SAMBA Health Benefit Plan

http://www.SambaPlans.com
Customer Service 1-800-638-6589

2014

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

This plan's health coverage qualifies as minimum essential coverage and meets the minimum value standard for the benefits it provides. See page 6 for details.

Sponsored and administered by: the Special Agents Mutual Benefit Association (SAMBA)

IMPORTANT
- Rates: Back Cover
- Changes for 2014: Page 13
- Summary of benefits: Page 105

CareAllies health and medical management programs are administered by Cigna Health Management, Inc. Cigna Health Management, Inc. has earned URAC Health Utilization Management and Case Management accreditation.

See the 2014 FEHB Guide for more information on accreditation.

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

Authorized for distribution by the:

United States
Office of Personnel Management

Healthcare and Insurance
http://www.opm.gov/insure

Important Notice from SAMBA About

Our Prescription Drug Coverage and Medicare

The Office of Personnel Management (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 (October 15th through December 7th) 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 1-877-486-2048).

SAMBA Health Benefit Plan Notice of Privacy Practices

We protect the privacy of your protected health information as described in our current Notice of Privacy Practices. You can obtain a copy of our Notice by calling us at 1-800-638-6589 or by visiting our Web site at www.SambaPlans.com.

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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. Customer service may be reached at 1/800-638-6589 or 301/984-1440 (for TDD, use 301/984-4155) or through our website: www.SambaPlans.com. 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, 2014, unless those benefits are also shown in this brochure.

OPM negotiates benefits and rates with each plan annually. Benefit changes are effective January 1, 2014, and changes are summarized on pages 12 and 13. Rates are shown at the end of this brochure.

Coverage under this plan qualifies as minimum essential coverage (MEC) and satisfies the Patient Protection and Affordable Care Act's (ACA) individual shared responsibility requirement. Please visit the Internal Revenue Service (IRS) website at www.irs.gov/uac/Questions-and-Answers-on-the-Individual-Shared-Responsibility-Provision for more information on the individual requirement for MEC.

The ACA establishes a minimum value for the standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). The health coverage of this plan does meet the minimum value standard for the benefits the plan provides.

Plain Language

All FEHB brochures are written in plain language to make them easy to understand. Here are some examples:

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

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.
- Periodically review your claim history for accuracy to ensure we have not been billed for services that you did not receive.

- 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
877-499-7295
OR go to www.opm.gov/oig

You can also 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); or
  - Your child age 26 or over (unless he/she was disabled and incapable of self -support prior to age 26).
- 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.
- Fraud or intentional misrepresentation of material fact is prohibited under the Plan. You can be prosecuted for fraud and your agency may take action against you. Examples of fraud include, falsifying a claim to obtain FEHB benefits, trying to or obtaining services or coverage for yourself or for someone who is not eligible for coverage, or enrolling in the Plan when you are no longer eligible.
- If your enrollment continues after you are no longer eligible for coverage (i.e., you have separated from Federal service) and premiums are not paid, you will be responsible for all benefits paid during the period in which premiums were not paid. You may be billed by your provider for services received. You may be prosecuted for fraud for knowingly using health insurance benefits for which you have not paid premiums. It is your responsibility to know when you or a family member is no longer eligible to use your health insurance coverage.

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 and dosage that you take, including non-prescription (over-the-counter) medicines and nutritional supplements.
- Tell your doctor and pharmacist about any drug, food, and other allergies you have such as latex.
- 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 or nutritional supplements you are taking.

Patient Safety Links

- www.ahrq.gov/consumer.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.
- www.npsf.org. The National Patient Safety Foundation has information on how to ensure safer health care for you and your family.
- www.talkaboutrx.org. The National Council on Patient Information and Education is dedicated to improving communication about the safe, appropriate use of medicines.
- www.leapfroggroup.org. The Leapfrog Group is active in promoting safe practices in hospital care.
- www.ahqa.org. The American Health Quality Association represents organizations and health care professionals working to improve patient safety.

Never Events

You will not be billed for inpatient services related to treatment of specific hospital acquired conditions or for inpatient services needed to correct never events, if you use Cigna preferred providers. This policy helps to protect you from preventable medical errors and improve the quality of care you receive.

When you enter the hospital for treatment of one medical problem, you don't expect to leave with additional injuries, infections or other serious conditions that occur during the course of your stay. Although some of these complications may not be avoidable, too often patients suffer from injuries or illnesses that could have been prevented if the hospital had taken proper precautions.

We have a benefit payment policy that encourages hospitals to reduce the likelihood of hospital-acquired conditions such as certain infections, severe bedsores and fractures; and reduce medical errors that should never happen called "Never Events." When a Never Event occurs, neither your FEHB plan nor you will incur cost to correct the medical error.

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.

- **Minimum essential coverage (MEC)**

Coverage under this plan qualifies as minimum essential coverage (MEC) and satisfies the ACA's individual shared responsibility requirement. Please visit the Internal Revenue Service (IRS) website at www.irs.gov/uac/Questions-and-Answers-on-the-Individual-Shared-Responsibility-Provision for more information on the individual requirement for MEC.

- **Minimum value standard**

The ACA establishes a minimum value for the standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). The health coverage of this plan does meet the minimum value standard for the benefits the plan provides.

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

See www.opm.gov/healthcare-insurance/healthcare 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
- 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. For information on your premium deductions, you must also contact 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 dependent children under age 26, including any foster children authorized for coverage by your employing agency or retirement office. Under certain circumstances, you may also continue coverage for a disabled child 26 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 of changes in family member status, including your marriage, divorce, annulment, or when your child reaches age 26.

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.

If you have a qualifying life event (QLE) – such as marriage, divorce, or the birth of a child – outside of the Federal Benefits Open Season, you may be eligible to enroll in the FEHB Program, change your enrollment, or cancel coverage. For a complete list of QLEs, visit the FEHB website at www.opm.gov/healthcare-insurance/life-event. If you need assistance, please contact your employing agency, Tribal Benefits Officer, personnel/payroll office, or retirement office.

- **Family Member Coverage**

Family members covered under your Self and Family enrollment are your spouse (including a valid common law marriage) and children as described in the chart below.

Children	Coverage
Natural, adopted children, and stepchildren	Natural, adopted children and stepchildren are covered until their 26th birthday.
Foster Children	Foster children are eligible for coverage until their 26th birthday if you provide documentation of your regular and substantial support of the child and sign a certification stating that your foster child meets all the requirements. Contact your human resources office or retirement system for additional information.
Children Incapable of Self-Support	Children who are incapable of self-support because of a mental or physical disability that began before age 26 are eligible to continue coverage. Contact your human resources office or retirement system for additional information.
Married Children	Married children (but **NOT** their spouse or their own children) are covered until their 26th birthday.
Children with or eligible for employer-provided health insurance	Children who are eligible for or have their own employer-provided health insurance are covered until their 26th birthday.

You can find additional information at www.opm.gov/healthcare-insurance.

- **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 2014 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 2013 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.

If your enrollment continues after you are no longer eligible for coverage (i.e. you have separated from Federal service) and premiums are not paid, you will be responsible for all benefits paid during the period in which premiums were not paid. You may be billed for services received directly from your provider. You may be prosecuted for fraud for knowingly using health insurance benefits for which you have not paid premiums. It is your responsibility to know when you or a family member are no longer eligible to use your health insurance 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).

- **Upon divorce**

If you are divorced from a Federal employee or an 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/healthcare-insurance/healthcare/plan-information/guides.

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

If you leave Federal service, Tribal employment, 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 or Tribal job, if you are a covered dependent child and you turn age 26, regardless of marital status, etc.

You may not elect TCC if you are fired from your Federal or Tribal 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/healthcare-insurance/healthcare/plan-information/guides. It explains what you have to do to enroll.

We also want to inform you that the Patient Protection and Affordable Care Act (ACA) did not eliminate TCC or change the TCC rules.

- **Finding replacement 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 or Tribal 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, have no waiting period, and no limitation on your coverage due to pre-existing conditions.

This Plan no longer offers its own non-FEHB plan for conversion purposes. In lieu of offering a non-FEHB plan for conversion purposes, we will assist you in obtaining health benefits coverage inside or outside the Affordable Care Acts's Health Insurance Marketplace. For assistance in finding coverage, please contact us at 1-800/638-6589 or 301/984-1440 (for TDD, use 301/984-4155 or visit our website at www.SambaPlans.com.

- **Health Insurance Marketplace**

If you would like to purchase health insurance through the Affordable Care Act's Health Insurance Marketplace, please visit www.HealthCare.gov. This is a website provided by the U.S. Department of Health and Human Services that provides up-to-date information on the Marketplace.

- **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/healthcare-insurance/healthcare; 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 1. How this plan works

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 Open Access Plus (OAP) Network to serve as the Plan's PPO for SAMBA enrollees in all states. When you use our 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 affiliate) at 1-800/887-9735 for the names of OAP 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 participating Cigna OAP Network 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 Cigna OAP Network 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.

Other Participating Providers

The Plan offers access to certain non-PPO health care providers that have agreed to discount their charges. These providers include MultiPlan, Viant, and Private Healthcare System (PHCS). Since these Other Participating Providers are not PPO providers, the regular non-PPO benefits will apply.

How we pay providers

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

Non-PPO facilities and providers do not have special agreements with the Plan. When you use a non-PPO provider to perform the service or provide the supply, our Plan allowance for covered expenses is based on the lesser of (a) the provider's billed charges or (b) the Maximum Non-PPO Reimbursable Charge. The Maximum Non-PPO Reimbursable Charge is a Medicare-based fee schedule developed by Cigna that approximates 200% of the Medicare (RBRVS) allowance for the same or similar service within the geographic area (see page 93). The non-PPO allowance is 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 not-for-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. Changes for 2014

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

- Montana and South Dakota were designated as a Medically Underserved Area in 2013, but will not be so designated for 2014.

Changes to both our High and Standard Options

- We have added a fourth tier for specialty medications under the Plan's Prescription drug benefits. Covered specialty medications will be subject to a flat copayment. Under the High Option, $80 for a 30-day supply; $160 for a 60-day supply; and $240 for a 90-day supply. Under the Standard Option, $120 for a 30-day supply; $240 for a 60-day supply; and $360 for a 90-day supply. Specialty drugs purchased through "tier four" will require prior authorization. See page 72.
- SAMBA has added the Cigna "Your Health First" (YHF) Program. YHF is a chronic condition management program that takes a unique approach to help people who have ongoing conditions such as asthma, diabetes, depression, and weight complications better manage their health. See page 78.
- The Plan will make a charitable donation of $20 ($40 per family enrollment) if you complete an on-line Health Risk Assessment (HRA). See Section 5(h); page 78.
- High tech radiology services (NC, MRI, MRA, CT/CAT, and PET) now require precertification. If precertification is not obtained and covered services are deemed medically necessary, benefits will be reduced by $100 per occurrence. If the services are not considered medically necessary, we will not pay any benefits. See pages 17 and 29.
- The following outpatient services now require precertification: durable medical equipment; home infusion therapy; home nursing care; speech therapy; and spinal procedures. If precertification is not obtained and covered services are deemed medically necessary, we will reduce our Plan allowance by 20% per occurrence. If the services are not considered medically necessary, we will not pay any benefits. See page 17.
- The Plan has added "Other Participating Providers" to allow member access to certain non-PPO health care providers that have agreed to discount their charges. This will help reduce your out of pocket expenses. See page 10.
- Benefits have been increased for Chiropractic services from 12 manipulations per person, per calendar year to 26 manipulations per person, per calendar year. See page 44.

Changes to our High Option only

- Your share of the non-Postal premium will decrease for Self Only and Self and Family. See page 106.
- Under the *Prescription drug benefits*, retail purchases will now be limited to the initial fill (not to exceed a 30-day supply) and one refill. Medications needed longer than 60 days should be obtained through the CVS Caremark Mail Service or the CVS Caremark Maintenance Choice Program or you will be required to pay the entire cost of the medication at the retail pharmacy. Previously, there were no dispensing limitations for retail purchases. See page 68, *Dispensing Limitations.*
- The High Option per prescription copayment structure has been changed as follows. See page 71.
  - At Retail: generic drugs from $10 to $8; preferred name brand drugs from 15% of the Plan allowance ($40 minimum/$55 maximum) to 20% of the Plan allowance ($40 minimum/$55 maximum); and non-preferred name brand drugs from 30% of the Plan allowance ($60 minimum/$90 maximum) to 35% of the Plan allowance ($60 minimum/$100 maximum).
  - At Mail Order: preferred name brand drugs from 15% of the Plan allowance ($80 minimum/$110 maximum) to 20% of the Plan allowance ($80 minimum/$110 maximum); and non-preferred name brand drugs from 30% of the Plan allowance ($120 minimum/$180 maximum) to 35% of the Plan allowance ($120 minimum/$225 maximum). The generic drug copayment will remain $12.
- The Plan will now include copayments paid under the Plan's "Specialty drugs" benefit listed on page 38 when we calculate your catastrophic protection out-of-pocket maximum under *Section 4. Your costs for covered services.* See page 23.

Changes to our Standard Option only

- Your share of the non-Postal premium is unchanged for Self Only and Self and Family. See page 106.
- The Standard Option per prescription copayment structure has been changed as follows. See page 71.
- At Retail: generic drugs from $10 to $8; preferred name brand drugs from 25% of the Plan allowance ($40 minimum/ $70 maximum) to 30% of the Plan allowance ($40 minimum/ $70 maximum); and non- preferred name brand drugs from 35% of the Plan allowance ($60 minimum/$100 maximum) to 40% of the Plan allowance ($60 minimum/$110 maximum).
- At Mail Order: preferred name brand drugs from 25% of the Plan allowance ($80 minimum/$150 maximum) to 30% of the Plan allowance ($80 minimum/$150 maximum); and non-preferred name brand drugs from 35% of the Plan allowance ($120 minimum/ $225 maximum) to 40% of the Plan allowance ($120 minimum/$275 maximum). The generic drug copayment will remain $15.
- The Plan will now include the following expenses when we calculate your catastrophic protection out-of-pocket maximum under *Section 4. Your costs for covered services*: the calendar year deductible; the inpatient hospital per confinement copayment; the office visit copayment under PPO benefits; and copayments paid under the Plan's "Specialty drugs" benefit listed on page 38. See *catastrophic protection limits* on page 23.

