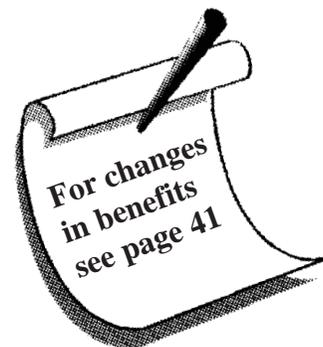




SAMBA Health Benefit Plan

1998

A Managed Fee-for-Service Plan
with Preferred Provider Organizations



Sponsored by the Special Agents Mutual Benefit Association

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

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

Membership dues: There are no membership dues.

Enrollment code for this Plan:

- 441 Self only
- 442 Self and family

Visit this Plan's WEB page at <http://www.samba-insurance.com>

Authorized for distribution by the:



United States
Office of
Personnel
Management



Federal Employees
Health Benefits Program

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SAMBA Health Benefit Plan

The Special Agents Mutual Benefit Association (SAMBA) (Carrier) has entered into Contract No. CS 1074 with the Office of Personnel Management (OPM) to provide a health benefits plan (Plan) authorized by the Federal Employees Health Benefits (FEHB) law. The FEHB contract specifies the manner in which it may be modified or terminated.

This brochure is based on text incorporated into the contract between OPM and the Carrier as of January 1, 1998, and is intended to be a complete statement of benefits available to FEHB members. It describes the benefits, exclusions, limitations, and maximums of the SAMBA Health Benefit Plan for 1998 and until amended by future benefit negotiations between OPM and the Carrier. It also describes procedures for obtaining benefits. You should use this brochure to determine your entitlement to benefits. However, if conflicts are discovered between the language of this brochure and the contract, the contract will control. Oral statements cannot modify the benefits described in this brochure.

An enrollee does not have a vested right to receive the benefits in this brochure in 1999 or later years, and does not have a right to benefits available prior to 1998 unless those benefits are contained in this brochure.

Inspector General Advisory: Stop Health Care Fraud!

Fraud increases the cost of health care for everyone. Anyone who intentionally makes a false statement or a false claim in order to obtain FEHB benefits or increase the amount of FEHB benefits is subject to prosecution for FRAUD which may result in CRIMINAL PENALTIES.

Please review all medical bills, medical records and claims statements carefully. If you find that a provider, such as a doctor, hospital, pharmacy, etc., charged your Plan for services you did not receive, billed for the same service twice, or misrepresented any other information, take the following actions:

- Call the provider (doctor, hospital, etc.) and ask for an explanation – sometimes the problem is a simple error.
- If the provider does not resolve the matter, or if you remain concerned, call your Carrier at 1-800/638-6589 (for TDD, use 301/984-4155) and explain the situation.
- If the matter is not resolved after speaking to your Carrier (and you still suspect fraud has been committed), call or write:

**THE HEALTH CARE FRAUD HOTLINE
202/418-3300**

The Office of Personnel Management
Office of the Inspector General Fraud Hotline
1900 E Street, N.W., Room 6400
Washington, D.C. 20415

The inappropriate use of membership identification cards, e.g., to obtain benefits for a person who is not an eligible family member or after you are no longer enrolled in the Plan, is also subject to review by the Inspector General and may result in an adverse administrative action by your agency.

When you need help with Plan benefits, or getting your ID card, call your Plan at 1-800/638-6589 or 301/984-1440. TDD line for hearing-impaired: 301/984-4155 (TDD equipment needed). The Fraud Hotline cannot help you with these.

Using This Brochure

The Table of Contents will help you find the information you need to make the best use of your benefits. To get the best value for your money, you should read **Facilities and Other Providers**. It will help you understand how your choice of doctors and hospitals will affect how much you pay for services under this Plan.

This brochure explains all of your benefits. It's important that you read about your benefits so you will know what to expect when a claim is filed. Most of the benefit headings are self-explanatory. **Other Medical Benefits** and **Additional Benefits**, on the other hand, both include a variety of unrelated benefits. What is different about these benefits is how they are paid: Other Medical Benefits are paid after you satisfy the calendar year deductible and Additional Benefits are generally not subject to the calendar year deductible.

The last part of the brochure contains information useful to you under certain circumstances. For example, if you have to go to the hospital you need to read **Precertification**; hospital stays must be precertified for all payable benefits to apply. If you are enrolled in Medicare, take a look at **This Plan and Medicare**. And, the **Enrollment Information** section tells you about several FEHB enrollment requirements that could affect your future coverage.

Table of Contents

How This Plan Works

	Page
Help Contain Costs	4
Ways you and the Carrier can work together to keep costs down	
Facilities and Other Providers	5
Medical personnel and facilities covered by this Plan and how your choice of provider will affect what you pay for benefits	
Cost Sharing	7
What you need to know about deductibles, coinsurance and copayments, your share of covered health care expenses, and the maximum amounts this Plan will pay for certain types of care	
General Limitations	9
How the Plan works if you have other health care coverage or receive health care services through another Government program; limit on your costs if you are 65 or older and don't have Medicare	
General Exclusions	11
What is not covered by this Plan	

Benefits

Inpatient Hospital Benefits	12
Your benefits for inpatient hospital care (see below for mental conditions/substance abuse care)	
Surgical Benefits	13
Your benefits for doctors' services for inpatient and outpatient surgery and related procedures	
Maternity Benefits	16
Your benefits for prenatal care, childbirth, and infertility treatment	
Mental Conditions/Substance Abuse Benefits	18
Your benefits for outpatient, inpatient and other facility care for mental conditions, alcoholism, and substance abuse	
Other Medical Benefits (deductible applies)	20
Your benefits for diagnostic X-ray and laboratory tests, doctors' hospital and office visits, routine screening services, radiation and chemotherapy, infertility treatment, chiropractic services, ambulance service, durable medical equipment (e.g., crutches and hospital beds), private duty nursing services, allergy tests and injections, renal dialysis, physical, occupational and speech therapy	
Additional Benefits (no deductible)	23
Your benefits for care of an accidental injury, blood and blood plasma, childhood immunizations, convalescent nursing home/skilled nursing facility, home health care and hospice care	
Prescription Drug Benefits	24
Your benefits for prescription drugs and supplies you get from pharmacies or by mail order	
How to Claim Benefits	26
Getting your claims paid when your provider does not file them for you; how to ask OPM to review a claims dispute between you and the Carrier	
Protection Against Catastrophic Costs	28
The maximum amount of covered expenses you can expect to pay for health care	

Other Information

Precertification	29
Hospital stays must be precertified to avoid a \$500 benefit reduction	
This Plan and Medicare	31
Information you need if you are covered by Medicare	

Table of Contents *continued*

	Page
Enrollment Information	33
Your enrollment in the Federal Employees Health Benefits Program and how to maintain FEHB coverage when enrollment ends	
Definitions	36
Explanations of some of the terms used in this brochure	
Non-FEHB Benefits	40
Other services available to members of this Plan	
<i>How This Plan Changes</i>	
How the SAMBA Health Benefit Plan Changes January 1998	41
<i>Summary of Benefits</i>	
Summary of Benefits	42

How This Plan Works

Help Contain Costs

You can help

FEHB plans are expected to manage their costs prudently. All FEHB plans have cost containment measures in place. All fee-for-service plans include two specific provisions in their benefits packages: precertification of all inpatient admissions and the flexible benefits option. Some include managed care options, such as PPOs, to help contain costs.

As a result of your cooperative efforts, the FEHB Program has been able to control premium costs. Please keep up the good work and continue to help keep costs down.

Precertification

Precertification evaluates the medical necessity of proposed admissions and the number of days required to treat your condition. You are responsible for ensuring that the precertification requirement is met. You or your doctor must check with Prudential HealthCare (Prudential) or HealthCare COMPARE (COMPARE) before being admitted to the hospital. If that doesn't happen, your Plan will reduce benefits by \$500. Be a responsible consumer. Be aware of your Plan's cost containment provisions. You can avoid penalties and help keep premiums under control by following the procedures specified on pages 29, 30 and 31 of this brochure.

