pay, you generally pay any difference between our allowance and the billed amount if you use a non-PPO physician or other health care professional.

Standard Option Benefits	You Pay	You Pay
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	22
Services provided by a hospital:		
• Inpatient	PPO: $200 copayment per confinement, nothing for room & board and 15% for other hospital services Non-PPO: $300 copayment per confinement and 30% of the Plan allowance	42
• Outpatient	PPO: 15% of the Plan allowance Non-PPO: 30%* of the Plan allowance	44
Emergency benefits:		
• Accidental injury	Nothing within 72 hours	46
• Medical emergency	Regular benefits apply	46
Mental health and substance abuse treatment:	In-Network: Regular cost sharing Out-of-Network: Benefits are limited	47 50
Prescription drugs:		
• Catastrophic limit	Copayments and coinsurance expenses for prescription drugs obtained from a Network retail pharmacy or through our Mail Order program will count toward a $5,000 per person, per calendar year prescription our-of-pocket limit.	16
• Retail pharmacy	$10 generic, 25% of the Plan allowance ($30 minimum/$60 maximum) preferred name brand or 35% of the Plan allowance ($45 minimum/$90 maximum) non-preferred name brand; limited to the initial fill (not to exceed a 30-day supply) and one refill	55
• Mail order	$20 generic, 25% of the Plan allowance ($50 minimum/$100 maximum) preferred name brand or 35% of the Plan allowance ($65 minimum/ $120 maximum) non-preferred name brand	55
Dental care:		57

	The difference between the Plan allowance and the billed amount for routine dental services and all charges after the Plan pays $400	
Special features:	Flexible benefits option; Travel benefit/services overseas; Services for deaf and hearing impaired; Online Resources; Healthy Rewards Program	59
Protection against catastrophic costs (out-of-pocket maximum)**:**	PPO: Nothing after $4,000 per calendar year Non-PPO: Nothing after $6,000 per calendar year Some costs do not count toward this protection	15

2009 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 *Guide to Federal Benefits* 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 *Guide to Benefits for Career United States Postal Service Employees*, RI 70-2, and to the rates shown below.

The rates shown below do not apply to Postal Service Inspectors, Office of Inspector General (OIG) employees and Postal Service Nurses. Rates for members of these groups are published in special Guides. Postal Service Inspectors and OIG employees should refer to the *Guide to Benefits for United States Postal Inspectors and Office of Inspector General Employees* (RI 70-2IN). Postal Service Nurses should refer to the *Guide to Benefits for United States Postal Nurses* (RI 70-2NU).

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 *Guide to Federal Benefits*.

		Non-Postal Premium				Postal Premium	
		Biweekly		Monthly		Biweekly	
Type of Enrollment	**Enrollment Code**	**Gov't Share**	**Your Share**	**Gov't Share**	**Your Share**	**USPS Share**	**Your Share**
High Option Self Only	441	$155.66	$97.89	$337.26	$212.10	$179.45	$74.10
High Option Self and Family	442	$352.56	$244.56	$763.88	$529.88	$406.42	$190.70
Standard Option Self Only	444	$141.87	$47.29	$307.39	$102.46	$163.62	$25.54
Standard Option Self and Family	445	$324.01	$108.00	$702.02	$234.00	$373.69	$58.32
High Option Self Only		0	0	0	0	0	0
High Option Self and Family		0	0	0	0	0	0
Standard Option Self Only		0	0	0	0	0	0
Standard Option Self and Family		0	0	0	0	0	0