Clarifications

- The Plan's benefit description in *Section 5(c) Services provided by a hospital or other facility, and ambulance services* has been updated to clarify that the Plan will apply outpatient benefits to covered hospital observation services up to 48 hours. See page 58.
- *Infertility services* benefit description has been updated to better explain the types of services that are covered under this benefit. See page 36.
- The Plan's benefit language has been updated to state that orthopedic and corrective shoes are only covered if prescribed for a patient with diabetes or when attached to a brace. See pages 41 and 42.
- The *Maternity care* benefit in Section 5(a) has been clarified to show that sonograms and other related tests that are not included in routine prenatal or postnatal care are covered under *Lab, x-ray, and other diagnostic tests.* See page 34.
- The benefit language for routine mammograms under *Preventive care, adult* has been updated to comply with the United States Preventive Services Task Force (USPSTF) recommendations for routine screenings. See page 31.
- The Plan's benefit description under *Maternity care* better explains the covered benefits available for breastfeeding supplies and equipment. See page 34.
- The Plan's language under *Organ/tissue transplants* in Section 5(b) has been updated to provide a clearer understanding of the donor screening tests and donor search expenses that are covered by the Plan. See page 56.
- Language has been added to state that the Plan will not honor or coordinate benefits with drug coupon/copay cards. See *Section 5 (f). Prescription drug benefits* on page 67.
- The list of covered specialty drugs that are covered under the Plan's *Specialty drugs* benefit has been updated. See Section 5(a); page 38.
- The types of medications that are covered by the Plan for tobacco cessation has been clarified. See Section 5(f); page 73.
- The Plan's benefit description under *Preventive care, adult* has been updated to specify that the elements of a biometric screening are included in this benefit. See page 30.
- The Plan's coverage of FDA approved female over-the-counter (OTC) contraceptive drugs and devices when obtained with a physician's written prescription has been clarified. See pages 35 and 73.
- The Plan has added "Other Participating Providers" that allows member access to certain non-PPO health care providers that have agreed to discount their charges. This will help reduce your out of pocket expenses. See page 10.
- *Section 5(f).Prescription drug benefits* has been updated to show that when Medicare Part B is your primary carrier, some Medicare Part B medicines and supplies (such as for diabetes) may not be available through the CVS Caremark Mail Service. See page 70.

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 and who bills for the covered services. 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.)
- dentist (D.D.S., D.M.D.)
- chiropractor
- licensed registered physical threapist
- licensed occupational therapist
- licensed speech therapist
- qualified clinical psychologist
- clinical social worker
- optometrist
- audiologist
- respiratory therapist
- physician's assistant
- nurse midwife
- nurse practitioner/clinical specialist
- nursing school-administered clinic
- certified registered nurse anesthetist (C.R.N.A.)
- 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 2014, the states are: Alabama, Arizona, Idaho, Illinois, Louisiana, Mississippi, Missouri, New Mexico, North Dakota, Oklahoma, South Carolina, and Wyoming.

- **Covered facilities**

Covered facilities include:

- Ambulatory surgical center —

1. A facility which is licensed by the state as an ambulatory surgery center or has Medicare certification as an ambulatory surgical center, has permanent facilities and equipment for the primary purpose of performing surgical and/or renal dialysis procedures on an outpatient basis; provides treatment by or under the supervision of doctors and nursing services whenever the patient is in the facility; does not provide inpatient accommodations; and is not a facility used as an office or clinic for the private practice of a doctor or other professional.
2. In the Sate of California, ambulatory surgical facilities do not require a license if they are physician owned. To be covered these facilities must be accredited by one of the following: AAAHC (Accreditation Assocation for Ambulatory Health Care), AAAASF (American Association for Accreditation for Ambulatory Surgery Facilities), IMQ (Institute for Medical Quality), or JCAHO (Joint Commission on Accreditation of Healthcare Organizations).

- 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.

- Skilled nursing facility — an institution or that part of an institution that provides skilled nursing care 24 hours a day and is classified as a skilled nursing care facility under Medicare.
- Managed In-Network providers — The Plan may approve coverage of providers who are not currently shown as Covered providers, to provide mental health/substance abuse treatment under the managed In-Network benefit. Coverage of these providers is limited to circumstances where the Plan has approved the treatment plan.

- **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;
- 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.

You need prior Plan approval for certain services

The pre-service claim approval processes for inpatient hospital admissions (called precertification) and for other services, are detailed in this Section. A **pre-service claim** is any claim, in whole or in part, that requires approval from us in advance of obtaining medical care or services. In other words, a pre-service claim for benefits (1) requires precertification, prior approval or a referral and (2) will result in a reduction of benefits if you do not obtain precertification, prior approval or a referral.

- **Inpatient hospital admission**

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 requesting 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 only pay for any covered medical services and supplies that are otherwise payable on an outpatient basis.

Exceptions:

You do not need precertification in these cases:

- You are admitted to a hospital outside the United States.
- You have another group health insurance policy that is the primary payor for the hospital stay.

- Medicare Part A is the primary payor 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 payor 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 page 64 for additional information.
- Certain classes of drugs including, but not limited to, human growth hormone therapy (GHT) drugs. See Section 5(f) on page 67. Contact CVS Caremark at 1-855/566-8395 for additional information.
- Surgical treatment of morbid obesity (bariatric surgery). Contact Cigna/CareAllies at 1-800/887-9735.
- Organ/tissue transplants. The prior authorization process for organ/tissue transplants is more extensive than the normal authorization process. 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. See Section 5 (b) on page 56.
- Services for genetic testing. Call SAMBA at 1-800/638-6589 or 301/984-1440 (for TDD, use 301/984-4155).
- Durable medical equipment. Call Cigna/CareAllies at 1-800/887-9735
- Home infusion therapy. Contact Cigna/CareAllies at 1-800/887-9735
- Home nursing care. Contact Cigna/CareAllies at 1-800/887-9735
- Speech therapy. Contact Cigna/CareAllies at 1-800/887-9735
- Outpatient spinal procedure. Call Cigna/CareAllies at 1-800/887-9735

Warning:

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

- **Radiology/Imaging procedures**

The following outpatient radiology/imaging services require precertification.

- CT/CAT scan - Computed Tomography/Computerized Axial Tomography
- MRA - Magnetic Resonance Angiography
- MRI - Magnetic Resonance Imaging
- NC - Nuclear Cardiology Studies
- PET - Positron Emission Tomography

For these outpatient procedures, you, your representative, your doctor, or facility must call Cigna/CareAllies at 1-800/887-9735 before scheduling the procedure. We will reduce our benefits for these procedure by $100 per occurence if no one contacts us for precertification. If the procedure is not medically necessary we will not pay any benefits. Refer to page 29 for additional information.

Exceptions:

You do not need precertification, preauthorization, or prior approval if you have other group health insurance, including Medicare, when they are your primary payer.

How to request precertification for an admission

First, you, your representative, your physician, or your hospital must call Cigna/CareAllies at 1-800-887-9735 before admission or services requiring prior authorization are rendered.

Next, provide the following information:

- enrollee's name and Plan identification number;
- patient's name, birth date, identification number and phone number;
- reason for hospitalization, proposed treatment, or surgery;
- name and phone number of admitting physician;
- name of hospital or facility; and
- number of planned days of confinement.

- **Non-urgent care claims**

For non-urgent care claims, we will tell the physician and/or hospital the number of approved inpatient days, or the care that we approve for other services that must have prior authorization. We will make our decision within 15 days of receipt of the pre-service claim.

If matters beyond our control require an extension of time, we may take up to an additional 15 days for review and we will notify you of the need for an extension of time before the end of the original 15 day period. Our notice will include the circumstances underlying the request for the extension and the date when a decision is expected.

If we need an extension because we have not received necessary information from you, our notice will describe the specific information required and we will allow you up to 45 days from the receipt of the notice to provide the information.

- **Urgent care claims**

If you have an **urgent care claim** (i.e., when waiting for the regular time limit for your medical care or treatment could seriously jeopardize your life, health, or ability to regain maximum function, or in the opinion of a physician with knowledge of your medical condition, would subject you to severe pain that cannot be adequately managed without this care or treatment), we will expedite our review and notify you of our decision within 72 hours. If you request that we review your claim as an urgent care claim, we will review the documentation you provide and decide whether it is an urgent care claim by applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine.

If you fail to provide sufficient information, we will contact you within 24 hours after we receive the claim to provide notice of the specific information we need to complete our review of the claim. We will allow you up to 48 hours from the receipt of this notice to provide the necessary information. We will make our decision on the claim within 48 hours of (1) the time we received the additional information or (2) the time you received the notice to provide the additional information, whichever is earlier.

We may provide our decision orally within these time frames, but we will follow up with written or electronic notification within three days of oral notification.

You may request that your urgent care claim on appeal be reviewed simultaneously by us and OPM. Please let us know that you would like a simultaneous review of your urgent care claim by OPM either in writing at the time you appeal our initial dicision, or by calling us at 1-800/638-6589 or 301/984-1440 (for TDD, use 301/984-4155). You may also call OPM's Health Insurance II at 202/606-3818 between 8 a.m. and 5 p.m. Eastern Time to ask for the simultaneous review. We will cooperate with OPM so they can quickly review your claim on appeal. In addition, if you did not indicate that your claim was a claim for urgent care, call us at 1-800/638-6589 or 301/984-1440 (for TDD, use 301/984-4155). If it is determined that your claim is an urgent care claim, we will expedite our review (if we have not yet responded to your claim).

- **Concurrent care claims**

A concurrent care claim involves care provided over a period of time or over a number of treatments. We will treat any reduction or termination of our pre-approved course of treatment before the end of the approved period of time or number of treatments as an appealable decision. This does not include reduction or termination due to benefit changes or if your enrollment ends. If we believe a reduction or termination is warranted we will allow you sufficient time to appeal and obtain a decision from us before the reduction or termination takes effect.

If you request an extension of an ongoing course of treatment at least 24 hours prior to the expiration of the approved time period and this is also an urgent care claim, then we will make a decision within 24 hours after we receive the claim.

- **Emergency inpatient 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 physician, 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. If you do not telephone the Plan within two business days, penalties may apply - see *Warning* under *Inpatient hospital admissions* earlier in this Section and *If your hospital stay needs to be extended* below.

- **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 you, your representative, your physician, or the hospital must contact us for precertification of additional days. Further, if your baby stays after you are discharged, then you, your representative, your physician, or the hospital must contact us for precertification of additional days for your baby

- **If your hospital stay needs to be extended**

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

- **If your treatment needs to be extended**

If you request an extension of an ongoing course of treatment at least 24 hours prior to the expiration of the approved time period and this is also an urgent care claim, then we will make a decision within 24 hours after we receive the claim.

If you disagree with our pre-service claim decision

If you have a **pre-service claim** and you do not agree with our decision regarding precertification of an inpatient admission or prior approval of other services, you may request a review in accord with the procedures detailed below.

If you have already received the service, supply, or treatment, then you have a post-service claim and must to follow the entire disputed claims process detailed in Section 8.

- **To reconsider a non-urgent care claim**

Within 6 months of our initial decision, you may ask us in writing to reconsider our initial decision. Follow Step 1 of the disputed claims process detailed in Section 8 of this brochure.

In the case of a pre-service claim and subject to a request for additional information, we have 30 days from the date we receive your written request for reconsideration to

1. Precertify your hospital stay or, if applicable, arrange for the health care provider to give you the care or grant your request for prior approval for a service, drug, or supply; or

2. Ask you or your provider for more information.

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.

3. Write to you and maintain our denial.

- **To reconsider an urgent care claim**

  In the case of an appeal of a pre-service urgent care claim, within 6 months of our initial decision, you may ask us in writing to reconsider our initial decision. Follow Step 1 of the disputed claims process detailed in Section 8 of this brochure.

  Subject to a request for additional information, we will notify you of our decision within 72 hours after receipt of your reconsideration request. We will expedite the review process, which allows oral or written requests for appeals and the exchange of information by telephone, electronic mail, facsimile, or other expeditious methods.

- **To file an appeal with OPM**

  After we reconsider your **pre-service claim**, if you do not agree with our decision, you may ask OPM to review it by following Step 3 of the disputed claims process detailed in Section 8 of this brochure.

Section 4. Your costs for covered services

Your costs for covered services

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.

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.

Other separate copayments include, but are not limited to:

- High Option inpatient hospital confinement; PPO: $200 per confinement; non-PPO: $300 per confinement
- Standard Option inpatient hospital confinement; PPO: $150 per day copayment up to $450 per confinement; non-PPO: $200 per day copayment up to $600 per confinement
- High Option outpatient hospital or ambulatory surigical center; non-PPO: $150 per facility, per occurrence
- High Option specialty drugs listed in Section 5(a); $300 per prescription fill (see page 38)
- Standard Option specialty drugs listed in Section 5(a); $500 per prescription fill (see page 38)

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 $300 per person under the High Option and $350 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 $600 under the High Option and $1,050 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 and 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 ($220 under High Option/$270 under Standard Option) 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 does not begin until you have met your calendar year 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% High Option 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 under High Option, 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:

High Option

- PPO: $3,500 for you and any covered family members when PPO providers are used.
- Non-PPO: $5,000 for you and nay covred family members. Eligible PPO expenses will also count toward this limit.

Standard Option

- PPO: $5,000 for one person or $7,000 for you and any covered family members when PPO providers are used.
- Non-PPO: $7,000 for one person or $9,000 for you and any covered family members. Eligible PPO expenses will also count toward this limit.

High Option:

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

- $300 calendar year deductible ($600 family);
- $200 PPO and $300 non-PPO per inpatient hospital confinement copayment;
- $150 non-PPO outpatient facility services copayment;
- copayments you pay under the *Specialty drugs* benefit (see page 38);
- $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 and coinsurances 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 $350 per person ($1,050 family) calendar year deductible;
- the inpatient hospital per confinement copayment; PPO: $150 per day up to $450 per confinement; non-PPO: $200 per day up to $600 per confinement;
- the $20 office visit copayment under PPO benefits;
- copayments you pay under the *specialty drugs* benefit (see page 38); 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 Standard Option out-of-pocket expenses:

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

Prescription drugs: Copayments and coinsurance expenses for prescription drugs obtained from a CVS Caremark network retail pharmacy or through the CVS Caremark Mail Service, including the CVS Caremark Specialty Pharmacy, will count toward a separate prescription drug out-of-pocket limit of $4,000 per person, per calendar year under High Option and $5,000 per person, per calendar year under Standard Option. 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.

Note: We will generally first seek recovery from the provider if we paid the provider directly or from the person (covered family member, guardian, custodial parent, etc.) to whom we sent our payment.

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. You may be responsible for certain services and charges. Contact the government facility directly for more information.

High and Standard Option Benefits

See page12 and 13 for how our benefits changed this year. Page 104 and page 105 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.

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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 filing advice, or more information about High and Standard Option benefits, contact us at 1-800/638-6589 (TDD, use 301/984-4155) or on our Web site at www.SambaPlans.com.

Each option offers unique features.

- **High Option**
  - Extensive PPO network
  - No referral needed to see a specialist
  - $20 per office visit copament when PPO providers are used
  - $12 copayment for generic drugs purchased through the Mail Order Program
  - 100% coverage for room and board and 90% for other hospital charges after the $200 per confinement copayment when a PPO facility is used
  - 70% of the Plan allowance coverage for most eligible out-of-network expenses

- **Standard Option**
  - Extensive PPO network
  - Affordable premiums
  - No referral needed to see a specialist
  - $20 per office visit copayment when PPO providers are used
  - $15 copayment for generic drugs purchased through the Mail Order Program
  - 100% coverage for room and board and 85% for other hospital charges after the $150 per day copayment up to $450 per confinement
  - 65% of the Plan allowance coverage for most eligible out-of-network expenses

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: $300 per person ($600 per family) under the High Option and $350 per person ($1,050 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. Also read Section 9 about coordinating benefits with Medicare and other coverage.