Flexible benefits option

Under the flexible benefits option, the Carrier has the authority to determine the most effective way to provide services. The Carrier may identify medically appropriate alternatives to traditional care and coordinate the provision of Plan benefits as a less costly alternative benefit. Alternative benefits are subject to ongoing review. The Carrier may decide to resume regular contract benefits at its sole discretion. Approval of an alternative benefit is not a guarantee of any future alternative benefits. The decision to offer an alternative benefit is solely the Carrier's and may be withdrawn at any time. It is not subject to OPM review under the disputed claims process.

PPO

This Plan offers most of its members the opportunity to reduce out-of-pocket expenses by choosing providers who participate in the Plan's preferred provider organization (PPO). Consider the PPO cost savings when you review Plan benefits and check with the Carrier to see whether PPO providers are available in your area.

Facilities and Other Providers

Covered facilities

Ambulatory surgical center

A permanent facility that is equipped and operated primarily for the purpose of performing surgical procedures on patients whose post-anesthesia recovery permits discharge from the facility the same day.

Birthing center

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

Convalescent nursing home

An institution that meets all of these tests:

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

Hospice

A facility that provides short periods of stay for a terminally ill person in a home-like setting for either direct care or respite. This facility may be either free-standing or affiliated with a hospital. It must operate as an integral part of the hospice care program.

Hospital

- 1) An institution that is accredited as a hospital 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 that is primarily engaged in providing:
 - (a) general inpatient care and treatment of sick and injured persons through medical, diagnostic and major surgical facilities, all of which facilities must be provided on its premises or under its control, or
 - (b) specialized inpatient medical care and treatment of sick or injured persons through medical and diagnostic facilities (including X-ray and laboratory) on its premises, under its control, or through a written agreement with a hospital (as defined above) or with a specialized provider of those facilities.

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 convalescent nursing home or institution or part thereof that:

- 1) is used principally as a convalescent facility, rest facility, nursing facility or facility for the aged;
- 2) furnishes primarily domiciliary or custodial care; or
- 3) is operated as a school.

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.

Facilities and Other Providers *continued*

Covered providers

For purposes of this Plan, covered providers include, but are not limited to: 1) a licensed doctor of medicine (M.D.); a licensed doctor of osteopathy (D.O.), hereafter referred to as doctor; and 2) for certain specified services covered by this Plan, a licensed doctor of podiatry (D.P.M.), a licensed dentist, chiropractor, and a Christian Science practitioner listed in the Christian Science Journal.

Coverage in medically underserved areas

Other covered providers include a qualified clinical psychologist, clinical social worker, optometrist, nurse midwife, nurse practitioner/clinical specialist, and nursing school administered clinic. For purposes of this FEHB brochure, the term “doctor” includes all of these providers when the services are performed within the scope of their license or certification. Within states designated as medically underserved areas, any licensed medical practitioner will be treated as a covered provider for any covered services performed within the scope of that license. For 1998, the States designated as medically underserved are: Alabama, Louisiana, Mississippi, New Mexico, South Carolina, South Dakota, West Virginia and Wyoming.

PPO arrangements

Benefits under this Plan are available from facilities, such as hospitals, and from providers, such as pharmacies, doctors and other health care personnel, who provide covered services. This Plan covers two types of facilities and providers: (1) those who participate in a preferred provider organization (PPO) and (2) those who do not. Who these health care providers are, and how benefits are paid for their services, are explained below. In general, it works like this.

PPO facilities and providers have agreed to provide services to Plan members at a lower cost than you’d usually pay a non-PPO provider. Although PPOs are not available in all locations or for all services, when you use these providers you help contain health care costs and reduce what you pay out of pocket. The selection of PPO providers is solely the Carrier’s responsibility; continued participation of any specific provider cannot be guaranteed. While PPO providers agree with the Carrier to provide covered services, final decisions about health care are the sole responsibility of the doctor and patient and are independent of the terms of the insurance contract.

PPO benefits apply only when you use a PPO provider. If no PPO provider is available, or you do not use a PPO provider, the standard non-PPO benefits apply.

When you use a PPO hospital, keep in mind that the professionals who provide services to you in the hospital, such as radiologists, anesthesiologists and pathologists, may **not** all be preferred providers. If they are not, they will be paid by this Plan as non-PPO providers. However, the Plan will pay the inpatient services of anesthesiologists, radiologists, and pathologists who are non-PPO providers at the PPO provider rate if the inpatient service is rendered at a Network hospital.

Non-PPO facilities and providers do not have special agreements with the Carrier. The Plan makes its regular payments toward the bills, and you’re responsible for any balance.

This Plan’s PPOs

Enrollees who reside or work in the Washington, DC or Greater Baltimore areas or the Tri-State area of New York, New Jersey and Connecticut may utilize the Prudential HealthCare PPO Network. Subject to the Plan’s definitions, limitations and exclusions, the Plan pays its PPO benefits as outlined in this brochure when services are provided or authorized by a Network primary care doctor. Your primary care doctor will provide all routine health care and arrange for referrals to the specialists and hospitals associated with the Prudential HealthCare PPO Network. If you reside or work in the Washington, DC or Greater Baltimore areas, call 1-800/648-4483; in the Tri-State area of New York, New Jersey, and Connecticut, call 1-800/422-7399 for information concerning the PPO; The Prudential HealthCare PPO Service Areas are defined on page 30.

HealthCare COMPARE Corp./Affordable offers a national network of Preferred Provider Organizations (PPO). This PPO Network offers hospitals and doctors that have agreed to provide services at negotiated rates to SAMBA enrollees and their eligible family members in numerous geographic areas. Use of a participating Network doctor or hospital does not guarantee that the associated ancillary providers such as specialists, emergency room doctors, anesthesiologists, radiologists, and pathologists participate in the Network. Subject to the Plan’s definitions, limitations, and exclusions, the Plan pays its PPO benefits as outlined in this brochure when services are provided by a doctor or other provider participating in the Affordable Network outside the Prudential HealthCare PPO Service Areas described on page 30. If you elect to use a non-PPO provider, however, SAMBA will provide its usual coverage as outlined in this brochure.

Facilities and Other Providers *continued*

Managed Care Advisor (MCA) Program

Enrollees lacking Network access (as defined) may join the Plan's Managed Care Advisor (MCA) Program offered through HealthCare COMPARE Corp. To determine eligibility and to join the MCA Program, call 1-800/346-6755 and speak with a Referral Management Coordinator who will help you select a primary care physician who will manage all of your medical needs. Your primary care physician will evaluate the need to see specialists or other providers. If your primary care physician recommends specialty care, you or your provider must contact a COMPARE Referral Management Coordinator at 1-800/346-6755 for a referral. Enrollees who join and comply with the requirements of the MCA Program will receive the Plan's enhanced PPO benefits (subject to the Plan's definitions, limitations, and exclusions); see page 30.

By calling HealthCare COMPARE Corp. at 1-800/346-6755, you may also access OnCall by Affordable. OnCall is a 24-hour, seven-day-a-week nurse advisor line which answers general medical questions, provides educational materials, assists you in making health care decisions, and assists in locating Network providers. OnCall is only available to enrollees in the Affordable Medical Networks and MCA Program service areas.

The Plan is solely responsible for the selection of PPO providers and continued participation of any specific PPO provider cannot be guaranteed. Any questions regarding PPO providers should be directed to the Plan. Call 1-800/346-6755 to find out if a PPO Network hospital or doctor is available in your area.

The Prudential HealthCare PPO and Affordable Networks both offer integrated organ transplant programs. See pages 14 and 15.

Cost Sharing

Deductibles

A deductible is the amount of expense an individual must incur for covered services and supplies before the Plan starts paying benefits for the expense involved. A deductible is not reimbursable by the Plan and benefits paid by the Plan do not count toward a deductible. When a benefit is subject to a deductible, only expenses allowable under that benefit count toward the deductible.