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 • Vists and consultation services provided in a convenient care clinic Note: We cover one routine physical exam and one routine gynecologic exam (for women 18 or over) per person, per calendar year; see page 30.	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: 35% 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 Note: Specialty drugs purchased from and billed by the doctor, home health agency, or outpatient facility are covered under *Specialty drugs*; see page 38.	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: 35% 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: 35% 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 and their interpretations, such as: • Blood tests • Urinalysis • Non-routine Pap tests • Pathology • X-rays • Non-routine mammograms • Ultrasound • Electrocardiogram and EEG • CT/CAT; MRI; MRA; NC; PET - Note: Preauthorization for these high-tech radiology procedures is required. Contact Cigna/CareAllies at 1-800/887-9735 before schduling the procedure. See *Other services* under *You need prior Plan approval for certain services* on page 17. 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 Non-PPO: 35% 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.
Lab Program — You can use this voluntary program for covered lab services. Testing must be performed by a Quest Diagnostics laboratory or a LabCorp laboratory. Ask your doctor to use Quest or LabCorp for lab processing. To find a Quest or LabCorp laboratory location near you, visit our Web site at www.SambaPlans.com. Note: This benefit applies to expenses for laboratory tests performed by Quest Diagnostics or LabCorp only. Related expenses or laboratory tests referred to and/or performed by an associated laboratory (not participating in the Lab Program) are subject to applicable deductible, copayments and coinsurance.	Nothing for services obtained through the Lab Program (No deductible)	Nothing for services obtained through the Lab Program (No deductible)

Benefit Description	You Pay	
Preventive care, adult	**High Option**	**Standard Option**
One routine physical examination per person, per calendar year including the following laboratory tests and screenings: • Comprehensive Metabolic Panel • Lipid Panel • Blood pressure • Glucose or Hemoglobin A1c measurement • Urinalysis • Body mass index (BMI) Note: Contact us for information on the specific tests covered underthis benefit. Other medically necessary laboratory and diagnostic tests and X-rays not included in the above list that are during a routine exam are subject to the benefits under *Diagnostic and treatment services*. **Note:** Your physician's bill must clearly state "routine physical exam." If a medical diagnosis is provided on the bill, those services will be paid under the medical benefit.	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: 35% of the Plan allowance and any difference between our allowance and the billed amount
One annual routine gynecological visit for women age 18 or over. **Note:** Your physician's bill must clearly state "routine physical exam." If a medical diagnosis is provided on the bill, those services will be paid under the medical benefit.	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: 35% of the Plan allowance and any difference between our allowance and the billed amount
Routine screenings, such as: • Total Blood Cholesterol • Chlamydial infection • Colorectal Cancer Screening, including Note: See page 47 *Surgical procedures* for benefits for colonoscopies performed by a physician to diagnose or treat a specific condition. - Fecal occult blood test for members age 40 and older - Sigmoidoscopy screening- every five years starting at age 50 - Double contrast barium enema- every five years startting at age 50 - Routine screening colonoscopy, including facility and anesthesia charges related to the colonoscopy exam - every ten years starting at age 50	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: 35% 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**
Routine Prostate Specific Antigen (PSA) test- one annually for men age 40 and older	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: 35% of the Plan allowance and any difference between our allowance and the billed amount
Well woman care – including, but not limited to: • Well woman exam; one annually • Routine pap test; one annually • Human papillomavirus testing for women age 30 and up; once every three years • Annual counseling for sexually transmitted infections • Annual counseling and screening for human immune-deficiency virus • Contraceptive methods and counseling • Screening and counseling for interpersonal and domestic violence	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: 35% 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 Note: When billed by a facility, such as the outpatient department of a hospital, we provide benefits as shown here.	PPO: Nothing (No deductible) Non-PPO: 35% of the Plan allowance and any difference between our allowance and the billed amount Note: When billed by a facility, such as the outpatient department of a hospital, we provide benefits as shown here.

Preventive care, adult - continued on next page

Benefit Description	You Pay	
Preventive care, adult (cont.)	**High Option**	**Standard Option**
Preventive services under the Grade A and B recommendations of the United States Preventive Services Task Force (USPSTF) Covered services include: • Blood pressure screeing in adults • BRCA screening for women whose family history is associated with an increased risk for deleterious mutations in BRCA1 or BRCA2 genes • Diabetes screeing for type 2 diabetes in adults with sustained blood pressure greater than 135/80 mmHg • Gonorrhea screening for women who are at increased risk for infection • Human immunodeficiency virus (HIV) screeinging for adults at increased risk for infection • Osteoporosis screening for women aged 60 and older • Syphilis screening for persons at increased risk for syphilis infection **Note:** A complete list of the preventive care services recommended under the USPSTF is available online at www.uspreventiveservicestaskforce.org/uspstf/uspsabrecs.htm.	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: 35% of the Plan allowance and any difference between our allowance and the billed amount
Adult routine immunizations endorsed by the Centers for Disease Control and Prevention (CDC) based on their Recommended Adult Immunization Schedule by Vaccine and Age Group: • Influenza (Flu) • Tetanus, diphtheria, pertussis (Td/Tdap) • Varicella (chickenpox) • Human papillomavirus (HPV) • Zoster (shingles) • Measles, mumps, rubella (MMR) • Pneumococcal (polysaccharide) • Meningococcal • Hepatitis A and B	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*

Benefit Description	You Pay	
Preventive care, children	**High Option**	**Standard Option**
• Childhood immunizations recommended by the American Academy of Pediatrics	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 **Note:** Your physician's bill must clearly state "routine well-child exam." If a medical diagnosis is provided on the bill, those services will be paid under the medical benefit.	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: 35% of the Plan allowance and any difference between our allowance and the billed amount
Preventive services under the Grade A and B recommendations of the United States Task Force (USPSTF) Covered services include: • Blood pressure screening for children • Hearing screening for newborns • Hematocrit or Hemoglobin screening for children • Phenylketonuria (PKU) screening in newborns • Visual acuity screening in children **Note:** A complete list of the preventive care services recommended under the USPSTF is available online at www.uspreventiveservicestaskforce.org/uspstf/uspsabrecs.htm. Services recommended and guidelines for plan coverage are subject to Federal regulations.	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: 35% of the Plan allowance and any difference between our allowance and the billed amount

Benefit Description	You Pay	
Maternity care	**High Option**	**Standard Option**
Complete maternity (obstetrical) care, such as: • Prenatal care • Delivery • Postnatal care • Prenatal sonograms • Stand-by doctor for cesarean section Note: Here are some things to keep in mind: • You do not need to precertify your normal delivery; see page 19 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. Surgical benefits apply to circumcision (see page 47). • We pay hospitalization and surgeon services for non-maternity care the same as for illness and injury. • Sonograms and other related tests that are not included in your routine prenatal or postnatal care are covered under *Lab, x-ray, and other diagnostic tests,* see page 29.	PPO: 10% of the Plan allowance Note: For facility care related to maternity, including care at birthing facilities, see Section 5 (c). Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount	PPO: Nothing (No deductible) Note: For facility care related to maternity, including care at birthing facilities, see Section 5 (c). Non-PPO: 35% of the Plan allowance and any difference between our allowance and the billed amount
• Screening for gestational diabetes for pregnant women between 24-28 weeks gestation or first prenatal visit for women at high risk. • Breastfeeding support and counseling for each birth • Breastfeeding equipment rental or purchase • Breastfeeding supplies limited to tubing, adapters and cap replacements for breast pumps, breast shield and splash protector replacements Note: Benefits for the rental of breastfeeding equipment are limited to an amount no greater than what we would have paid if the equipment had been purchased. We will only cover the cost of standard equipment.	PPO: Nothing (No deductible) Non-PPO: 30% of the Plan allowance and any difference between our allance and the billed amount	PPO: Nothing (No deductible) Non-PPO: 35% 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**
Not covered: • *Routine sonograms to determine fetal age, size or sex* • *Services before enrollment in the Plan begins or after enrollment ends*	*All charges*	*All charges*
Family Planning	**High Option**	**Standard Option**
Contraceptive counseling on an annual basis	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: 35% of the Plan allowance and any difference between our allowance and the billed amount
Food and Drug Administration (FDA) approved female contraceptive methods and devices, female sterilization procedures, and patient education and counseling for all women with reproductive capacity including: • Voluntary sterilization for women (including related expenses for anesthesia and outpatient facility services, if necessary) • Surgically implanted contraceptives (including related expenses for anesthesia and outpatient facility services, if necessary) • Injectable contraceptive drugs (such as Depo provera) • Intrauterine devices (IUDs) • Diaphragms • Over-the-counter (OTC) FDA approved contraceptive drugs and devices for women (written prescription is required) Note: We cover women's oral contraceptives under the prescription drug benefit. Note: We cover voluntary sterilization for men under *Surgical procedures*, Section 5(b).	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: 35% of the Plan allowance and any difference between our allowance and the billed amount
Not covered: • *Reversal of voluntary surgical sterilization* • *Genetic counseling* • *Genetic screening* • *Expenses for sperm collection and storage*	*All charges*	*All charges*

Benefit Description	You Pay	
Infertility services	**High Option**	**Standard Option**
Diagnosis and treatment of infertility, limited to: • Initial diagnostic tests and procedures rendered only to identify the cause of infertility • medical or surgical procedures rendered to create or enhance fertility, except as shown in *Not covered* below 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: 35% 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:* - *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: 35% 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*

Benefit Description	You Pay	
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 51 through 55. • Dialysis – hemodialysis and peritoneal dialysis • Intravenous (IV)/Infusion Therapy – Home IV and antibiotic therapy Note: Preauthorization is required for Home Infusion Therapy. Contact Cigna/CareAllies at 1-800/887-9735. See *Other services* on page 17 for more information. • Transparenteral nutrition (TPN) • Medical foods and nutritional supplements when administered by catheter or nasogastric tubes • Respiratory and inhalation therapies • Cardiac rehabilitation • Hyperbaric oxygen therapy Note: Contact the Plan at 1-800/638-6589 or 301/984-1440 (For TDD, use 301/984-4155) for details about coverage and information about hyperbaric oxygen therapy. • Growth hormone therapy (GHT) Note: Growth hormone medications are covered under Section 5(f) *Prescription drug benefits*. Some medications, including specialty drugs, some oncology drugs, and growth hormones, require preauthorization. See *Specialty drugs* on page 67 and *Other services* under *You need prior Plan approval for certain services* on page 17 for more information.	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: 35% of the Plan allowance and any difference between our allowance and the billed amount
Not covered: • *Applied Behavior Analysis (ABA) therapy* • *Chelation therapy except for acute arsenic, gold or lead poisoning* • *Topical hyperbaric oxygen therapy* • *Prolotherapy*	*All charges*	*All charges*

Benefit Description	You Pay	
Specialty drugs	**High Option**	**Standard Option**
Specialty drugs are those used to treat some severe, chronic medical conditions. The drugs listed below, by category, when dispensed by some other source than through the CVS Caremark Pharmacy system are subject to the *Specialty drugs* benefit on this page. Prior authorization may be required for certain listed medications. Please call CVS Caremark for details at 1-855/566-8395. • Cancer medications: Afinitor, Gleevec, Hycamtin Oral, Nexavar, Oforta, Revlimid, Sprycel, Sutent, Tarceva, Temodar (oral), Thalomid, Tykerb, Votrient, Xeloda, and Zolinza • Growth stimulating agents: Genotropin, Humatrope, Increlex, Norditropin (all forms), Nutropin (all forms), Omnitrope, Saizen, Tev-Tropin, Serostim, and Zorbtive • Hemophilia medications: Advate (all forms), Alphanate, Alphanine SD, Bebulin VH, Benefix, Corifact, Feiba VH, Helixate FS,Hemofil M, Humate-P, Koate DVI, Kogenate FS, Monoclate P, Mononine, Novoseven (all forms), Profilnine SD, Recombinate, Riastap, Stimate, Wilate, and Xyntha • Hepatitis medications: Infergen, Pegasys, and Peg-Intron (all forms), Copegus, Victrelis, Incivek, Rebetol, Ribapak, Ribasphere, and Ribavirin • HIV medication: Fuzeon • Immune deficiency medications: Actimmune and Adagen • Metabolic disorder medications: Carbaglu, Cystadane, Kuvan,and Orfadin • Multiple Sclerosis medications: Avonex, Betaseron, Copaxone, Extavia, Gilenya, and Rebif • Ophthalmics medications: Ozurdex and Retisert • Osteoporosis medication: Forteo • Pulmonary medications: Pulmozyme and Tobi • Pulmonary Arterial Hypertension medications: Adcirca, Epoprostenol, Flolan, Letairis, Remodulin, Revatio (oral and IV forms), Tracleer, Tyvaso, Veletri (RTS Epoprostenol sodium brand), and Ventavis • Respiratory Syncytial Virus medication: Synagis • Rheumatoid Arthritis and other autoimmune conditions medications: Amevive, Cimzia, Enbrel (all forms), Humira (all forms), Kineret, Simponi, and Stelara • Other specialty agents: Apokyn, Arcalyst, Exiade, Sensipar, Somatuline Depot, Somavert, and Xenazine	**Medications purchased through a physician's office, home health agency, outpatient hospital, or other outpatient facility:** • PPO: $300 copayment per prescription fill and 10% of the Plan allowance • Non-PPO: $300 copayment prescription fill and 30% of the Plan allowance Note: A separate copayment applies per prescription fill up to a 30-day supply. **Note: To receive the Plan's maximum benefit, these medications should be purchased directly from a participating CVS Caremark Specialty Pharmacy. See *Section 5(f). Prescription drug benefits*, page 67.**	**Medications purchased through a physician's office, home health agency, outpatient hospital, or other outpatient facility:** • PPO: $500 copayment per prescription fill and 15% of the Plan allowance • Non-PPO: $500 copayment prescription fill and 35% of the Plan allowance Note: A separate copayment applies per prescription fill up to a 30-day supply. **Note: To receive the Plan's maximum benefit, these medications should be purchased directly from a participating CVS Caremark Specialty Pharmacy. See *Section 5(f). Prescription drug benefits*, page 67.**

Benefit Description	You Pay	
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 75 visits per person, per calendar year under **High Option** and 50 visits per person, per calendar year under **Standard Option**. Note: Visits that you pay for while meeting your calendar year deductible count toward the per person, per calendar year visit limitation.	PPO: 10% of the Plan allowance and all charges in excess of the 75 visit limitation Non-PPO: 50% of the Plan allowance and any difference between our allowance and the billed amount and all charges in excess of the 75 visit limitation	PPO: 15% of the Plan allowance and all charges in excess of the 50 visit limitation Non-PPO: 50% of the Plan allowance and any difference between our allowance and the billed amount and all charges in excess of the 50 visit limitation
Not covered: • *Any charges in excess of the 75 visit High Option or 50 visit Standard Option plan limitation for covered physical and occupational therapies* • *Exercise programs*	*All charges*	*All charges*
Speech therapy	**High Option**	**Standard Option**
Speech therapy 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. Note: Preauthorization is required for speech therapy. Contact Cigna/CareAllies at 1-800/887-9735. See *Other services* on page 17 for additional information. Benefits are limited to 50 visits per person, per calendar year under **High Option** and 30 visits per person, per calendar year under **Standard Option**. Note: Visits that you pay for while meeting your calendar year deductible count toward the per person, per calendar year visit limitation.	PPO: 10% of the Plan allowance and all charges in excess of the 50 visit limitation Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount and all charges in excess of the 50 visit limitation	PPO: 15% of the Plan allowance and all charges in excess of the 30 visit limitation Non-PPO: 35% of the Plan allowance and any difference between our allowance and the billed amount and all charges in excess of the 30 visit limitation
Not covered: • *Voice therapy for occupation or performing arts* • *Training or therapy to improve articulation in the absence of an injury, illness, or medical condition affecting articulation* • *Any charge in excess of the 50 visit HighOption or 30 visit Standard Option plan limitation for covered speech therapy*	*All charges*	*All charges*