Calendar year

The calendar year deductible is the amount of expenses an individual must incur for covered services and supplies each calendar year before the Plan pays certain benefits. The deductible for PPO benefits is \$200 per person per calendar year; the deductible for non-PPO benefits is \$300 per person per calendar year. Covered expenses applied to the calendar year deductible for either PPO benefits or non-PPO benefits are applied toward both calendar year deductibles. Covered expenses paid as Surgical Benefits, Maternity Benefits, inpatient visits and Outpatient care under Mental Conditions/Substance Abuse Benefits and Other Medical Benefits are subject to the calendar year deductibles. It applies only once in a calendar year, regardless of the number of illnesses or injuries.

Copayments under the Plan's PPO benefits, Prescription drug program charges, and expenses used to satisfy the dental accident deductible do not count toward the calendar year deductible.

Hospital confinement

There is a \$200 deductible per inpatient confinement for PPO and non-PPO benefits, that applies to covered expenses under Inpatient Hospital Benefits, Maternity Benefits, and Mental Conditions/Substance Abuse Benefits.

Dental accident

The dental accident deductible is the first \$100, per person, per accident, of expenses for dental treatment of an accidental injury to sound, natural teeth under Surgical Benefits.

Carryover

If you changed to this Plan during open season from a plan with a deductible and the effective date of the change was after January 1, any expenses that would have applied to that plan's deductible in the prior year will be covered by your old plan if they are for care you got in January **before** the effective date of your coverage in this Plan. If you have already met the deductible in full, your old plan will reimburse these covered expenses. If you have not met it in full, your old plan will first apply your covered expenses to satisfy the rest of the deductible and then reimburse you for any additional covered expenses. The old plan will pay these covered expenses according to this year's benefits; benefit changes are effective on January 1.

Cost Sharing *continued*

Family limit

There is a separate calendar year deductible of \$200 per person for PPO benefits and \$300 per person for non-PPO benefits. Covered expenses applied to the calendar year deductible for either PPO benefits or non-PPO benefits are applied toward both calendar year deductibles. Under a family enrollment the deductible is considered satisfied and benefits are payable for all family members when the combined covered expenses of three or more people applied to the calendar year deductible for all family members reach \$400 for PPO benefits and \$600 for non-PPO benefits during a calendar year. (A maximum of \$200 per person applied to satisfy the \$300 non-PPO calendar year deductible may be applied to the \$400 PPO calendar year family limit.)

Coinsurance

Coinsurance is the stated percentage of covered charges you must pay after you have met any applicable deductible. The Plan will base this percentage on either the billed charge **or** the reasonable and customary charge, whichever is less. For instance, when a Plan pays **70%** of reasonable and customary charges for a covered service, you are responsible for **30%** of the reasonable and customary charges, i.e., the coinsurance. In addition, you may be responsible for any excess charge over the Plan's reasonable and customary allowance. For example, if the provider ordinarily charges \$100 for a service but the Plan's reasonable and customary allowance is \$95, the Plan will pay **70%** of the allowance (\$66.50). You must pay the **30%** coinsurance (\$28.50), plus the difference between the actual charge and the reasonable and customary allowance (\$5), for a total member responsibility of \$33.50.

If provider waives your share

If a provider routinely waives (does not require you to pay) your share of the charge for services rendered, the Plan is not obligated to pay the full percentage of the amount of the provider's original charge it would otherwise have paid. A provider or supplier who routinely waives coinsurance, copayments or deductibles is misstating the actual charge. This practice may be in violation of the law. The Plan will base its percentage on the fee actually charged. For example, if the provider ordinarily charges \$100 for a service but routinely waives the **30%** coinsurance, the actual charge is \$70. The Plan will pay \$49 (**70%** of the actual charge of \$70).

Copayments

A copayment is the stated amount the Plan may require you to pay for a covered service, such as \$15 per generic drug prescription by mail or \$20 per office visit charge at a PPO provider.

Lifetime maximums

Benefits for up to a 30-day confinement in a rehabilitation facility for treatment of alcoholism or substance abuse are limited to two confinements per lifetime.

Benefits for dental prosthetic appliances to treat conditions due to a congenital anomaly or defect are limited to a lifetime maximum of \$3,000 per person.

Benefits for orthodontic treatment following surgery for closure of a cleft palate or cleft palate with cleft lip are limited to a lifetime maximum of \$2,500 per person.

Benefits for orthodontic correction of cleft lip, prognathism or micrognathism are limited to a lifetime maximum per person of \$1,000.

Benefits for the diagnostic testing and treatment of infertility are limited to a lifetime maximum of \$5,000.

Benefits for enrollment in a smoking cessation program are limited to one per lifetime.

General Limitations

All benefits are subject to the definitions, limitations and exclusions in this brochure and are payable when determined by the Carrier to be medically necessary. Coverage is provided only for services and supplies that are listed in this brochure. **No oral statement of any person shall modify or otherwise affect the benefits, limitations and exclusions of this brochure, convey or void any coverage, increase or reduce any benefits under the Plan or be used in the prosecution or defense of a claim under the Plan.** This brochure is based on text included in the contract between OPM and this Plan and is intended to be the complete statement of benefits available to FEHB members. You should use this brochure to determine your entitlement to benefits. However, if conflicts are discovered between the language of this brochure and the contract, the contract will control.

Other sources of benefits

This section applies when you or your family members are entitled to benefits from a source other than this Plan. You must disclose information about other sources of benefits to the Carrier and complete all necessary documents and authorizations requested by the Carrier.

Medicare

If you or a covered family member is enrolled in this Plan and Part A, Part B, or Parts A and B of Medicare, the provisions on coordination of benefits with Medicare described on pages 31 and 32 apply.

Group health insurance and automobile insurance

Coordination of benefits (double coverage) applies when a person covered by this Plan also has, or is entitled to benefits from any other group health coverage, or is entitled to the payment of medical and hospital costs under no-fault or other automobile insurance that pays benefits without regard to fault. Information about the other coverage must be disclosed to this Carrier.

When there is double coverage, one plan normally pays its benefits in full as the primary payer, and the other plan pays a reduced benefit as the secondary payer. When this Plan is the secondary payer, it will pay the lesser of (1) its benefits in full, or (2) a reduced amount that, when added to the benefits payable by the other coverage, will not exceed **100%** of allowable expenses.

The determination of which health coverage is “primary” (pays its benefits first) is made according to guidelines provided by the National Association of Insurance Commissioners (NAIC). When benefits are payable under automobile insurance, including no-fault, the automobile insurer is primary (pays its benefits first) if it is legally obligated to provide benefits for health care expenses without regard to other health benefits coverage the enrollee may have.

The double coverage provision is administered in accordance with the National Association of Insurance Commissioners’ Group Coordination of Benefits Model Regulation.

This provision applies whether or not a claim is filed under the other coverage. When applicable, authorization must be given this Carrier to obtain information about benefits or services available from the other coverage, or to recover overpayments from other coverages.

CHAMPUS

If you are covered by both this Plan and the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS), this Plan will pay benefits first.

Medicaid

If you are covered by both this Plan and Medicaid, this Plan will pay benefits first.

Workers’ compensation

The Plan will not pay for benefits or services required as the result of occupational disease or injury for which any medical benefits are determined by the Office of Workers Compensation Programs (OWCP) to be payable under workers’ compensation (under section 8103 of title 5, U.S.C.) or by a similar agency under another Federal or State law. This provision also applies when a third party injury settlement or other similar proceeding provides medical benefits in regard to a claim under workers’ compensation or similar laws. If medical benefits provided under such laws are exhausted, medical benefits may be provided for services or supplies covered by this Plan. The Plan is entitled to be reimbursed by OWCP (or the similar agency) for benefits paid by the Plan that were later found to be payable by OWCP (or the agency).

DVA facilities, DoD facilities, and Indian Health Service

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

Other Government agencies

The Plan will not provide benefits for services and supplies paid for directly or indirectly by any other local, State, or Federal Government agency.

General Limitations *continued*

Liability insurance and third party actions

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

Overpayments

The Carrier will make reasonably diligent efforts to recover benefit payments made erroneously but in good faith and may apply subsequent benefits otherwise payable to offset any overpayments.