Benefit Description	You Pay	
Hearing services (testing, treatment, and supplies)	**High Option**	**Standard Option**
• Hearing testing, diagnostic examination, and treatment by a licensed hearing professional for dependent children up to age 22. • External hearing aids - Benefits are limited to $1,000 per hearing aid, per ear, every five calendar years. Note: See page 42 for coverage of implanted hearing-related devices.	PPO: 10% of the Plan allowance and all charges in excess of the benefit limitations. Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount and all charges in excess of the benefit limitations.	PPO: 15% of the Plan allowance and all charges in excess of the benefit limitations. Non-PPO: 35% of the Plan allowance and any difference between our allowance and the billed amount and all charges in excess of the benefit limitations.
• Hearing testing, diagnostic examination, and treatment by a licensed hearing professional for adults. • External hearing aids - Benefits are limited to $500 per hearing aid, per ear, every five calendar years. Note: See page 42 for coverage of implanted hearing-related devices.	PPO: 10% of the Plan allowance and all charges in excess of the benefit limitations Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount and all charges in excess of the benefit limitations	PPO: 15% of the Plan allowance and all charges in excess of the benefit limitations Non-PPO: 35% of the Plan allowance andany difference between our allowance and the billed amount and all charges in excess of the benefit limitations
Not covered: • *Testing and examinations for prescribing or fitting of hearing aids, except as stated above* • *Hearing aid replacements within five years after the Plan has paid $1,000 per hearing aid, per ear for children up to age 22* • *Hearing aid replacements within five years after the Plan has paid $500 per hearing aid, per ear for adults.* • *Replacement batteries or adjustments for hearing aids*	*All charges*	*All charges*

Benefit Description	You Pay	
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: 35% 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: 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: 35% of the Plan allowance and any difference between our allowance and the billed amount
One pair of diabetic shoes per person, per calendar year	**PPO: 10% of the Plan allowance** **Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount**	**PPO: 15% of the Plan allowance** **Non-PPO: 35% 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 when attached to a brace • 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 • Implanted hearing-related devices, such as bone anchored hearing aids (BAHA) and cochlear implants • Internal prosthetic devices, such as artificial joints, pacemakers, and surgically implanted breast implant following mastectomy. Note: For information on the professional charges for the surgery to insert an implant, see Section 5(b) *Surgical procedures*. For information on the hospital and/or ambulatory surgery center benefits, see Section 5 (c) *Services provided by a hospital or other facility, and ambulance services*. Note: See page 40 for coverage of external hearing aids and testing to fit them. 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(g).	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* • Orthopedic and corrective shoes unless attached to a brace	*All charges*	*All charges*

Benefit Description	You Pay	
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 necessary repair and adjustment. Covered items include: - Oxygen equipment and oxygen - Hospital beds - Wheelchairs - Walkers Note: Preauthorization is required for durable medical equipment. Contact Cigna/CareAllies at 1-800/887-9735. See *Other services* on page 17 for additional information. 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 Non-PPO: 50% of the Plan allowance and any difference between our allowance and the billed amount
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* • *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*

Benefit Description	You Pay	
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. Note: Preauthorization is required for home nursing care. Contact Cigna/CareAllies at 1-800/887-9735. See *Other services* on page 17 for additional information. Benefits are limited to 50 visits per person, per calendar year under **High Option** and 25 visits per person, per calendar year under **Standard Option**. Note: Each visit taking 4 hours or less is counted as one visit. If a visit exceeds 4 hours, each 4 hours or fraction is counted as a separate visit.	PPO: 10% of the Plan allowance and all charges in excess of the 50 visit limitation Non-PPO: 50% of the Plan allowance and any difference between our allowance and the billed amount and all charges in excess of the 50 visit limitation	PPO: 15% of the Plan allowance and all charges in excess of the 25 visit limitation Non-PPO: 50% of the Plan allowance and any difference between our allowance and the billed amount and all charges in excess of the 25 visit limitation
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* • *Any charges in excess of the 50 visit High Option or 25 visit Standard Option plan limitation for covered private duty nursing care*	*All charges*	*All charges*
Chiropractic	**High Option**	**Standard Option**
Chiropractic services limited to: • the initial visit/examination • 26 manipulations per person, per calendar year Note: X-rays are covered under *Lab, X-ray and other diagnostic tests.* Note: Services that you pay for while meeting your calendar year deductible count toward the 26 manipulations limit.	PPO: 10% of the Plan allowance and all charges in excess of the benefit limitations Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount and all charges in excess of the benefit limitations	PPO: 15% of the Plan allowance and all charges in excess of the benefit limitations Non-PPO: 35% of the Plan allowance and any difference between our allowance and the billed amount and all charges in excess of the benefit limitations

Benefit Description	You Pay	
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 26 visits per person, per calendar year. Note: Visits that you pay for while meeting your calendar year deductible count toward the 26 visit limit.	PPO: 10% of the Plan allowance and all charges in excess of the 26 visit limitation Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount and all charges in excess of the 26 visit limitation	PPO: 15% of the Plan allowance and all charges in excess of the 26 visit limitation Non-PPO: 35% of the Plan allowance and any difference between our allowance and the billed amount and all charges in excess of the 26 visit limitation
Not covered: • *Naturopathic practitioner* • *Massage therapist* • *Any charges in excess of the visit limitation for covered acupuncture and chiropractic services* *(Note: Benefits of certain alternative treatment providers may be covered in medically underserved areas; see page 14).*	*All charges*	*All charges*
Educational classes and programs	**High Option**	**Standard Option**
Tobacco Cessation – Coverage is limited to: • We cover counseling sessions for tobacco cessation including proactive telephone counseling, group couseling, and individual counseling. Benefits are payable for up to two attempts per person, per calendar year with up to four counseling sessions per attempt. • We cover over-the-counter (with a physician's prescription) and prescription drugs approved by the FDA to treat tobacco dependence when obtained from a Network retail pharmacy, a non-Network retail pharmacy, or Mail Order Program. The quantity of drugs reimbursed will be subject to recommended courses of treatment. See Section 5(f) for additional information on our coverage of tobacco cessation drugs (page 73). Note: See Section 5(h) *Special features* (page 79) for more information on our tobacco cessation program.	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)

Educational classes and programs - continued on next page

Benefit Description	You Pay	
Educational classes and programs (cont.)	**High Option**	**Standard Option**
• Educational classes and nutritional therapy for self-management of diabetes, hyperlipidemia, hypertension, and obesity when: - Prescribed by the attending physician, and - Administered by a covered provider, such as a registered nurse or a licensed or registered dietician/ nutritionist.	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: 35% of the Plan allowance and any difference between our allowance and the billed amount
• Weight management program -- CIGNA Health Steps to Weight Loss^{sm} This personalized approach to weight management will be based on the participant's personal goals, preferences and health status. To join our Healthy Steps to Weight Loss^{sm} program, see Section 5(h) *Special Features*, page 79.	See page 79 for details	See page 79 for details

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: $300 per person ($600 per family) under the High Option and $350 per person ($1,050 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. Also read Section 9 about coordinating benefits with Medicare and other coverage.
- 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 56 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 • Removal of tumors and cysts • Correction of congenital anomalies (see *Reconstructive surgery*) • Treatment of burns • Voluntary sterilization for men Note: Voluntary sterilization for women is covered under *Family planning*, Section 5(a). • Insertion of internal prosthetic devices. See 5(a) – *Orthopedic and prosthetic devices* for device coverage information • Assistant surgeons-we cover up to 20% of our allowance for the surgeon's charge Note: Preauthorization is required for outpatient spinal surgeries. Contact Cigna/CareAllies at 1-800/887-9735. See *Other services* on page 17 for additional information.	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: 35% 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**
• Surgical treatment of morbid obesity (bariatric surgery) may be eligible for benefits when the following plan criteria are met: - Eligible patients must be age 18 or over - The patient has a documented body mass index (BMI) of 40 or greater or 35-39.9 with at least one clinically significant obesity-related comorbidity that have a morbid effect on the clinical course and are related to or accentuated by obesity - Medical management including evidence of active participation within the last 12 months in a weight-management program that is supervised either by a physician or a registered dietician for a minimum of three consecutive months. The weight-management program must include monthly medical documentation - A thorough multidisciplinary evaluation has been completed within the previous six months which includes ALL of the following: • an evaluation by bariatric surgeon recommending surgical treatment • a separate medical evaluation from a physician other than the requesting surgeon that includes both a recommendation for bariatric surgery as well as a medical clearance for surgery • unequivocal clearance for bariatric surgery by a mental health provider • a nutritional evaluation by a physician or registered dietician - Documented failure to sustain weight loss with medically supervised dietary and conservative treatment within the two years preceding the surgery Note: A repeat or revised bariatric surgical procedure is covered only when medically necessary or a complication has occured Note: Preauthorization of this procedure is required. Contact CIGNA/CareAllies at 1-800/887-9735. See *Other services* on page 17 for additional information.	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: 35% 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.

Surgical procedures - continued on next page

Benefit Description	You Pay After the calendar year deductible…	
Surgical procedures (cont.)	**High Option**	**Standard Option**
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: 35% of the Plan allowance for the primary procedure and 35% 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*
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.	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: 35% of the Plan allowance and any difference between our allowance and the billed amount

Reconstructive surgery - continued on next page

Benefit Description	You Pay After the calendar year deductible…	
Reconstructive surgery (cont.)	**High Option**	**Standard Option**
• 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: 35% 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 • 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: 35% 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*

Benefit Description	You Pay After the calendar year deductible…	
Organ/tissue transplants	**High Option**	**Standard Option**
These **solid organ transplants** are subject to medical necessity and experimental/investigational review by the Plan. See *Other services* under *You need prior Plan approval for certain services* on page 17. Solid organ transplants are limited to: • Cornea • Heart • Heart/lung • Kidney • Liver • Pancreas • Lung: single/bilateral/lobar • Autologous pancreas islet cell transplant (as an adjunct to total or near total pancreatectomy) only for patients with chronic pancreatitis • 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: 35% 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
These **tandem blood or marrow stem cell transplantsfor covered transplants** are subject to medical necessity review by the Plan. Refer to *Other services* in Section 3 for prior authorization procedures. • Autologous tandem transplants for: – AL Amyloidosis – Multiple myeloma (de novo and treated) – Recurrent germ cell tumors (including testicular cancer)	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: 35% 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**
Blood or marrow stem cell transplants limited to the stages of the following diagnoses. For diagnosis listed below, the medical necessity limitation is considered satisfied if the patient meets the staging description. Refer to "*Other services*" in Section 3 for prior authorization procedures. • Allogeneic transplants for: - Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia - Advanced Hodgkin's lymphoma with recurrence (relapsed) - Advanced non-Hodgkin's lymphoma with recurrence (relapsed) - Acute myeloid leukemia - Advanced Myeloproliferative Disorders (MPD's) - Advanced neuroblastoma - Amyloidosis - Chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL) - Hemoglobinopathy - Infantile malignant osteopetrosis - Kostmann's Syndrome - Leukocyte adhesion deficiencies - Marrow failure and related disorders (i.e., Fanconi's, PNH, Pure Red Cell Aplasia) - Mucolipidosis (e.g., Gaugher's disease, metachromatic leukodystrophy, adrenoleukodystrophy) - Mucopolysaccharidosis (e.g., Hunter's syndrome, Hurler's syndrome, Sanfilippo's syndrome, Maroteaux-Lamy syndrome variants) - Myelodysplasia/Myelodysplastic syndromes - Paroxysmal Nocturnal Hemoglobinuria - Phagocytic/Hemophagocytic deficiency diseases (e.g., Wiskott-Aldrich syndrome) - Severe combined immunodeficiency - Sickle cell anemia - X-linked lymphoproliferative syndrome	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: 35% 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 non-lymphocytic (i.e., myelogenous) leukemia - Advanced Hodgkin's lymphoma with recurrence (relapsed) - Advanced non-Hodgkin's lymphoma with recurrence (relapsed) - Amyloidosis - Ependymoblastoma - Ewing's sarcoma - Medulloblastoma - Multiple myeloma - Neuroblastoma - Pineoblastoma - Testicular, mediastinal, retroperitoneal, and ovarian germ cell tumors	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: 35% 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
Mini-transplants performed in a clinical trial setting (non-myeloablative, reduced intensity conditioning or RIC) for members with a diagnosis listed below are subject to medical necessity review by the Plan. Refer to *Other services* in Section 3 for prior authorization procedures:: • Allogeneic transplants for: - Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia - Advanced Hodgkin's lymphoma with recurrence (relapsed) - Advanced non-Hodgkin's lymphoma with reurrence (relapsed) - Acute myeloid leukemia - Advanced Myeloproliferative Disorders (MPDs) - Amyloidosis - Chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL) - Hemoglobinopathy - Marrow failure and related disorders (i.e., Fanconi's, PNH, Pure Red Cell Aplasia) - Myelodysplasia/Myelodysplastic syndromes - Paroxysmal Nocturnal Hemoglobinuria - Severe combined immunodeficiency - Severe or very severe aplastic anemia	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: 35% 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**
Mini-transplants performed in a clinical trial setting (non-myeloablative, reduced intensity conditioning or RIC) for members with a diagnosis listed below are subject to medical necessity review by the Plan. Refer to *Other services* in Section 3 for prior authorization procedures: • Autologous transplants for: - Acute lymphocytic or nonlymphocytic (i.e., myelogenous) leukemia - Advanced Hodgkin's lymphoma with recurrence (relapsed) - Advanced non-Hodgkin's lymphoma with recurrence (relapsed) - Amyloidosis - Neuroblastoma	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: 35% 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
These blood or marrow stem cell transplants are covered only in a National Cancer Institute or National Institutes of Health **approved clinical trial** or a Plan-designated LIFESOURSE transplant facility and if approved by the Plan's medical director in accordance with the Plan's protocols. Refer to *Other services* in Section 3 for prior authorization procedures. If you are a participant in a clinical trial, the Plan will provide benefits for related routine care that is medically necessary (such as doctor visits, lab tests, x-rays, scans, and hospitalization related to treating the patient's condition) if it is not provided by the clinical trial. Section 9 has additional information on costs related to clinical trials. We encourage you to contact the Plan to discuss specific services if you participate in a clinical trial. • Allogeneic transplants for: - Multiple myeloma - Sickle cell anemia - Beta Thalassemia Major	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: 35% 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**
• Mini-transplants (non-myeloablative allogeneic transplants Reduced intensity conditioning RIC) for: - Acute lymphocytic or non-lymphocytic (i.e. myelogenous) leukemia - Chronic lymphocytic leukemia - Chronic myelogenous leukemia - Chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL) - Multiple myeloma - Myeloproliferative disorders (MPDs) - Myelodysplasia/Myelodysplastic Syndrome • Autologous transplants for: - Advanced childhood kidney cancers - Advanced Ewing sarcoma - Aggressive non-Hodgkin's lymphomas - Childhood rhabdomyosarcoma - Chronic lymphocytic leukemia/small lymphocytic lymphona (CLL/SLL) - Epithelial ovarian cancer - Mantle cell (non-Hodgkin lymphoma)	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: 35% 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.	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: 35% 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**
The Plan uses specific Plan-designated organ/tissue transplant facilities. Before your initial evaluation as a potential candidate for a transplant procedure, you, your representative, 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 approved through CareAllies Cigna LIFESOURCE Transplant Unit and are not covered by any other health plan.	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: 35% 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
Travel/Lodging Benefit – If the recipient lives more than 100 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 under the **High Option** and up to $5,000 per transplant under the **Standard Option**. 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. **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.	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: 35% 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
Not covered: • *Donor screening tests and donor search expenses, except those* approved through the CareAllies Cigna LIFESOURCE Transplant Unit • *Implants of artificial organs* • *Transplants and related services not listed as covered*	*All charges*	*All charges*