Vested rights

An enrollee does not have a vested right to receive the benefits in this brochure in 1999 or later years, and does not have a right to benefits available prior to 1998 unless those benefits are contained in this brochure.

Limit on your costs if you're age 65 or older and don't have Medicare

The information in the following paragraphs applies to you when 1) you are not covered by either **Medicare Part A** (hospital insurance) or **Part B** (medical insurance), or both, 2) you are enrolled in this Plan as an annuitant or as a former spouse or family member covered by the family enrollment of an annuitant or former spouse, and 3) you are not employed in a position which confers FEHB coverage.

Inpatient hospital care

If you are not covered by **Medicare Part A**, are age 65 or older or become age 65 while receiving inpatient hospital services, and you receive care in a Medicare participating hospital, the law (5 U.S.C. 8904(b)) requires the Plan to base its payment on an amount equivalent to the amount Medicare would have allowed if you had Medicare Part A. This amount is called the **equivalent Medicare amount**. After the Plan pays, the law prohibits the hospital from charging you for covered services after you have paid any deductibles, coinsurance, or copayments you owe under the Plan. Any coinsurance you owe will be based on the equivalent Medicare amount, not the actual charge. You and the Plan, together, are not legally obligated to pay the hospital more than the equivalent Medicare amount.

The Carrier's explanation of benefits (EOB) will tell you how much the hospital can charge you in addition to what the Plan paid. If you are billed more than the hospital is allowed to charge, ask the hospital to reduce the bill. If you have already paid more than you have to pay, ask for a refund. If you cannot get a reduction or refund, or are not sure how much you owe, call the Plan at 1-800/638-6589 or 301/984-1440 (for TDD, use 301/984-4155) for assistance.

Physician services

Claims for physician services provided for retired FEHB members age 65 and older who do not have Medicare Part B are also processed in accordance with 5 U.S.C. 8904(b). This law mandates the use of Medicare Part B limits for covered physician services for those members who are not covered by Medicare Part B.

The Plan is required to base its payment on the **Medicare-approved amount** (which is the Medicare fee schedule for the service), **or** the actual charge, whichever is lower. The Plan will base its payment on the lower of these two amounts and you are responsible only for any deductible and copayment or coinsurance.

If you go to a PPO doctor who does not participate with Medicare, you are responsible for any copayment. In addition, you must pay the difference between the Medicare-approved amount and the **limiting charge (115%** of the Medicare-approved amount).

If your physician is not a Plan PPO doctor but participates with Medicare, the Plan will base its regular benefit payment on the Medicare-approved amount. For instance, under this Plan's benefit, the Plan will pay **70%** of the Medicare-approved amount. You will only be responsible for any deductible and coinsurance equal to **30%** of the Medicare-approved amount.

If your physician does not participate with Medicare, the Plan will still base its payment on the Medicare-approved amount. However, in most cases you will be responsible for any deductible, the coinsurance or copayment amount, **and** any balance up to the limiting charge amount (**115%** of the Medicare-approved amount).

General Limitations *continued*

Since a physician who participates with Medicare is only permitted to bill you up to the Medicare fee schedule amount even if you do not have Medicare Part B, it is generally to your financial advantage to use a physician who participates with Medicare.

The Carrier's explanation of benefits (EOB) will tell you how much the physician can charge you in addition to what the Plan paid. If you are billed more than the physician is allowed to charge, ask the physician to reduce the bill. If you have already paid more than you have to pay, ask for a refund. If you cannot get a reduction or refund, or are not sure how much you owe, call the Plan at 1-800/638-6589 or 301/984-1440 (for TDD, use 301/984-4155) for assistance.

General Exclusions

These exclusions apply to more than one or to all benefits categories. Exclusions that are primarily identified with a single benefit category are listed along with that benefit category, but may apply to other categories. Therefore, please refer to the specific benefit sections as well to assure that you are aware of all benefit exclusions.

Benefits are provided only for services and supplies that are medically necessary (see definition). The Carrier reserves the right to determine medical necessity. The fact that a covered provider has prescribed, recommended, or approved a service or supply does not, in itself, make it medically necessary.

Benefits will not be paid for services and supplies when:

- No charge would be made if the covered individual had no health insurance coverage
- Furnished without charge (except as described on page 9); while in active military service; or required for illness or injury sustained on or after the effective date of enrollment (1) as a result of an act of war within the United States, its territories, or possessions or (2) during combat
- Furnished by immediate relatives or household members, such as your parents, your spouse, and your own and your spouse's children, brothers and sisters by blood, marriage or adoption
- Furnished or billed by a provider or facility that has been barred from the FEHB Program
- Furnished or billed by a noncovered facility, except that medically necessary prescription drugs are covered
- For or related to sex transformation, sexual dysfunction or sexual inadequacy
- Not specifically listed as covered
- Investigational or experimental
- Not provided in accordance with accepted professional medical standards in the United States

Benefits will not be paid for:

- 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, copay or coinsurance, the Carrier will calculate the actual provider fee or charge by reducing the fee or charge by the amount waived
- Charges the enrollee or Plan has no legal obligation to pay, such as: excess charges for an annuitant age 65 or older who is not covered by Medicare Parts A and/or B (see pages 10 and 11), doctor charges exceeding the amount specified by the Department of Health and Human Services when benefits are payable under Medicare (limiting charge) (see page 33), or State premium taxes however applied
- Dental treatment, including X-rays and treatment by a dentist or oral surgeon except to the extent shown on pages 13 and 14
- Dental appliances, study models, splints and other devices or services associated with the treatment of temporomandibular joint (TMJ) dysfunction
- Expenses incurred while not covered by this Plan
- Eyeglasses or hearing aids, or examinations for them, except as shown on page 20
- Marital counseling
- Practitioners who do not meet the definition of covered provider on page 6
- Charges for services and supplies to the extent they are not reasonable and customary
- Services in connection with custodial care as defined on page 37
- Treatment 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 13
- Services by a massage therapist
- Services by a naturopathic practitioner
- Services and supplies for cosmetic purposes, e.g., Retin A, Minoxidil, Rogaine
- Procedures, services, drugs and 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.

Benefits

Inpatient Hospital Benefits

What is covered	The Plan pays for inpatient hospital services as shown below.
Precertification	The medical necessity of your hospital admission must be precertified for you to receive full Plan benefits. Emergency admissions not precertified must be reported within two business days following the day of admission even if you have been discharged. Otherwise, the benefits payable will be reduced by \$500. See pages 29, 30 and 31 for details.
Waiver	This precertification requirement does not apply to persons whose primary coverage is Medicare Part A or another health insurance policy or when the hospital admission is outside the United States. For information on when Medicare is primary, see page 32.
Room and board	The Plan pays covered charges for semiprivate room accommodations, including general nursing care. If a private room is used, you must pay the difference between the charge for the private room and the hospital's charge for standard semiprivate accommodations or, if it has no semiprivate rooms, the hospital's lowest rate for a private room. If the confinement is caused by an infectious or communicable disease, the private room charge will be covered.
Other charges	Other hospital charges include but are not limited to: <ul style="list-style-type: none">• Administration of anesthetics in a hospital by a doctor• Blood and blood plasma to the extent not donated or otherwise replaced• The professional services of a radiologist or pathologist• Hospital services and supplies (other than professional services), such as use of operating, treatment, and recovery rooms; X-rays; anesthetics; laboratory and diagnostic tests; surgical dressings; and drugs and medicines for use in the hospital• Local professional ambulance service to and from a hospital
Non-PPO benefit	After a \$200 per confinement deductible, the Plan pays 70% of covered Room and board and Other charges.
PPO benefit	<p>Prudential HealthCare PPO — After a \$200 per confinement deductible, the Plan pays 100% of covered Room and board and 95% of Other charges when services are authorized by a Network primary care doctor.</p> <p>Affordable — After a \$200 per confinement deductible, the Plan pays 100% of covered Room and board and 95% of Other charges made by the hospital (including the inpatient services of an anesthesiologist, radiologist, and pathologist) when a Network hospital is used. Other services listed must be provided by an Affordable Network provider to qualify for PPO benefits.</p>

Limited benefits

Hospitalization for dental work Medically necessary hospitalization for dental procedures requires precertification as indicated on pages 29, 30 and 31.

Related benefits

Private duty nursing services Private duty nursing care is covered under Other Medical Benefits.

Professional charges Doctors' charges for hospital calls and consultations are covered under Other Medical Benefits.

What is not covered

- Room and board expenses in any place that is not a covered facility as defined on pages 5 and 6 or in 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 services, such as radio, telephone, television, beauty and barber services

The non-PPO benefits are the standard benefits of this Plan. PPO benefits apply only when you use a PPO provider. When no PPO provider is available, non-PPO benefits apply (except as noted on pages 6 and 7).

Surgical Benefits

What is covered

The Plan pays for the following services:

Hospital inpatient and outpatient

The Plan pays for covered surgical procedures when performed on an inpatient or outpatient basis. Surgical procedures include the immediate preoperative examination by the surgeon and postoperative care by the surgeon required by and directly related to covered surgical procedures, including voluntary sterilizations. Also included are:

- Services of an assistant surgeon required by the nature of the surgical procedure or by the patient's condition.
- Services of a licensed podiatrist (chiropracist) for:
 - An open cutting operation
 - Removal of a nail root
 - Treatment (including cutting or removal) of corns, calluses, or toenails when the individual is under treatment by a doctor for a metabolic disease, such as diabetes mellitus, or a peripheral-vascular disease such as arteriosclerosis.

Multiple surgical procedures

When multiple or bilateral surgical procedures that add significant time or complexity to patient care are performed during the same operative session, the Plan pays as follows: the reasonable and customary charge is calculated allowing full value for the major procedure and **50%** for the lesser procedures. The determination of what constitutes multiple surgical procedures is made solely by the Plan.

Incidental procedures

When an incidental procedure is performed, the reasonable and customary charge is calculated based on the major procedure only. The determination of what constitutes incidental surgical procedures is made solely by the Plan.

Anesthesia

The Plan pays for reasonable and customary charges made for the administration of anesthesia when not otherwise payable under Inpatient Hospital Benefits.

Services related to outpatient surgery

- Charges made by an ambulatory surgical center for use of the facility
- Surgical supplies, operating room charges and related X-rays and tests performed on the day of surgery, when surgery is performed in a doctor's office or in the outpatient department of a hospital.

Second opinion (voluntary)

Charges for a second (or third) opinion are covered under Other Medical Benefits.

Oral and maxillofacial surgery

Plan pays reasonable and customary charges for the services of a doctor, dentist or oral surgeon, including the related anesthesia, limited to the following procedures:

- excision of impacted teeth, bony cysts of the jaw, torus palatinus, leukoplakia, or malignant tissue
- removal of stones from salivary ducts
- freeing of muscle attachments
- excision of cysts and incision and drainage of abscesses not involving the teeth
- surgical correction of cleft lip, cleft palate, or protruding mandible
- reduction of fractures or dislocations of the jaws or facial bones
- other oral surgery that does not involve any tooth or tooth structure, alveolar process, periodontal disease, or disease of gingival tissue

Mastectomy surgery

Women who undergo mastectomies may, at their option, have this procedure performed on an inpatient basis and remain in the hospital up to 48 hours after the procedure without obtaining precertification for the admission or the length of stay. Inpatient stays may be extended if approved following precertification.

Non-PPO benefit

After the \$300 calendar year deductible, the Plan pays **70%** of reasonable and customary charges for the above services and supplies.

The non-PPO benefits are the standard benefits of this Plan. PPO benefits apply only when you use a PPO provider. When no PPO provider is available, non-PPO benefits apply (except as noted on pages 6 and 7).

Surgical Benefits *continued*

PPO benefit

Prudential HealthCare PPO — After the \$200 calendar year deductible, the Plan pays **95%** of covered charges when services are provided or authorized by a Network primary care doctor.

Affordable — After the \$200 calendar year deductible, the Plan pays **95%** of covered charges when services are provided by a Network hospital or other Network provider.

Accidental injury to sound, natural teeth

Plan pays reasonable and customary charges for surgical and dental treatment of accidental injury to sound, natural teeth. Treatment must be rendered within 24 months of the accident. Accidental injury and sound, natural tooth are defined on pages 36 and 39.

Non-PPO benefit

After a \$100 deductible per accident, the Plan pays **75%**.

PPO benefit

Prudential HealthCare PPO — After a \$100 deductible per accident, the Plan pays **95%** of covered charges when services are provided or authorized by a Network Primary care doctor.

Affordable — After a \$100 deductible per accident, the Plan pays **95%** of covered charges when services are provided by a Network provider.

Organ/tissue transplants and donor expenses

All reasonable and customary charges incurred for a covered surgical transplant, whether incurred by the recipient or donor, will be considered expenses of the recipient and will be covered the same as for any other illness or injury. Surgical transplants must be authorized by the Plan's pre-certification contractor. This benefit applies only if the recipient is covered by the Plan.

What is covered

- Cornea, heart, kidney, liver, pancreas, heart/lung, single lung and double lung transplants
- Bone marrow transplants as follows:
 - Allogeneic (donor) bone marrow transplants;
 - Autologous bone marrow transplants (autologous stem cell support) and autologous peripheral stem cell support for: acute lymphocytic or non-lymphocytic leukemia; advanced Hodgkin's lymphoma; advanced non-Hodgkin's lymphoma; advanced neuroblastoma; breast cancer; multiple myeloma; epithelial ovarian cancer; and testicular, mediastinal, retroperitoneal and ovarian germ cell tumors.
- Related medical and hospital expenses of the donor are covered when the recipient is covered by the Plan. Recipient means an insured person who undergoes an operation to receive an organ transplant. Donor means a person who undergoes an operation for the purpose of donating an organ for transplant surgery.

The Managed Transplant System/Institutes of Quality Program — The Plan pays **100%** of covered expenses for the organ transplants listed above (except cornea and pancreas) when performed through The HealthCare COMPARE Managed Transplant System or Prudential HealthCare's Institutes of Quality Program. Covered expenses are:

- The pretransplant evaluation;
- Organ procurement, including donor expenses (except donor screening tests);
- The transplant procedure itself (hospital and doctor fees);
- Transplant-related follow-up care for up to one year; and
- Pharmacy costs for immunosuppressant and other transplant-related medication.

Travel/Lodging Benefit — If the recipient lives more than 50 miles from a designated transplant facility, the Plan will provide an allowance for preapproved travel and lodging expenses up to \$10,000 per transplant. The allowance will not be subject to the calendar year deductible or coinsurance. 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). Covered travel and lodging expenses will be established by the Plan's case manager during the precertification process. Travel and lodging to a designated facility for the pretransplant evaluation is covered under this benefit even if the transplant is not eventually certified as medically necessary (see *Transplant Precertification*).

The non-PPO benefits are the standard benefits of this Plan. PPO benefits apply only when you use a PPO provider. When no PPO provider is available, non-PPO benefits apply (except as noted on pages 6 and 7).

Surgical Benefits *continued*

Transplant Precertification — As a potential candidate for an organ transplant procedure, you or your doctor must contact the COMPARE Managed Transplant System at 1-800/346-6755 or Prudential HealthCare's Institutes of Quality Program (Washington, DC and Baltimore area at 1-800/648-4483 or Tri-State area of New York, New Jersey and Connecticut at 1-800/422-7399) 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 COMPARE or Prudential HealthCare case manager will assist the patient in accessing the appropriate transplant facility. This includes providing information to facilitate travel and lodging arrangements and coordinating the pretransplant evaluation.

Limitations

If you do not use either the COMPARE Managed Transplant System or Prudential HealthCare's Institutes of Quality Program, standard Plan benefits will be applied to your expenses. Total benefit payments, including donor expenses, the transplant procedure itself, transplant-related follow-up care for one year, and pharmacy costs for immunosuppressant and other transplant-related medication will be limited to a maximum payment of \$100,000 per transplant. The travel and lodging allowance will not be available.