Benefit Description	You Pay After the calendar year deductible…	
Anesthesia	**High Option**	**Standard Option**
Professional services provided in – • Hospital (inpatient) Note: When anesthesia services are performed and billed by two providers (e.g., a CRNA under the direction of an M.D.) for the same procedure or operative session, the total Plan allowance for both providers may not exceed the amount that the Plan would allow had the services been rendered solely by one provider, unless the PPO contract provides for a different amount.	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: 35% 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 Note: When anesthesia services are performed and billed by two providers (e.g., a CRNA under the direction of an M.D.) for the same procedure or operative session, the total Plan allowance for both providers may not exceed the amount that the Plan would allow had the services been rendered soley by one provider, unless the PPO contract provides for a different amount.	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: 35% 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: $300 per person ($600 per family) under the High Option and $350 per person ($1,050 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. Also read Section 9 about coordinating benefits with Medicare and other coverage.
- 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).
- When you receive hospital observation services, we apply outpatient benefits to covered services up to 48 hours. Inpatient benefits will apply only when your physician formally admits you to the hospital as an inpatient. It is your responsibility to ensure that we are contacted for precertification if you are admitted as an inpatient. Please refer to the precertification information shown in Section 3.
- **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 • 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 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 Note: For facility care related to maternity, including care at birthing facilities, we waive the per confinement copayment when you use a PPO facility. Non-PPO: $300 copayment per confinement and 30% of the Plan allowance and any difference between our allowance and the billed amount Note: A confinement is defined in Section 10, page 96.	PPO: Nothing after a $150 per day copayment, up to $450 per confinement Note: For facility care related to maternity, including care at birthing facilities, we waive the per confinement copayment when you use a PPO facility. Non-PPO: $200 per day copayment, up to $600 per confinement and 35% of the Plan allowance and any difference between our allowance and the billed amount Note: A confinement is defined in Section 10, page 96.

Inpatient hospital - continued on next page

Benefit Description	You Pay	
Inpatient hospital (cont.)	**High Option**	**Standard Option**
Other hospital services and supplies, such as: • Operating, recovery, maternity, and other treatment rooms • Prescribed drugs and medicines • Diagnostic laboratory tests and X-rays • Blood or blood plasma, if not donated or replaced • Dressings, splints, casts, and sterile tray services • Medical supplies and equipment, including oxygen • Anesthetics Note: We base payment on whether the facility or a health care professional bills for the services or supplies. For example, when the hospital bills for anesthetics services, we pay Hospital benefits and when the anesthesiologist bills, we pay Anesthesia benefits.	PPO: 10% of the Plan allowance Note: For facility care related to maternity, including care at birthing facilities, we waive the coinsurance and pay covered services in full when you use a PPO facility. 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 a radiologist, pathologist, anesthesiologist, assistant surgeon, or emergency room physician who is not a PPO provider.	PPO: 15% of the Plan allowance Note: For facility care related to maternity, including care at birthing facilities, we waive the coinsurance and pay covered services in full when you use a PPO facility. Non-PPO: 35% 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 a radiologist, pathologist, anesthesiologist, assistant surgeon, or emergency room physician 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 on page 97* • *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*

Benefit Description	You Pay	
Outpatient hospital or ambulatory surgical center or clinic	**High Option**	**Standard Option**
• Operating, recovery, observation, 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. Note: For outpatient facility care related to maternity, including care at birthing facilities, we waive the deductible and coinsurance and pay covered services in full when you use a PPO facility.	PPO: 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. Note: If you use a PPO hospital or ambulatory surgical center, we pay PPO benefits if you receive treatment from a radiologist, pathologist, anesthesiologist, assistant surgeon, or emergency room physician who is not a PPO provider.	PPO: 15% of the Plan allowance (calendar year deductible applies) Non-PPO: 35% of the Plan allowance and any difference between our allowance and the billed amount (calendar year deductible applies) Note: If you use a PPO hospital or ambulatory surgical center, we pay PPO benefits if you receive treatment from a radiologist, pathologist, anesthesiologist, assistant surgeon, or emergency room physician who is not a PPO provider.
Extended care benefits/Skilled nursing care facility benefits	**High Option**	**Standard Option**
Inpatient confinement at a skilled nursing facilitiy following transfer from a covered acute inpatient confinement when skilled care is still required. Benefits are limited to the first 10 days per person, per confinement under the **High Option** and the first 5 days per person, per confinement under the **Standard Option**. Note: If Medicare Part A pays for the first 10 days of skilled nursing facility confinement, then no benefits will be payable by the Plan.	PPO: 10% of the Plan allowance and all charges after the first 10 days Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount and all charges after the first 10 days	PPO: 15% of the Plan allowance and all charges after the first 5 days Non-PPO: 35% of the Plan allowance and any difference between our allowance and the billed amount and all charges after the first 5 days
Not covered: • *Custodial care* • *Personal comfort services such as beauty and barber services* • *Any charges in excess of the first 10 days (High Option) or the first 5 days (Standard Option) plan limitation for covered skilled nursing facility care*	*All charges*	*All charges*

Benefit Description	You Pay	
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 individual whose life expectancy is six months or less, as certified by the primary doctor. Benefits are limited to 14 days per person, per caledar year for inpatient services. Outpatient care has no day limitation.	PPO: 10% of the Plan allowance and all charges in excess of the 14 day limitation for inpatient care Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount and all charges in excess of the 14 day limitation for in patient care	PPO: 15% of the Plan allowance and all charges in excess of the 14 day limitation for inpatient care Non-PPO: 35% of the Plan allowance and any difference between our allowance and the billed amount and all charges in excess of the 14 day limitation for inpatient care
Not covered: • *Any charges in excess of the 14 day per person, per calendar year plan limitation for covered inpatient 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 (within 100 miles) to the first hospital equipped to treat your condition	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: 35% 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: 35% of the Plan allowance and any difference between our allowance and the billed amount (calendar year deductible applies)
Not covered: • *Ambulance transport for you or your family's convenience* • *Air ambulance if transport is beyond the nearest available suitable facility, but is requested by the patient or physician for continuity of care or other reasons*	*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: $300 per person ($600 per family) under the High Option and $350 per person ($1,050 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. Also read Section 9 about coordinating benefits with Medicare and other coverage.

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.

What is an emergency medical condition?
An emergency medical condition is a medical condition so severe that a prudent layperson could reasonably expect that the lack of immediate medical attention would result in (a) placing the patient's health in serious jeopardy, (b) seriously impairing the patient's physical or mental functions, or (c) seriously impairing any of the patient's bodily organs or parts.

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)

Benefit Description	You pay After the calendar year deductible…	
Medical emergency	**High Option**	**Standard Option**
If you receive outpatient care for your medical emergency in a hospital emergency room, we cover: • Non-surgical physician services and supplies • Related outpatient hospital services • Observation room • Surgery and related services Note: We pay inpatient hospital benefits if you are admitted. See Section 5(c).	PPO: 10% of the Plan allowance Non-PPO: 10% of the Plan allowance and any difference between our allowance and the billed amount	PPO: 15% of the Plan allowance Non-PPO: 15% of the Plan allowance and any difference between our allowance and the billed amount
If you receive care for your medical emergency in other than an outpatient hospital emergency room, we cover: • Non-surgical physician services and supplies • Surgery and related services • Other related outpatient services	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: 35% of the Plan allowance and any difference between our allowance and the billed amount
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 need to get Plan approval (preauthorization) for services and follow a treatment plan we approve in order to get benefits. When you receive services as part of an approved treatment plan, cost-sharing and limitations for Plan mental health and substance abuse benefits are no greater than for similar benefits for other illnesses and conditions.

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 or, for facility care, the inpatient deductible applies to almost all benefits in this Section. 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 Medicare and other coverage.
- **YOU MUST GET PREAUTHORIZATION FOR THESE SERVICES.** 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. The treatment plan may include services, drugs, and supplies described elsewhere in this brochure. To be eligible to receive full benefits, you must follow the preauthorization process and get Plan approval of your treatment plan:
  - 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. See Section 3 for details.
  - 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%.
  - To obtain preauthorization call Cigna/CareAllies at 1-800/887-9735.
- We will provide medical review criteria or reasons for treatment plan denials to enrollees, members or providers upon request or as otherwise required.
- 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 orprovide one clinically appropriate treatment plan in favor of another.

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.		
Professional services	**High Option**	**Standard Option**
We cover professional services by licensed professional mental health and substance abuse practitioners when acting within the scope of their license, such as psychiatrists, psychologists, clinical social workers, licensed professional counselors, or marriage and family therapists.	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.

Professional services - continued on next page

Benefit Description	You Pay After the calendar year deductible…	
Professional services (cont.)	**High Option**	**Standard Option**
Diagnosis and treatment of psychiatric conditions, mental illness, or mental disorders. Services include: • Diagnostic evaluation • Crisis intervention and stabilization for acute episodes • Medication evaluation and management (pharmacotherapy) • Treatment and counseling (including individual or group therapy visits) • Diagnosis and treatment of alcoholism and drug abuse, including detoxification, treatment and counseling • Professional charges for intensive outpatient treatment in a provider's office or other professional setting • Electroconvulsive therapy	PPO: $20 copayment per outpatient office visit (No deductible); 10% of the Plan allowance for inpatient visits Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount	PPO: $20 copayment per outpatient office visit (No deductible); 15% of the Plan allowance for inpatient visits Non-PPO: 35% of the Plan allowance and any difference between our allowance and the billed amount
Diagnostics	**High Option**	**Standard Option**
• Psychological and neuropsychological testing necessary to determine the appropriate psychiatric treatment • Outpatient diagnostic tests provided and billed by a licensed mental health and substance abuse practitioner • Outpatient diagnostic tests provided and billed by a laboratory, hospital or other covered facility • Inpatient diagnostic tests provided and billed by a hospital or other covered facility	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: 35% of the Plan allowance and any difference between our allowance and the billed amount
Inpatient hospital or other covered facility	**High Option**	**Standard Option**
Inpatient services provided and billed by a hospital or other covered facility • Room and board, such as semiprivate or intensive accommodations, general nursing care, meals and special diets, and other hospital services	PPO: $200 copayment per confinement, nothing for room and board and 10% of the Plan allowance for other hospital services (No deductible) Non-PPO: $300 copayment per confinement plus 30% of the Plan allowance and any difference between our allowance and the billed amount (No deductible)	PPO: $150 per day copayment, up to $450 per confinement, nothing for room and board and 15% of the Plan allowance for other hospital services (No deductible) Non-PPO: $200 per day copayment, up to $600 per confinement plus 35% of the Plan allowance and any difference between our allowance and the billed amount (No deductible)

Benefit Description	You Pay After the calendar year deductible…	
Outpatient hospital or other covered facility	**High Option**	**Standard Option**
Outpatient services provided and billed by a hospital or other covered facility • Services such as partial hospitalization, half-way house, residential treatment, full-day hospitalization, or facility-based intensive outpatient treatment	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: 35% of the Plan allowance and any difference between our allowance and the billed amount
Not covered	**High Option**	**Standard Option**
Not covered: • *Marital counseling* • *Treatment for learning disabilities and mental retardation* • *Applied Behavior Analysis (ABA) therapy* • *Telephone consultations and/or therapy* • *On-line consultations* • *Travel time to the patient's home to conduct therapy* • *Services rendered or billed by schools or members of their staff* • *Services that are not part of a preauthorized approved treatment plan*	*All charges*	*All charges*

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 71.
- 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 authorization by CVS Caremark, such as specialty drugs that are used to treat chronic complex conditions including, but not limited to, hemophilia, immune deficiency, growth hormone deficiencies, rheumatoid arthritis, and multiple sclerosis. Call CVS Caremark at 1-855/566-8395 for more information.
- We do not honor or coordinate benefits with drug coupon/copay cards. You are responsible for your copay or coinsurance as indicated in this brochure.
- 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 Medicare and other coverage.

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

- **Who can write your prescription.** A U.S. licensed physician or other covered provider acting within the scope of their license must write the prescription.
- **Where you can obtain them.** You may fill the prescription at a participating CVS Caremark network pharmacy, a non-network pharmacy, the CVS Caremark Mail Service, or the CVS Caremark Specialty Pharmacy. To receive the Plan's maximum benefit, you must fill the prescription at a participating CVS Caremark network pharmacy, through the CVS Caremark Mail Service for maintenance medications, or through a CVS Caremark Specialty Pharmacy for specialty drugs.
- **Specialty drugs,** including biotech drugs, require special handling and close monitoring and are used to treat chronic complex conditions including, but not limited to: hemophilia, immune deficiency, growth hormone deficiencies, multiple sclerosis, Crohn's disease, hepatitis C, HIV, hormonal disorders, rheumatoid arthritis, and pulmonary disorders. These drugs require preauthorization. You must fill the prescription for a specialty medication through the CVS Caremark Specialty Pharmacy system. Call CVS Caremark at 1-855/566-8395 for preauthorization and if you have any questions regarding quantity limits, or other issues related to their Specialty Pharmacy services.
- **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:

Tier I: generic drugs
Tier II: formulary or preferred name brand drugs
Tier III: non-formulary or non-preferred name brand drugs
Tier IV: specialty drugs

You may look up the formulary status of medications online at www.caremark.com or call 1-855/566-8395.

Prescription drugs *(continued)*

- **These are the Dispensing Limitations**
  - **High Option and Standard Option Retail:** You may only obtain a 30-day supply and one refill through the CVS Caremark system available at most pharmacies. Note: If you remain on a medication longer than 60 days (i.e., initial fill plus one refill), you must obtain subsequent refills through the CVS Caremark Mail Service or through the maintenance choice porgram as described below. If you continue to use the retail pharmacy after the second fill, you will pay the entire cost of the medication. This limit does not apply to medications not available through the CVS Caremark Mail Service. Call 1-855/566-8395 to locate a participating CVS Caremark 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 CVS Caremark Mail Service. You order your prescription or refill by mail from the CVS Caremark Mail Service. The CVS Caremark Mail Service will fill your prescription.

Note: Not all drugs may be available through the CVS Caremark Mail Service. Any drugs which cannot be dispensed in accordance with the CVS Caremark Mail Service dispensing protocols or which requires special record-keeping procedures may be excluded. However, these excluded drugs are covered under the retail prescription drug program.