Cornea and pancreas transplants are not available through the above programs; therefore the Travel/Lodging Benefit is not available and standard Plan benefits apply.

What is not covered

- Transplants not listed as covered; including, but not limited to, Islet of Langerhans and artificial heart
- Donor screening tests for organ transplants except those performed for the actual donor when the recipient is covered by the Plan

Limited benefit

Cosmetic surgery

Cosmetic surgery, and all expenses incurred in connection with cosmetic surgery, is limited to that required by an accidental injury, to correction of a congenital anomaly, and to breast reconstruction following a mastectomy.

What is not covered

- Eye surgery, such as radial keratotomy, when the primary purpose is to correct myopia (near sightedness), hyperopia (farsightedness) or astigmatism (blurring).
- Reversal of voluntary sterilization.

The non-PPO benefits are the standard benefits of this Plan. PPO benefits apply only when you use a PPO provider. When no PPO provider is available, non-PPO benefits apply (except as noted on pages 6 and 7).

Maternity Benefits

What is covered

The Plan pays the same benefits for hospital, surgery (delivery), laboratory tests and other medical expenses as for illness or injury. The mother, at her option, may remain in the hospital up to 48 hours after a regular delivery and 96 hours after a caesarean delivery without obtaining precertification for those lengths of stay. Inpatient stays may be extended if approved following precertification.

Inpatient hospital

Precertification

The medical necessity of your hospital admission must be precertified for you to receive full Plan benefits. Unscheduled or emergency admissions not precertified must be reported within two business days following the day of admission even if you have been discharged. Newborn confinements that extend beyond the mother's discharge must also be precertified. If any of the above are not done, the benefits payable will be reduced by \$500. See pages 29, 30 and 31 for details.

Room and board

The Plan pays covered semiprivate room and board charges (see Inpatient Hospital Benefits on page 12 for coverage of private room). Routine nursery care of the infant is considered a hospital expense of the mother and not an expense of the child.

Other charges

Other charges as shown under Inpatient Hospital Benefits, including charges for administration of anesthetics and local professional ambulance service.

Non-PPO benefit

After a \$200 per confinement deductible, the Plan pays **70%** of covered Room and board and Other charges.

PPO benefit

Prudential HealthCare PPO — After a \$200 per confinement deductible, the Plan pays **100%** of covered Room and board and **95%** of Other charges when services are authorized by a Network primary care doctor.

Affordable — After a \$200 per confinement deductible, the Plan pays **100%** of covered Room and board and **95%** of Other charges made by the hospital (including the inpatient services of an anesthesiologist, radiologist, and pathologist), when a Network hospital is used. Other services listed must be provided by an Affordable Network provider/facility to qualify for PPO benefits.

Outpatient care

Eligible charges for services provided by a covered birthing center (see page 5).

Obstetrical care

Charges of a doctor or State licensed midwife. Doctors' and midwives' fees for total obstetrical care cannot be considered until time of delivery.

Non-PPO benefit

After the \$300 calendar year deductible, the Plan pays **70%** of Outpatient care and Obstetrical care covered charges.

PPO benefit

Prudential HealthCare PPO — After the \$200 calendar year deductible, the Plan pays **95%** of Outpatient care covered charges and Obstetrical care when services are authorized by a Network primary care doctor.

Affordable — After the \$200 calendar year deductible, the Plan pays **95%** of Outpatient care covered charges and Obstetrical care from a Network provider. The services listed must be provided by an Affordable Network provider to qualify for PPO benefits.

Related benefits

Diagnosis and treatment of infertility

Charges for diagnostic tests, procedures, and prescription drugs to identify and treat the cause or causes of the inability to conceive are eligible charges under Other Medical Benefits and are limited to \$5,000 per person, per lifetime.

Newborn exam

Charges for the initial in-hospital exam of a newborn covered under a Self and Family enrollment are payable under Other Medical Benefits.

The non-PPO benefits are the standard benefits of this Plan. PPO benefits apply only when you use a PPO provider. When no PPO provider is available, non-PPO benefits apply (except as noted on pages 6 and 7).

Maternity Benefits *continued*

Prenatal monitoring

Services to monitor prenatal care and identify risk factors are available through the Plan's precertification program; see page 31.

Tests

Laboratory fees in connection with pregnancy, other related tests of the unborn child, and Group B streptococcus infection screening for pregnant women are payable under Other Medical Benefits at the time the expense is incurred.

Voluntary sterilization

Refer to Surgical Benefits, page 13.

For whom

Benefits are payable under Self Only enrollments and for family members under Self and Family enrollments.

What is not covered

- Genetic counseling
- Reversal of voluntary surgical sterilization
- Sonograms for fetal age determination
- Stand-by doctor for caesarean section
- Services before enrollment in the Plan begins or after enrollment ends
- Assisted Reproductive Technology (ART) procedures, such as artificial insemination, in vitro fertilization, embryo transfer and GIFT, as well as services and supplies related to ART procedures, are not covered.

The non-PPO benefits are the standard benefits of this Plan. PPO benefits apply only when you use a PPO provider. When no PPO provider is available, non-PPO benefits apply (except as noted on pages 6 and 7).

Mental Conditions/Substance Abuse Benefits

What is covered

The Plan pays for the treatment of mental conditions/substance abuse as shown below:

Inpatient care

Covered hospital and rehabilitation facility charges include:

- Room and board, including general nursing care, in semiprivate accommodations
- Other charges for hospital services and supplies (other than professional services) including but not limited to the use of operating, treatment and recovery rooms; X-rays; surgical dressings; and drugs and medicines
- Services of a doctor for inpatient hospital visits

Rehabilitation facility

When a covered person is admitted to an approved rehabilitation facility as an inpatient for a prescribed course of treatment of alcoholism or substance abuse upon recommendation of a doctor, the Plan will provide benefits subject to precertification and the following limitations: (a) benefits are limited to a maximum of up to 30 days per confinement and (b) benefits are limited to two confinements per person per lifetime.

Precertification

The medical necessity of your admission to a hospital or other covered facility must be precertified for you to receive full Plan benefits. Emergency admissions must be reported within two business days following the day of admission even if you have been discharged. Otherwise, the benefits payable will be reduced by \$500. See pages 29, 30 and 31 for details.

Non-PPO benefit

After a \$200 per confinement deductible, the Plan pays **70%** of Room and board charges and covered Other charges made by the hospital or rehabilitation facility. After the \$300 calendar year deductible, Plan pays **70%** of charges for doctors' inpatient visits.

PPO benefit

Prudential HealthCare PPO — After a \$200 per confinement deductible, the Plan pays **100%** of Room and board charges, and **95%** of Other charges made by the hospital or rehabilitation facility. After the \$200 calendar year deductible, Plan pays **95%** of charges for doctors' inpatient visits. Services must be authorized by a Network primary care doctor.

Affordable — After a \$200 per confinement deductible, the Plan pays **100%** of Room and board and **95%** of Other charges made by the hospital or rehabilitation facility when a Network provider is used. After the \$200 calendar year deductible, Plan pays **95%** of charges for doctors' inpatient visits. Other inpatient care must be provided by an Affordable Network provider to qualify for PPO benefits.

Catastrophic protection

After eligible out-of-pocket expenses under the Mental Conditions/Substance Abuse Benefits total \$4,000 per person in a calendar year, the Plan then pays **100%** of covered expenses under Mental Conditions/Substance Abuse Benefits for the remainder of that calendar year for that person.

The non-PPO benefits are the standard benefits of this Plan. PPO benefits apply only when you use a PPO provider. When no PPO provider is available, non-PPO benefits apply (except as noted on pages 6 and 7).

Mental Conditions/Substance Abuse Benefits *continued*

Outpatient care

Covered outpatient services for the treatment of mental conditions or substance abuse include doctors' visits, group therapy, collateral visits with members of the patient's immediate family, services of a licensed psychiatric social worker and of a psychiatric nurse (R.N.), and convulsive therapy visits and day or after care (partial hospitalization) in a hospital. These limitations apply:

- Covered expenses are limited to \$100 per visit
- The number of covered visits per member per calendar year is limited to 50, including visits you paid for while satisfying the calendar year deductible. Convulsive therapy visits and day or after care in a hospital are not subject to this limit.