- **Maintenance Choice Program**. Maintenance and long-term medications are taken regularly for chronic or long term therapy. Examples include medications for managing high blood pressure, diabetes, or high cholesterol. Through CVS Caremark's Maintenance Choice Program, you may purchase up to a 90-day supply of these covered long-term maintenance prescription drugs and supplies at a CVS Caremark retail pharmacy. You will pay the applicable mail order copayment for each prescription purchased.

If your physician prescribes a new medication that will be taken over an extended period of time and you prefer to receive your maintenance medication through the mail, you should request two prescriptions – one to be used for the participating CVS Caremark network pharmacy and the other for CVS Caremark Mail Service. You may obtain up to a 30-day supply right away through the prescription card program and up to a 90-day supply from the CVS Caremark Mail Service. In addition, you may utilize the Maintenance Choice Program (see above) for your maintenance medications and receive a 90-day supply from a CVS retail pharmacy. 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 plus the generic copay.

- **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 Programs**

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:

- **Quantity allowances.** Specific allowances are in place for certain medications, based on manufacturer and FDA recommended guidelines.

Prescription drugs *(continued)*

- **Drug Utilization Review (DUR).** When you fill your prescription at a network pharmacy or through the mail order drug program, we and/or the pharmacist may electronically access information about prior prescriptions, checking for harmful drug interactions, drug duplication, excessive use and the frequency of refills. DUR helps protect against potentially dangerous drug interactions or inappropriate use. When appropriate, your pharmacist(s) and or CVS Caremark may contact your physician(s) to discuss an alternative drug tratment option, prescription drug compliance, and the best and most cost-effective use of services. In addition, we may perform a periodic review of prescriptions to help ensure your safety and to provide health education and support. Upon review, we may contact you or your provider(s) to discuss your current medical situation and may offer assistance in coordinating care and treatment. For more information about this program, call CVS Caremark at 1-855-566-8395.
  - **Preauthorization.** Preauthorization must be obtained for certain prescription drugs and supplies to asses appropriate therapy and drug dosage before providing benefits. In addition to those drugs listed on page 67, other medications that require preauthorization include, but are not limited to, anabolic steroids, narcolepsy drugs, topical acne medications, testosterone products, and select pain medications.

Contact CVS Caremark at 1-855/566-8395 for additional information regarding Patient Safety programs listed above.

- **To claim benefits.**
  - **From a pharmacy** - When you purchase medication from a network pharmacy use your SAMBA/CVS Caremark Identification Card. In most cases, you simply present the card, together with the prescription, to the pharmacist; the claim is automatically filed through the CVS Caremark 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 CVS Caremark toll-free at 1-855/566-8395. Services is available 7 days a week, 24 hours a day. Follow the instructions on the form and mail it to:

CVS Caremark
Attention: Paper Claim Department
PO Box 52136
Phoenix AZ 85072-2136

Note: Reimbursement will be limited to SAMBA's cost had you used a participating pharmacy minus the copayments described on page 71.

- **By mail** - The Plan will send you information on CVS Caremark Mail Service:

1. Ask your doctor to give you a new prescription for up to a 90-day supply of your regular medication plus refills, if appropriate;
2. Complete the patient profile/order form 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:

CVS Caremark Prescription Service
1400 E Business Center Drive
Suite 100
Mount Prospect IL 60056

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 from CVS Caremark Mail Service. In the meantime, if you have questions about a particular drug or a prescription, and to request your first order forms, you may call 1-855/566-8395 toll-free. Customer service is available 7 days a week, 24 hours a day. You may also download order forms from www.caremark.com.

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

Prescription drugs*(continued)*

- **Coordinating with other drug coverage.**

If you have other prescription drug coverage and the other insurance carrier is primary, you should use that carrier's prescription drug benefits first. When purchasing your covered medications from a retail pharmacy, follow your primary insurance carrier's instructions on how to file a claim. After their consideration, submit the claim along with the primary carrier's explanation of benefits (EOB) directly to the CVS Caremark Paper Claim Department.

If you elect to use CVS Caremark Mail Service, you will be billed directly for the full discounted cost of the covered medication. Pay CVS Caremark Mail Service the billed amount and submit the bill to your primary insurance carrier. After their consideration submit the claim and the primary carrier's EOB to the CVS Caremark Paper Claim Department at:

CVS Caremark
Attention: Paper Claim Department
P. O. Box 52136
Phoenix AZ 85072-2136

- **For Medicare Part B insurance coverage.**

Prescriptions typically covered by Medicare Part B include diabetes supplies (test strips, meters), specific medications used to aid tissue acceptance from organ transplants, certain oral medications used to treat cancer, ostomy supplies, and various inhalants used in nebulizers (devices that deliver liquid medication in mist form). **Some Medicare Part B medicines and supplies (such as for diabetes) may not be available through the CVS Caremark Mail Service.** If Medicare Part B is primary, discuss with the retail pharmacy and/or CVS Caremark Mail Service the options to submit Medicare covered medications and supplies to allow Medicare to pay as the primary carrier.

When using a retail pharmacy for eligible Medicare Part B medication or supplies, be sure to present your Medicare ID card. If your medication or supplies are eligible for Medicare Part B, the retail pharmacy will submit your claim to Medicare for you. Most independent pharmacies and national chains are Medicare providers. To find a retail pharmacy that is a Medicare Part B participating provider, visit the Medicare website at www.medicare.gov/supplier/home.asp or call Medicare Customer Service at 1-800/633-4227.

- **Medicare Part D insurance coverage**

SAMBA supplements the coverage you get with your Medicare Part D prescription drug plan. Your Medicare Part D drug plan will provide your primary prescription drug benefit and SAMBA will provide your secondary prescription drug benefit. To ensure that you get all the coverage you are entitled to receive, use a pharmacy that participates in the networks for both SAMBA and your Medicare Part D plan. Show both the Medicare Part D ID card and the SAMBA ID card when filling a prescription so the pharmacy can coordinate coverage on your behalf.

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 • Prenatal vitamins available by prescription only Note: Retail copayments will apply to prescription drugs billed by a skilled nursing facility, nursing home or extended care facility. Note: You may purchase up to a 90-day supply of covered drugs and supplies at a CVS retail pharmacy through CVS Carmark's Maintenance Choice Program. You will pay the applicable mail order copayment for each presription purchased. See page 68. Note: There is catastrophic protection limit on your out-of-pocket copayment and coinsurance expenses for prescription medications obtained from a participating CVS Caremark network retail pharmacy, through the CVS Caremark Mail Service, or from a CVS Caremark Specialty Pharmacy. Under the **High Option**, it is $4,000 per person, per calendar year and $5,000 per person, per calendar year under the **Standard Option**. This limit does not apply to drugs obtained from any other source. Note: For generic and name brand drug purchases, if the cost of your prescription is less than your cost-sharing amount listed here, you pay only the cost of your prescription. If there is no generic equivalent available, you will have to pay the name brand copayment.	Copayments per prescription or refill are: Retail: • $8 generic • 20% of the Plan allowance ($40 minimum/$55 maximum) preferred name brand • 35% of the Plan allowance ($60 minimum/$100 maximum) non-preferred name brand **Note:** For retail purchases made at a non-Network pharmacy, you pay the same per prescription copayments/coinsurances 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: • $12 generic • 20% of the Plan allowance ($80 minimum/$110 maximum) preferred name brand • 35% of the Plan allowance ($120 minimum/$225 maximum) non-preferred name brand Note: Medicare enrollees pay the same per prescription drug copayments/coinsurances as listed above.	Copayments per prescription or refill are: Retail: • $8 generic • 30% of the Plan allowance ($40 minimum/$70 maximum) preferred name brand • 40% of the Plan allowance ($60 minimum/$110 maximum) non-preferred name brand **Note:** For retail purchases made at a non-Network pharmacy, you pay the same per prescription copayments/coinsurances 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: • $15 generic • 30% of the Plan allowance ($80 minimum/$150 maximum) preferred name brand • 40% of the Plan allowance ($120 minimum/$275 maximum) non-preferred name brand **Note:** Medicare enrollees pay the same per prescription drug copayments/coinsurances as listed above.

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**
Specialty drugs: • used to treat chronic complex conditions and require special handling and close monitoring • must be obtained through the CVS Caremark Specialty Pharmacy system See description of *Specialty drugs* on page 67. Note: Preauthorization for specialty drugs is required. Contact CVS Caremark at 1-855/566-8395. See *Other services* under *You need prior Plan approval for certain services* on page 17. Note: Certain specialty drugs dispensed by sources other than through the CVS Caremark Pharmacy system are covered under Specialty drugs, Section 5(a), see page 38.	Copayments per prescription or refill are: • 30-day supply: $80 • 60-day supply: $160 • 90-day supply: $240	Copayments per prescription or refill are: • 30-day supply: $120 • 60-day supply: $240 • 90-day supply: $360
Medicines to promote better health as recommended under the Patient Protection and Affordable Care Act, limited to: • Iron supplements for children age 6 months through 12 months • Oral fluoride supplements for children age 6 months through 5 years • Folic acid supplements, 0.4 mg to 0.8 mg, for women planning or capable of pregnancy • Aspirin for men age 45 through 79 and women age 55 through 79 - Note: Benefits are not available for non-aspirin pain relievers such as acetaminophen, ibuprofen or naproxen sodium based products. • Vitamin D for adults age 65 and older Note: Benefits for the medicines listed above are subject to the dispensing limitations described on page 68 and are limited to recommended prescribed limits. To receive benefits, you must have a written prescription from your physician.	Retail: Nothing Network Mail Order: Nothing	Retail: Nothing Network Mail Order: Nothing

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**
FDA approved women's contraceptive drugs and devices for the purpose of birth control, with a physician's written prescription. Note: You may purchase up to a 90-day supply of covered drugs and supplies at a CVS retail pharmacy through CVS Caremark's Maintenance Choice Program. You will pay the applicable mail order copayment for each prescription purchased. See page 68. Note: 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).	Retail: Nothing Note For retail purchases made at a non-Network pharmcy, you pay the same per prescription copayment/coinsurance as listed on page 71, 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: Nothing	Retail: Nothing Note For retail purchases made at a non-Network pharmcy, you pay the same per prescription copayment/coinsurance as listed on page 71, 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: Nothing
Tobacco cessation medications: Over-the-counter (with a physician's presciption) and prescription drugs approved by the FDA to treat tobacco dependence when obtained from a participating CVS Caremark network retail pharmacy, a non-Network retail pharmacy, or the CVS Caremark Mail Service. Note: To receive benefits for over-the-counter tobacco cessation medications and products, you must have a physician's prescription. Note: 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). Note: The quantity of drugs reimbursed will be subject to recommended courses of treatment.	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)

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**
Not covered: • *Drugs and supplies for cosmetic purposes, e.g., Retin A, Minoxidil, Rogaine* • *Vitamins (except injectable B-12)and prescription-only prenatal vitamins* • *Over-the-counter nutritional supplements and medical foods* • *Topical Fluoride* • *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* • *Nonprescription medicines (over-the-counter medications) not shown as covered*	*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 payor of any benefit payments and your FEDVIP Plan is secondary to your FEHB Plan. See Section 9. *Coordinating benefits with Medicare and other coverage*.
- The calendar year deductible is: $300 per person ($600 per family) under the High Option and $350 per person ($1,050 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. Also read Section 9 about coordinating benefits with Medicare and other coverage.
- 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: 35% 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 benefits - continued on next page

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

Section 5(h). Special features

Special feature	Description
Flexible benefits option	Under the flexible benefits option, we determine the most effective way to provide services. • We may identify medically appropriate alternatives to regular contract benefits as a less costly alternative. If we identify a less costly alternative, we will ask you to sign an alternative benefits agreement that will include all of the following terms in addition to other items as necessary. 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 do not 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 contract 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. However, if at the time we make a decision regarding alternative benefits, we also decide that regular contract benefits are not payable, then you may dispute our regular contract benefits decision under the OPM disputed claim process (see Section 8.)
Travel benefit/services overseas	For covered services rendered by a hospital or by a doctor outside of the United States, 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 85, *Section 7 Filing a claim for covered services*.
Services for deaf and hearing impaired	SAMBA has a TDD line for the hearing-impaired: 301/984-4155 (TDD equipment is needed).
Online Resources	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, • preventive care tips, and • tools to quit smoking, lose weight and live a healthier life.
Your Health First Program	Through our relationship with Cigna, you and your covered dependents will have access to the Your Health First (YHF) Program. This Program will assist with empowering our members to stay healthy. Under the Program members identified with chronic conditions (such as asthma, diabetes, depression, and weight complications) will have access to Cigna's "Care Coach." The care coaching model is geared to provide Lifesyle Coaching, Wellness Coaching, and Treatment Decision Support.

	For more information, visit our website at www.SambaPlans.com or call 1-800/887-9735.
Healthy Rewards Program	Through our relationship with Cigna/CareAllies, SAMBA members can participate in the Healthy Rewards Program. This Program provides access to discounts on treatments and items not covered under the Plan. For example: • Over 15,000 fitness facilities including Curves, Anytime Fitness, select Gold's Gym, Jazzercise, Snap Fitness and other chain/local centers. • Alternative medicine network featuring s network of over 27,000 chiropractors, acupuncturists, massage therapists, and registered dieticians. • Weight Management Programs • Mind/Body Programs • Online store featuring discounts to vitamins & supplements, herbal products, dental products, homeopathic remedies, natural products, diet & sports nutrition, yoga & fitness activities, personal body care, books, audio & DVDs. In addition, Healthy Rewards offers Vision and Hearing Care discounts including eye exams, eye wear, Lasik correction and hearing exams and aids, Just Walk 10,000 Steps a Day, weight management through Jenny Craig and other products through Drugstore.com Visit www.SambaPlans.com for more information.
Health Risk Assessment	The Health Risk Assessment (HRA) tool is available online at www.SambaPlans.com. The tool is designed to assess the member's health profile and suggest how they could achieve or maintain better health. To encourage you to complete an HRA, SAMBA will make at $20 ($40 per family enrollment) charitable contribution to the Federal Employee Education and Assistance Fund.
Gaps in Care	The Gaps in Care program uses clinical rule-based software, together with integrated medical, pharmacy, behavioral, and lab data to address members' gaps in care. Gaps in care occur when individuals do not receive or adhere to care that is consistent with medically proven guidelines for prevention or treatment. The Gaps in Care program provides coaching, integrated with Case Managaement, to identify any gaps or barrier preventing necessary medical care. Simple, easy to understand profiles are sent to members to increase their understanding of potential gaps and improve adherence to existing treatment plans. The program also generates patient reminders for medications and preventative appointments.
Quit for Life® Program	Quitting tobacco isn't easy, but the Quit For Life® Program can help. Quit For Life® is a voluntary tobacco cessation program offered by the Plan at no addtional cost to our members. When you enroll, you will receive: • One-on-one telephone support from an expert Quit Coach® who specializes in helping people quit tobacco • An easy-to-use printed Quit Guide you can reference in any situation to help you stick with your Quitting plan • Advice on type, dose, and duration of nicotine substitute or medication. You'll receive free nicotine replacement therapy (patch, gum) as part of your Quitting Plan. • Membership to Web Coach®, a private online community where you can complete activities, watch videos, track your progress, and join in discussions with other participants

	Don't let another year slip by without the support you need. Take the first step today to living a longer, healthier life. For more information on the Program or to join, visit www.quitnow.net/SAMBA or call 1-866-QUIT-4-LIFE (784-8454). Note: For group and individual counseling for tobacco cessation, see *Educational classes and programs* in Section 5(a).
Healthy Steps to Weight Loss℠	Lose weight and improve your health through Cigna's Healthy Steps to Weight Loss personalized weight loss program. This program helps you change your behaviors by learning healthier eating habits and how to incorporate exercise into your schedule – helping you to feel better, look better and improve your overall health. As a Healthy Steps participant, in addition to help developing a customized diet and exercise plan, you will receive: • One-on-one support and advice from a health coach by telephone or online • A personal telephone assessment that helps make sure your participation in the program will be safe and successful, • A valuable workbook filled with practical tips, nutrition guides and more, • Tools developed by medical experts that provide the participant's health coach with more detailed information about the participant's heart health and eating habits, • A toolkit that includes a pedometer, a tape measure and more, and • 24/7 access to the secure Healthy Steps website with helpful articles, tools, trackers, and more. For more information or to enroll, visit www.SambaPlans.com or call 1-800/887-9735.
24 hour nurse line	Through SAMBA's relationship with Cigna/CareAllies, our members have access to 24/7 Nurseline , an easy to use resource with anytime access to the information you need to make smart health decisions With 24/7 Nurseline you get: • Health inforamtion in language that is easy to understand and use • Help deciding the best method to treat a minor injury or illness, including ober-the-counter or home remedies • Peace of mind by having a registered nurse available around the clock Get expert health advice anytime, anywhere by calling 1-800/887-9735.