Non-PPO benefit

After the \$300 calendar year deductible, Plan pays **50%** of covered expenses.

PPO benefit

Prudential HealthCare PPO — Plan pays **100%** of covered expenses, with no deductible, after copayment of \$20 for each office visit and consultation. After the \$200 calendar year deductible the Plan pays **95%** of covered day or after-care (partial hospitalization) in a hospital. Services must be provided or authorized by a Network primary care doctor.

Affordable — Plan pays **100%** of covered expenses, with no deductible, after a copayment of \$20 for each office visit and consultation. After the \$200 calendar year deductible the Plan pays **95%** of covered day or after-care (partial hospitalization) in a hospital. Services must be provided by an Affordable Network provider.

Lifetime maximum

Benefits for confinements in a rehabilitation facility for treatment of alcoholism or substance abuse are limited to two confinements per lifetime.

What is not covered

- Marital counseling
- Treatment of learning disabilities

The non-PPO benefits are the standard benefits of this Plan. PPO benefits apply only when you use a PPO provider. When no PPO provider is available, non-PPO benefits apply (except as noted on pages 6 and 7).

Other Medical Benefits

What is covered

The Plan pays reasonable and customary charges for the following services and supplies to the extent that such charges are not covered by the Inpatient Hospital, Maternity, Surgical, Mental Conditions/Substance Abuse or Additional Benefits of this Plan.

Non-PPO benefit

After the \$300 calendar year deductible, the Plan pays **70%** of the remaining covered expenses incurred in that calendar year for the services and supplies listed below.

PPO benefit

After the \$200 calendar year deductible, the Plan pays 95% of covered charges for the services listed below except:

The Plan pays **100%** of covered charges after a copayment of \$20 for the doctor's office visits and consultations, including the services rendered by the doctor in conjunction with the office visit and consultation such as X-ray and laboratory tests.

Services rendered on a different date than the office visit or by any other provider will be payable at **95%** and subject to the \$200 calendar year deductible.

Listed services must be provided or authorized by a Prudential HealthCare PPO primary care doctor or provided by an Affordable Network provider. (Affordable providers are not available in all areas for all services.)

- Diagnostic X-rays and laboratory tests performed in connection with the diagnosis or treatment of a specific illness or condition (for diagnosis and treatment of infertility see page 21), including Group B streptococcus infection screening for pregnant women
- Doctors' services for home, office and hospital calls, and for consultations, except for those covered under Surgical Benefits and Maternity Benefits
- Treatment by chemotherapy and by X-ray, radium, or other radioactive substance
- Initial in-hospital examination of a newborn covered under a Self and Family enrollment
- Use of freestanding professional medical treatment centers, such as dialysis, cancer, or emergency or immediate-care facilities
- Artificial limbs, eyes, and larynges; surgical dressings, splints, casts, trusses, braces, and crutches. Braces exceeding \$1,000 in cost require authorization (see Durable medical equipment, below)
- Local ambulance service
- One pair of eyeglasses or contact lenses following intraocular surgery or accidental injury requiring vision correction
- One hearing aid necessitated by accidental injury
- Renal dialysis
- Treatment by a licensed physical therapist, licensed occupational therapist or licensed medical social worker
- Transparenter nutrition (TPN)
- Doctors examination including related X-rays and laboratory tests for second (or third) surgical opinion

Outpatient hospital services

Coverage is provided for the services and supplies listed below:

- Hospital services and supplies (other than professional services), such as use of operating, treatment, and recovery rooms; X-rays; anesthetics; laboratory and diagnostic tests; surgical dressings; and drugs and medicines for use in the hospital when such services and supplies are rendered in and billed by the outpatient department of a hospital.
- Doctors' and hospital charges for services performed in the outpatient department of a hospital during a medical emergency.

Durable medical equipment

Rental of durable medical equipment, such as wheelchair, hospital bed, iron lung, or oxygen equipment and oxygen, is covered. Preauthorization is required once accumulated rental charges or single purchase price exceeds \$1,000; call SAMBA at 1-800/638-6589; (for TDD, use 301/984-4155) to obtain preauthorization (Monday through Friday, 7:30 a.m.-3:30 p.m. Eastern time). If preauthorization is not obtained, benefits will be paid at **56%** of covered charges after satisfaction of the deductible.

The non-PPO benefits are the standard benefits of this Plan. PPO benefits apply only when you use a PPO provider. When no PPO provider is available, non-PPO benefits apply (except as noted on pages 6 and 7).

Other Medical Benefits *continued*

Routine physical	One routine physical examination per calendar year for all members, including related X-rays and laboratory tests, including the following screening exams and immunizations.
Breast cancer screening	Mammograms are covered for women age 35 and older as follows: <ul style="list-style-type: none">• From age 35 through 39, one mammogram screening during this five year period.• From age 40 through 49, one mammogram screening every one or two calendar years.• From age 50 through 64, one mammogram screening every calendar year.• At age 65 or over, one mammogram screening every two consecutive calendar years.
Cervical cancer screening	Annual coverage of one pap smear for women age 18 and older and the related doctor exam.
Colorectal cancer screening	Annual coverage of one fecal occult blood test for members age 40 and older
Immunizations	Annual coverage of an influenza and/or pneumococcal immunization. Coverage of a Tetanus-diphtheria (Td) booster, every 10 years for members age 19 and older.
Prostate cancer screening	Annual coverage of one PSA (Prostate Specific Antigen) test for men age 40 and older.
Well child care	Covered expenses for well child examinations and laboratory tests, including blood lead level screenings, for a covered dependent. Childhood immunizations are covered under Additional Benefits.

Limited benefits

Acupuncture	Covered expenses for acupuncture when rendered by a doctor for treatment of pain are limited to \$500 per calendar year.
Chiropractor	Covered expenses for services of a chiropractor are limited to \$500 per calendar year. Services of a chiropractor are not covered under any other Plan benefit except in medically underserved areas, as described on page 6 under Covered providers.
Dental prosthetic appliances	Covered expenses are limited to 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.
Diagnosis and treatment of infertility	Covered expenses for diagnostic tests, procedures, and prescription drugs to identify and treat the cause or causes of the inability to conceive are limited to \$5,000 per person per lifetime.
Orthodontic treatment	Covered expenses are limited to charges of an orthodontist for treatment after surgery for closure of a cleft palate or cleft lip, or for correction of prognathism or micrognathism. Lifetime benefits per person are: <ul style="list-style-type: none">• Cleft palate, or cleft palate with cleft lip limited to \$2,500• Cleft lip, prognathism or micrognathism limited to \$1,000
Private duty nursing care	Covered expenses for private duty nursing care are limited to charges of a registered graduate nurse (R.N.), licensed practical nurse (L.P.N.), or Christian Science nurse. A maximum Plan payment of \$10,000 per calendar year applies. Nursing services must be preauthorized by SAMBA; call SAMBA at 1-800/638-6589 (for TDD use 301/984-4155) to obtain preauthorization (Monday through Friday, 7:30 a.m.-3:30 p.m. Eastern time). If preauthorization is not obtained, benefits will be reduced to 80% of the benefit otherwise payable under Other Medical Benefits.

Other Medical Benefits *continued*

Smoking cessation benefit

After satisfaction of the calendar year deductible, the Plan will pay up to \$100 for enrollment in one smoking cessation program, including cost of any related prescription drugs, per member per lifetime.

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, except for speech loss or impairment due to a functional nervous disorder.

What is not covered

- Air conditioners, humidifiers, dehumidifiers, purifiers and other items that do not meet the definition of durable medical equipment on page 37
- Speech therapy for speech loss or impairment due to a functional nervous disorder
- Hospital and doctor charges for treatment of mental conditions or substance abuse. These are covered under Mental Conditions/Substance Abuse Benefits (see pages 18 and 19).