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.

Dental and Vision Plan

SAMBA offers you and your family a choice of two comprehensive dental plans options. The DMO Plan or The PPO Plan. You may ***enroll at any time*** — plus children are covered up to age 26. You pay the same low rates for either option **and** both plan options include **vision benefits at no additional cost**.

- **DMO Plan –** select a primary dentist; no claim forms needed; no deductible; less out-of-pocket expenses;no waiting period for orthodontic treatment; no maximum benefit
- **PPO Plan –** flexibility to choose any dentist; less out-of-pocket when an Aetna PPO participating dentist

Summary of Dental Plan Benefits

Coverage Type	DMO Plan Pays) (Primary Care Dentist)	PPO In-Network Plan Pays	PPO Out-of-Network Plan Pays
Preventive (A) – (exams, cleaning, x-rays)	100%	100%	70%
Basic (B) – (fillings, extractions)	100%	75%	60%
Major (C) – (crowns, onlays, inlays, dentures)	60%	50% 6 month waiting period	
Orthodontics (D)	50% – No lifetime maximum No waiting period	50% – $1,500 lifetime maximum per person, 12 month waiting period	50% – $1,500 lifetime maximum per person, 12 month waiting period
Annual Deductible	None	$50 per person, $150 per family (B&C only)	$50 per person, $150 per family (B&C only)
Annual Maximum	None	$2,000 per person, per calendar year	$2,000 per person, per calendar year

Summary of Vision Benefits
Included with both Dental Plan options at *no additional cost to you*

Calendar Year Benefits	EyeMed* In-Network Provider	Out-of-Network Provider
Eye exam (with dilation)	Covered in full after $10 copay	Up to $30 reimbursement
Eyeglasses (frames and lenses)	Covered in full – up to $140 (20% off balance over $140)	Up to $75 reimbursement
Contact lenses (in lieu of eyeglasses)	Covered in full – up to $100	Up to $75 reimbursement

*SAMBA uses the EyeMed program for vision services

Life Insurance Plans

The plans described below are underwritten by ReliaStar Life Insurance Company, a member of the ING family of companies. ***You can enroll for coverage at any time*** with the exception of the Employee Benevolent Fund. 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.

- **Term Life Insurance** – coverage from $25,000 to $600,000 for you and your spouse. Children are covered at $20,000 up to age 26. Includes member Accidental Death and Dismemberment coverage – benefit doubles in the event of an accidental death
- **10-Year and 20-Year Group Level Term Insurance** – available to members and spouses in coverage amounts from $200,000 to $1,000,000. Coverage will not reduce during the level term rate period. Children are covered at $20,000 up to age 26. Includes member Accidental Death and Dismemberment coverage – benefit doubles in the event of an accidental death.
- **Personal Accident Insurance** – Coverage from $10,000 to $500,000 for you and your family. Provides around-the-clock protection for a low premium. Additional benefits provided for mortgage payments, tuition reimbursement for spouse and children, and much more.
- **Employee Benevolent Fund** – provides an immediate death benefit to help sustain your loved ones until other survivor benefits can be paid. Two plan options; $17,500 or $35,000. The plan is open only to select agencies. To see a complete list of participating agencies, visit the SAMBA website at www.SambaPlans.com.

ING Travel Assistance Service and Funeral Plannig and Concierge Service is included in all of the above plans **at no additional cost.**

Other Plans

- **Disability Income Protection –** A benefit that provides much needed income for you and your family when a long-term illness or disability occurs and you are not able to work. The plan pays up to 65% of your covered salary, tax-free. Also included is a survivor benefit paid in the event you die while receiving the disability benefit and a benefit for you, your spouse and your children for each day while confined in a hospital.

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 – Services, drugs and supplies 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. For information on obtaining prior approval for specific services, such as transplants, see Section 3 *When you need prior Plan approval for certain services.*

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
- Experimental or investigational procedures, treatments, drugs or devices (see specifics regarding transplants)
- 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, or supplies for which 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 or supplies furnished by immediate relatives or household members, such as spouse, parents, children, brothers or sisters by blood, marriage or adoption
- Services or supplies furnished or billed by a non-covered facility, except that medically necessary prescription drugs and physical, speech and occupational therapy rendered by a qualified professional therapist on an outpatient basis are covered subject to plan limits
- 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 which 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 94), doctor charges exceeding the amount specified by the Department of Health and Human Services when benefits are payable under Medicare (limiting charge, see page 95), 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 and mental retardation
- Applied Behavior Analysis (ABA) therapy
- Marital counseling
- Practitioners who do not meet the definition of covered provider on page 14, Section 3
- Services, drugs or supplies ordered or provided by a non-covered provider.
- Charges for services and supplies that exceed the Plan allowance

General exclusions*(continued)*

- Services in connection with custodial care as defined on page 97
- 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 41, Section 5(a)
- Services by a massage therapist
- Services by a naturopathic practitioner
- Genetic counseling and/or genetic screening
- Services and supplies for cosmetic purposes, e.g., Retin A, Minoxidil, Rogaine
- Treatment of obesity or weight reduction, except as indicated on page 46, Section 5(a), page 48, Section 5(b), and on page 79, Section 5(h)
- 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
- Home test kits including but not limited to HIV and drug home test kits
- Telephone and on-line medical consultations
- "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 (see details on page 5). For additional information, please visit www.cms.gov, enter Never Events into SEARCH.

Section 7. Filing a claim for covered services

This Section primarily deals with post-service claims (claims for services, drugs or supplies you have already received).

See Section 3 for information on pre-service claims (services, drugs or supplies requiring prior Plan approval), including urgent care claims procedures.

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 CMS-1500, Health Insurance Claim Form. Your facility will file on the UB-04 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 CMS-1500 or a claim form that includes the information shown below. Bills and receipts should be itemized and show:

- Patient's name, date of birth, address, phone number, and relationship to enrollee
- Patient's Plan identification number
- Name and address of person or company providing the service or supply
- Dates that services or supplies were furnished
- Diagnosis
- Type of each service or supply
- 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:

- If another health plan is your primary payor, you must send a copy of the explanation of benefits (EOB) form you received from your primary payor (such as the Medicare Summary Notice (MSN)) with your claim.
- Bills for home nursing care must show that the nurse is a registered or licensed practical nurse.
- If your claim is for the rental or purchase of durable medical equipment; private duty nursing; and physical therapy, occupational therapy, or speech therapy, you must provide a written statement from the physician specifying the medical necessity for the service or supply and the length of time needed.
- Claims for prescription drugs and supplies must include receipts that show the prescription number, name of drug or supply, prescribing physician's name, date, and charge.
- We will provide translation and currency conversion services for claims for overseas (foreign) services.

Post-service claims procedures

We will notify you of our decision within 30 days after we receive the claim. If matters beyond our control require an extension of time, we may take up to an additional 15 days for review as long as we notify you before the expiration of the original 30-day period. Our notice will include the circumstances underlying the request for the extension and the date when a decision is expected.

If we need an extension because we have not received necessary information from you, our notice will describe the specific information required and we will allow you up to 60 days from the receipt of the notice to provide the information.

If you do not agree with our initial decision, you may ask us to review it by following the disputed claims process detailed in Section 8 of this brochure.

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. If you could not file on time because of Government administrative operations or legal incapacity, you must submit your claim 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	Charges for overseas (foreign) claims will 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. Our deadline for responding to your claim is stayed while we await all of the additional information needed to process your claim.
Authorized Representative	You may designate an authorized representative to act on your behalf for filing a claim or to appeal claims decisions to us. For urgent care claims, a health care professional with knowledge of your medical condition will be permitted to act as your authorized representative without your express consent. For the purposes of this section, we are also referring to your authorized representative when we refer to you.
Notice Requirements	The Secretary of Health and Human Services has identified counties where at least 10 percent of the population is literate only in certain non-English languages. The non-English languages meeting this threshold in certain counties are Spanish, Chinese, Navajo and Tagalog. If you live in one of these counties, we will provide language assistance in the applicable non-English language. You can request a copy of your Explanation of Benefits (EOB) statement, related correspondence, oral language services (such as telephone customer assistance), and help with filing claims and appeals (including external reviews) in the applicable non-English language. The English versions of your EOBs and related correspondence will include information in the non-English language about how to access language services in that non-English language. Any notice of an adverse benefit determination or correspondence from us confirming an adverse benefit determination will include information sufficient to identify the claim involved (including the date of service, the health care provider, and the claim amount, if applicable), and a statement describing the availability, upon request, of the diagnosis and procedure codes and its corresponding meaning, and the treatment code and its corresponding meaning).

Section 8. The disputed claims process

You may be able to appeal directly to the Office of Personnel Management (OPM) if we do not follow required claims processes. For more information about situations in which you are entitled to immediately appeal to OPM, including requirements not listed in Sections 3, 7 and 8 of this brochuare, please visit www.sambaplans.com/claims_appeal.aspx.

Please follow this Federal Employees Health Benefits Program disputed claims process if you disagree with our decision on your post-service claim (a claim where services, drugs, or supplies have already been provided). In Section 3 *If you disagree with our pre-service claim decision*, we describe the process you need to follow if you have a claim for services, referrals, drugs, or supplies that must have prior Plan approval, such as an inpatient hospital admissions.

To help you prepare your appeal, you may arrange with us to review and copy, free of charge, all relevant materials and Plan documents under our control relating to your claim, including those that involve any expert review(s) of your claim. To make your request, please contact our Customer Service Department by writing SAMBA, 11301 Old Georgetown Road, Rockville, MD 20852-2800 or calling 1-800/638-6589 or 301/984-1440 (for TDD, use 301/984-4155).

Our reconsideration will take into account all comments, documents, records, and other information submitted by you relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination.

When our initial decision is based (in whole or in part) on a medical judgment (i.e., medical necessity, experimental/investigational), we will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment and who was not involved in making the initial decision.

Our reconsideration decision will not afford deference to the initial decision and will be conducted by a plan representative who is neither the individual who made the initial decision that is the subject of the reconsideration, nor the subordinate of that individual.

We will not make our decisions regarding hiring, compensation, termination, promotion, or other similar matters with respect to any individual (such as a claims adjudicator or medical expert) based upon the likelihood that the individual will support the denial of benefits.

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.
e) Include your email address (optional for members), if you would like to receive our decision via email. Please note that by giving us your email, we may be able to provide our decision more quickly.

We will provide you, free of charge and in a timely manner, with any new or additional evidence considered, relied upon, or generated by us or at our direction in connection with your claim and any new rationale for our claim decision. We will provide you with this information sufficiently in advance of the date that we are required to provide you with our reconsideration decision to allow you a reasonable opportunity to respond to us before that date. However, our failure to provide you with new evidence or rationale in sufficient time to allow you to timely respond shall not invalidate our decision on reconsideration. You may respond to that new evidence or rationale at the OPM review stage described in step 4.

2 In the case of a post-service claim, we have 30 days from the date we receive your request to:

a) Pay the claim or
b) Write to you and maintain our denial or
c) Ask you or your provider for more information.

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.

3 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, Healthcare and Insurance, Federal Employee Insurance Operations, Health Insurance 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.
- Your email address, if you would like to receive OPM's decision via email. Please note that by providing your email address, you may receive OPM's decision more quickly.

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. However, for urgent care claims, a health care professional with knowledge of your medical condition may act as your authorized representative without your expess consent.

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

4 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 can 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 you did not indicate that your claim was a claim for urgent care, then call us at 1-800/638-6589 or 301/984-1440 (for TDD, use 301/984-4155). We will hasten our review (if we have not yet responded to your claim); or we will inform OPM so they can quickly review your claim on appeal. You may call OPM's Health Insurance II at (202) 606-3818 between 8 a.m. and 5 p.m. Eastern Time.

Please remember that we do not make decisions about plan eligibility issues. For example, we do not determine whether you or a dependent is covered under this plan. You must raise eligibility issues with your Agency personnel/payroll office if you are an employee, your retirement system if you are an annuitant or the Office of Workers' Compensation Programs if you are receiving Workers' Compensation benefits.

Section 9. Coordinating benefits with Medicare and 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 payor and the other plan pays a reduced benefit as the secondary payor. We, like other insurers, determine which coverage is primary according to the National Association of Insurance Commissioners' (NAIC) guidelines. For more information on NAIC rules regarding the coordinating of benefits, visit the NAIC web site at http://www.NAIC.org.

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

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

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 (or a covered family member) 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 (the enrollee or any covered family member) receive (or are entitled to) monetary recovery from any source as the result of an accidental injury or illness, you are required to reimburse us out of that recovery for any and all of our benefits paid to diagnose and treat that illness or injury. This is known as our reimbursement right.

The Plan may also, at its option, pursue recovery on your behalf, which includes the right to file suit and make claims in your name. This is known as our subrogation right.

The following are examples of situations to which our right to subrogate or to assert a right of reimbursement applies:

- When you are injured on premises owned by a third party; or
- When you are injured and benefits are available to you under any law or under any type of insurance, including but not limited to:
  - No-fault insurance and other insurance that pays without regard to fault, including personal injury benefits, regardless of any electin made by you to treat those benefits as secondary to this Plan
  - Third party liability coverage
  - Uninsured or underinsured motorist coverage
  - Workers Compensation benefits
  - Medical reimbursement coverage

Our reimbursement right applies even if the monetary recovery may not compensate you fully for all of the damages resulting 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 recovery 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 first priority lien against any and all recoveries you receive by court order, out-of-court settlement, insurance or benefit program claims, or otherwise, without regardo 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 seeking a recovery resulting from an accidental injury or illness and responding to our questionnaires;
- pursuing recovery of our benefit payments from the third party or available insurance company;
- accepting our lien for the full amount of the benefits we have paid;
- agreeing to assign any proceeds or right to proceeds from third party claims or any insurance to us;
- keeping us advised of the claim's status;
- advising us of any recoveries you obtain, whether by insurance claim, 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.

For more information about this process, 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.

Clinical Trials

An approved clinical trial includes a phase I, phase II, phase III, or phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition, and is either Federally-funded; conducted under an investigational new drug application reviewed by the Food and Drug Administration (FDA); or is a drug trial that is exempt from the requirement of an investigational new drug application.

If you are a participant in a clinical trial, this health plan will provide related care as follows, if it is not provided by the clinical trial:

- Routine care costs – costs for routine services such as doctor visits, lab tests, x-rays and scans, and hospitalizations related to treating the patient's condition, whether the patient is in a clinical trial or is receiving standard therapy. These costs are covered by this Plan.
- Extra care costs – costs related to taking part in a clinical trial such as additional tests that a patient may need as part of the trial, but not as part of the patient's routine care. This Plan does not cover these costs.
- Research costs – costs related to conducting the clinical trial such as research physician and nurse time, analysis of results, and clinical tests performed only for research purposes. These costs are generally covered by the clinical trials; this Plan does not cover these costs.

When you have Medicare

What is Medicare?

Medicare is a health insurance program for:

- People 65 years of age or older
- Some people with disabilities under 65 years of age
- People with End-Stage Renal Disease (permanent kidney failure requiring dialysis or a transplant)

Medicare has four parts:

- Part A (Hospital Insurance). Most people do not have to pay for Part A. If you or your spouse worked for at least 10 years in Medicare-covered employment, you should be able to qualify for premium-free Part A insurance. (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 (1-800-633-4227), (TTY 1-877-486-2048) 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 92.
- 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, (TTY 1-800-325-0778) 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 do not sign up for Medicare Part B when you are first eligible, you may be charged a Medicare Part B late enrollment penalty of a 10% increase in premium for every 12 months you are not enrolled. If you didn't take Part B at age 65 because you were covered under FEHB as an active employee (or you were covered under your spouse's group health insurance plan and he/she was an active employee), you may sign up for Part B (generally without an increased premium) within 8 months from the time you or your spouse stop working or are no longer covered by the group plan. You also can sign up at any time while you are covered by the group plan.

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 94 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.

All physicians and other providers are required by law to file claims directly to Medicare for members with Medicare Part B, when Medicare is primary. This is true whether or not they accept Medicare.

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 payor, we process the claim first.

When Original Medicare is the primary payor, 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 payor– 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: We do not waive the copayments and/or coinsurance for prescription drugs and do not waive the $300 High Option and the $500 Standard Option copayments for Specialty drugs (page 38) not purchased through the CVS Caremark pharmacy system. Also, all Plan benefit limitations and exclusions still apply.

- 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 payor. In these cases, we do not waive any out-of-pocket costs.

- **Tell us about your Medicare coverage**

You must tell us if you or a covered family member has Medicare coverage, and let us obtain information about services denied or paid under Medicare. You must also tell us about other coverage you or your covered family members may have, as this coverage may affect that primary/secondary status of this Plan and Medicare.

- **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), (TTY 1-877-486-2048) 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)**

When we are the primary payor, we process the claim first. If you enroll in Medicare Part D and we are the secondary payor, 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 payor. The following chart illustrates whether Medicare or this Plan should be the primary payor 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 Payor Chart		
A. When you - or your covered spouse - are age 65 or over and have Medicare and you...	**The primary payor 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 payor before eligibility due to ESRD **(for 30 month coordination period)**		✓
• Medicare was the primary payor 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.

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.
- 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 notaccept** 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.

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.

Clinical Trials Cost Categories

An approved clinical trial includes a phase I, phase II, phase III, or phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition, and is either Federally-funded; conducted under an investigational new drug application reviewed by the Food and Drug Administration (FDA); or is a drug trial that is exempt from the requirement of an investigational new drug application.

If you are a participant in a clinical trial, this health plan will provide related care as follows, if it is not provided by the clinical trial:

- Routine care costs – costs for routine services such as doctor visits, lab tests, x-rays and scans, and hospitalizations related to treating the patient's condition whether the patient is in a clinical trial or is receiving standard therapy
- Extra care costs – costs related to taking part in a clinical trial such as additional tests that a patient may need as part of the trial, but not as part of the patient's routine care
- Research costs – costs related to conducting the clinical trial such as research physician and nurse time, analysis of results, and clinical tests performed only for research purposes

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 21.

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*.

Convenient care clinic

A small healthcare clinic, usually located in a high-traffic retail outlet with a limited pharmacy, that traetd uncomplicated minor illnesses and provides preventative healthcare services on a walk-in basis. Examples of a convenient care clinic include MinuteClinic in CVS pharmacy locations and Take Care Clinic sm in Walgreens pharmacy locations. Convenient care clinics are different from Urgent care centers (see page 100) that primarily provide treatment to patients who have an illness or injury that requires immediate care but is not serious enough to warrant a visit to the emergency room.

Copayment

A copayment is a fixed amount of money you pay when you receive covered services. See page 21.

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 21.

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.

Health care professional

A physician or other health care professional licensed, accredited, or certified to perform specified health services consistent with state law.

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.

Observation services

Observation care is a well-defined set of specific, clinically appropriate services, which include ongoing short term treatment, assessment, and reassessment, that are provided while a decision is being made regarding whether a patient will require further treatment as a hospital inpatient or whether the patient will be able to be discharged from the hospital. Observation services are commonly ordered for a patient who presents to the emergency room department and who then requires a significant period of treatment or monitoring in order to make a decision regarding their inpatient admission or discharge. Some hospitals will bill for observation room status (hourly) and hospital incidental services.

The Plan provides outpatient hospital benefits for observation care. If you are in the hospital for more than a few hours, ask your physician or the hospital if your stay is considered inpatient or outpatient so that you are aware of how your hospital claim will be processed. Although you may stay overnight in a hospital room and receive meals and other hospital services, some hospital services, including "observation services," are actually outpatient care. Since observation services are billed as outpatient care, outpatient facility benefit levels apply and your out-of-pocket expenses may be higher as a result.

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 whoparticipates 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 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 determined based on the lesser of :
- the provider's billed charges, or
- **The Maximum Non-PPO Reimbursable Charge**. The Maximum Non-PPO Reimbursable Charge is a Medicare-based fee schedule developed by Cigna that approximates 200% of the Medicare (RBRVS) allowance for the same or similar services within the geographic area.

The Maximum Non-PPO Reimbursable Charge is subject to all other benefit limitations and applicable coding and payment methodologies by the Plan.

For services or supplies that do not have a Maximum Non-PPO Reimbursable Charge value, we may use FAIR Health, Inc. to determine an appropriate allowance. We may also conduct independent studies to determine the usual cost of a service or supply in a geographic area.

NOTE: The provider may bill the member the difference between the provider's normal charge and the Maximum Non-PPO Reimbursable Charge as determined by the benefit plan, in addition to applicable deductibles, co-payments and coinsurance.

For certain services, exceptions may exist to the use of the out-of-network fee schedule to determine the Plan's non-PPO allowance. For claims governed by OBRA '90 and '93, the Plan allowance will be based on Medicare allowable amounts as is required by law. For claims where the Plan is the secondary payor to Medicare, the Plan allowance is the Medicare allowable charge.

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

Note: We will not consider any fee charged above the Plan's allowance. The member is responsible for the difference between the Plan’s allowance and the provider’s charge.

- Other Participating Providers: When you use certain non-PPO providers that have agreed to discount their charges, our Plan allowance is the amount that the provider has negotiated and agreed to accept for the services and/or supplies. Benefits will be paid at the non-PPO benefit levels. You are not responsible for the difference between the Plan's allowance/negotiated amount and the provider's billed charges.

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

Post-service claims Any claims that are not pre-service claims. In other words, post-service claims are those claims where treatment has been performed and the claims have been sent to us in order to apply for benefits.

Pre-service claims Those claims (1) the require precertification, prior approval, or a referral and (2) where failure to obtain precertification, prior approval, or referral results in a reduction of benefits.

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.

Urgent care center An ambulatory care center, outside of a hospital emergency department, that provides treatment for medical conditions that are not life-threatening, but need quick attention, on a walk-in basis. Urgent care centers are different from convenient care clinics, see page 96.

Urgent care claims A claim for medical care or treatment is an urgent care claim if waiting for the regular time limit for non-urgent care claims could have one of the following impacts:

- Waiting could seriously jeopardize your life or health;
- Waiting could seriously jeopardize your ability to regain maximum function; or
- In the opinion of a physician with knowledge of your medical condition, waiting would subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

Urgent care claims largely involve Pre-service claims and not Post-service claims. We will judge whether a claim is an urgent care claim by applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine.

If you believe your claim qualifies as an urgent care claim, please contact our Customer Service Department at 1-800/638-6589 or 301/984-1440 (For TDD, use 301/984-4155). You may also prove that your claim is an urgent care claim by providing evidence that a physician with knowledge of your medical condition has determined that your claim involves urgent care.

Us/We Us and We refer to SAMBA.

You You refers to the enrollee and each covered family member.

Section 11 Other Federal Programs

Please note, the following programs are not part of your FEHB benefits. They are separate Federal programs that complement your FEHB benefits and can potentially reduce your annual out-of-pocket expenses. These programs are offered independent of the FEHB Program and require you to enroll separately with no government contribution.

Important information about 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. Participating employees save an average of about 30% on products and services they 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. The maximum annual election for a health care flexible spending account (HCFSA) or a limited expense health care spending account (LEX HCFSA) is $2,500 per person. The maximum annual election for a dependent care flexible spending account (DCFSA) is $5,000 per household.

- **Health Care FSA (HCFSA)** – Reimburses you for eligible health care expenses (such as copayments, deductibles, insulin products, physician prescribed over-the-counter drugs and medications, vision and dental expenses, and much more) for you and your tax dependents including adult children (through the end of the calendar year in which they turn 26) which are not covered or reimbursed by FEHBP or FEDVIP coverage or other insurance.

FSAFEDS offers paperless reimbursement for your HCFSA through a number of FEHB and FEDVIP plans. This means that when you or your provider files claims with your FEHB or FEDVIP plan, FSAFEDS will automatically reimburse your eligible out-of-pocket expenses based on the claim information it receives from your plan.

- **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 tax 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.

If you are a new or newly eligible employee you have 60 days from your hire date to enroll in an HCFSA or LEX HCFSA and/or DCFSA, but you must enroll before October 1. If you are hired or become eligible on or after October 1 you must wait and enroll during the Federal Benefits Open Season held each fall.

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 separate and different from the FEHB Program. This Program provides comprehensive dental and vision insurance at competitive group rates with no pre-existing condition limitations for enrollment. 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	All dental plans provide a comprehensive range of services, including: • 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 12-month waiting period. Beginning in 2014, most FEDVIP dental plans cover adult orthodontia. **Review your FEDVIP dental plan's brochure for information on this benefit.**
Vision Insurance	All 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/dental and www.opm.gov/vision. These sites also provide 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, 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 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 such as Alzheimer's disease. For example, long term care can be received in your home from a home health aide, in a nursing home, in an assisted living facility or in adult day care. To qualify for coverage under the FLTCIP, you must apply and pass a medical screening (called underwriting). Federal and U.S. Postal Service employees and annuitants, active and retired members of the uniformed services, and qualified relatives are eligible to apply. 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. For more information, call 1-800-LTC-FEDS (1-800-582-3337) (TTY 1-800-843-3557), or visit www.ltcfeds.com.

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Summary of benefits for the High Option of the SAMBA Health Benefit Plan - 2014

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.

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	28
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	58
• Outpatient	PPO: 10% of the Plan allowance Non-PPO: $150 per facility charge and 30%* of the Plan allowance	60
Emergency benefits: • Accidental injury	Nothing within 72 hours	62
• Medical emergency	Regular benefits apply	63
Mental health and substance abuse treatment	Regular cost-sharing	64
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 $4,000 per person, per calendar year prescription out-of-pocket limit	71
• Retail pharmacy	$8 generic, 20% of the Plan allowance ($40 minimum/$55 maximum) preferred name brand or 35% of the Plan allowance ($60 minimum/ $100maximum) non-preferred name brand; limited to the initial fill (not to exceed a 30-day supply) and one refill	71
• Mail order	$12 generic, 20% of the Plan allowance ($80minimum/$110 maximum) preferred name brand or 35% of the Plan allowance ($120 minimum/ $225 maximum) non-preferred name brand copayment	71
Dental care:	PPO: 10%* of the Plan allowance for certain covered services Non-PPO: 30%* of the Plan allowance for certain covered services	75
Special features:	Flexible benefits option; Travel benefit/services overseas; Services for deaf and hearing impaired; Online Resources; Your Health First Program; Healthy Rewards Program; Health Risk Assessment; Gaps in Care; Quit for Life® Program; Healthy Steps to Weight Loss℠; 24-hour Nurse Line	77
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	23

	Some costs do not count toward this protection	

Summary of benefits for the Standard Option of the SAMBA Health Benefit Plan - 2014

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 $350 calendar year deductible. And, after we pay, you generally pay any difference between our allowance and the billed amount if you use a non-PPO physician or other health care professional.

Standard Option Benefits	You Pay	Page
Medical services provided by physicians: • Diagnostic and treatment services provided in the office	PPO: $20 copayment per office visit Non-PPO: 35%* of the Plan allowance	28
Services provided by a hospital: • Inpatient	PPO: $150 per day copayment up to $450 per confinement, nothing for room & board and 15% for other hospital services Non-PPO: $200 per day copayment up to $600 per confinement and 35% of the Plan allowance	58
• Outpatient	PPO: 15%* of the Plan allowance Non-PPO: 35%* of the Plan allowance	60
Emergency benefits: • Accidental injury	Nothing within 72 hours	62
• Medical emergency	Regular benefits apply	63
Mental health and substance abuse treatment:	Regular cost-sharing	64
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 out-of-pocket limit	71
• Retail pharmacy	$8 generic, 30% of the Plan allowance ($40 minimum/$70 maximum) preferred name brand or 40% of the Plan allowance ($60 minimum/ $110 maximum) non-preferred name brand; limited to the initial fill (not to exceed a 30-day supply) and one refill	71
• Mail order	$15 generic, 30% of the Plan allowance ($80 minimum/$150 maximum) preferred name brand or 40% of the Plan allowance ($120 minimum/$275 maximum) non-preferred name brand	71
Dental care:	We cover surgical and dental treatment of accidental injury to sound natural teeth. Treatment must be rendered within 24 months of the accident. Regular benefits apply.	75
Special features:	Flexible benefits option; Travel benefit/services overseas; Services for deaf and hearing impaired; Online Resources; Your Health First Program; Healthy Rewards Program; Health Risk Assessment; Gaps in Care; Quit for Life® Program; Healthy Steps to Weight Loss℠; 24 hour Nurse Line	77
Protection against catastrophic costs (out-of-pocket maximum)**:**		23

	PPO: Nothing after $5,000 per person, per calendar year/$7,000 per family, per calendar year Non-PPO: Nothing after $7,000 per person, per calendar year/$9,000 per family, per calendar year Some costs do not count toward this protection	

2014 Rate Information

For 2014 health premium information, please see:
http://www.opm.gov/healthcare-insurance/indian-tribes/health-insurance/#url=Premiums or contact your tribe's Human Resources department.