Additional Benefits

Accidental injury

Plan pays **100%** of covered expenses incurred as a result of, and within 72 hours after, an accidental injury. Accidental injury to sound, natural teeth is covered under Surgical Benefits and subject to a \$100 deductible and **25%** coinsurance (see page 14).

Blood and plasma

Plan pays **100%** of covered expenses for blood and blood plasma to the extent not donated or replaced when not otherwise payable under Inpatient Hospital Benefits.

Childhood immunizations

Plan pays **100%** of covered charges for childhood immunizations as recommended by the American Academy of Pediatrics, for dependent children under age 22.

Convalescent nursing home/skilled nursing facility

If the doctor recommends that a patient be transferred to a convalescent nursing home or a skilled nursing facility in lieu of continued hospitalization, this Plan will pay up to **50%** of the standard semiprivate room rate in the hospital in which the patient was confined for a maximum of 60 days, providing the confinement in the convalescent nursing home or skilled nursing facility begins within 10 days after a covered hospital confinement of at least 3 days.

Home health care

Services under this benefit must be furnished: (a) by a home health care agency; (b) in accordance with a home health care plan; and (c) in the patient's home. Plan pays **100%** of reasonable and customary charges of a home health aide provided through a home health care agency. Covered expenses are limited to 100 visits for any one covered person in a calendar year. Each visit taking four hours or less is counted as one visit. If a visit exceeds four hours, each four hours or fraction is counted as a separate visit.

Medically necessary services of registered graduate or licensed practical nurses or of physical, occupational, or speech therapists are covered under Other Medical Benefits.

Hospice care

What is covered

Expenses are covered for a hospice care program, as defined on page 38, that begins after a person's primary doctor certifies terminal illness and life expectancy of six months or less. The Plan pays **100%** of covered **outpatient** services and supplies up to **\$2,000** for each period of hospice care. Sixty days of **inpatient** care are also covered. The Plan pays **\$300** per day until the member incurs **\$700** of out-of-pocket expenses for the inpatient care. The Plan then pays **100%** of reasonable and customary charges during the remainder of the 60-day period of inpatient care. Covered services and supplies are:

- hospice room and board, while an inpatient in a hospice; and
- services and supplies furnished to a terminally ill person by a hospice or a hospice team.

The hospice care must be:

- 1) provided while the person is covered by this Plan;
- 2) ordered by the supervising doctor;
- 3) charged by the hospice care program; and
- 4) provided within six months from the date the person entered or reentered (after a period of remission as defined below) a hospice care program.

What is not covered

- Charges incurred during a period of 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. 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.

Prescription Drug Benefits

What is covered

You may purchase the following medications and supplies prescribed by a doctor from either a pharmacy or by mail:

- Drugs that by Federal law of the United States require a doctor's written prescription for purchase
- Insulin
- Needles and syringes for the administration of prescribed medication, including insulin

What is not covered

- Contraceptive drugs and devices, including Norplant
- Nonprescription medicines (over-the-counter medication)
- Drugs for cosmetic purposes, e.g., Retin A, Minoxidil, Rogaine
- Nutritional supplements and vitamins (except injectable B-12)
- The difference in cost between the name brand drug and the generic substitute, if requested by you but not required by your doctor, when a generic equivalent is available.

Drugs to aid in smoking cessation are covered only under the Smoking cessation benefit.

The copayments, and any amounts you are required to pay when you purchase a name brand drug when a generic equivalent is available, are not eligible for reimbursement by the Plan and do not count toward the calendar year deductible or the catastrophic protection benefit.

From a pharmacy

You may purchase up to a 30-day supply of covered drugs or supplies through the PAID system available at most pharmacies. Call 1-800/222-7186 to locate a Plan network pharmacy in your area. Your SAMBA health insurance identification card serves as a PAID identification card. In most cases, you simply present the card, together with the prescription, to the pharmacist. A \$15 generic, \$25 name brand drug copayment is required for each prescription. You may fill your prescription at any PAID Prescriptions pharmacy participating in the SAMBA Program that transmits claim information via the PAID system.

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

To claim benefits

Use a completed direct reimbursement claim form to claim benefits for prescription drugs and supplies you purchased without your SAMBA/PAID identification card. You may obtain these forms by calling PAID at 1-800/222-7186. Service is available Monday through Friday 8:30 a.m. to 8:00 p.m., Eastern Time. Follow the instructions on the form and mail it to:

PAID Prescriptions, Inc.
P.O. Box 702
Parsippany, NJ 07054-0702

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

By mail

If your doctor orders more than a 30-day supply of drugs or covered supplies, up to a 90-day supply, you may order your prescription or refill by mail from the Merck-Medco Rx Services Program. Merck-Medco Rx Services will fill your prescription. All drugs and supplies listed above are covered under this Program.

Under the Merck-Medco Rx Services Program, if a generic equivalent to the prescribed drug is available, the pharmacy will dispense the generic equivalent instead of the name brand unless you request the name brand, or your doctor specifies that the name brand is required.

You pay a \$15 generic, \$25 name brand drug copayment for each prescription drug, supply or refill you purchase through the Merck-Medco Rx Services Program.

Prescription Drug Benefits *continued*

To claim benefits

The Plan will send you information on the Merck-Medco Rx Services Program. To use the Program:

- 1) ask your doctor to give you a new prescription for up to a 90-day supply of your regular medication plus refills, if appropriate;
- 2) complete the patient profile questionnaire the first time you order under the program; and
- 3) complete a mail order envelope, enclose your prescriptions, and mail them along with the required copayment (\$15 generic, \$25 name brand drug) for each prescription or refill to:

Merck-Medco Rx Services
P.O. Box 67006
Harrisburg, PA 17106-7006

As at your local pharmacy, if you request a name brand prescription but your doctor has not required it, Merck-Medco Rx Services will also charge you the difference in price between the name brand drug and its generic equivalent, and bill you for any balance due. This will be included with the delivery of your filled prescription. You must pay your share of the cost by check, money order, Visa, Discover or MasterCard (complete the space provided on the order envelope to use your charge card).

You will receive forms for refills and future prescription orders each time you receive drugs or supplies under this Program. In the meantime, if you have any questions about a particular drug or a prescription, and to request your first order forms, you may call toll-free: 1-800/283-3478. Service is available Monday through Friday, 8:00 a.m. to 12:00 midnight or Saturday, from 8:00 a.m. to 6:00 p.m., Eastern Time. Emergency pharmacy consultation is available 7 days a week, 24 hours a day; call 1-800/283-3478.

Coordinating with other drug coverage

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

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

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

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

How to Claim Benefits

Claim forms and identification cards

If you do not receive your identification card(s) within 60 days after the effective date of your enrollment, call the Carrier at 1-800/638-6589 (for TDD, use 301/984-4155) to report the delay. In the meantime, use your copy of the SF 2809 enrollment form or your annuitant confirmation letter from OPM as proof of enrollment when you obtain services. This is also the number to call for claim forms or advice on filing claims.

If you made your open season change by using Employee Express and have not received your new ID card by the effective date of your enrollment, call the Employee Express HELP number to request a confirmation letter. Use that letter to confirm your new coverage with providers.

How to file claims

Claims filed by your doctor that include an assignment of benefits to the doctor are to be filed on the form HCFA-1500, Health Insurance Claim Form. Claims submitted by enrollees may be submitted on the HCFA-1500 or a claim form that includes the information shown below. Bills and receipts should be itemized and show:

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

In addition:

- A copy of the explanation of benefits (EOB) from any primary payer (such as Medicare) must be sent with your claim.
- Bills for private duty nurses must show that the nurse is a registered or licensed practical nurse.
- Claims for rental or purchase of durable medical equipment, private duty nursing, and physical, occupational and speech therapy require a written statement from the doctor specifying the medical necessity for the service or supply and the length of time needed. Rental or purchase of durable medical equipment costing in excess of \$1,000 and private duty nursing care must be preauthorized by SAMBA. See pages 20 and 21.
- Claims for overseas (foreign) services should include an English translation. Charges should be converted to U.S. dollars using the exchange rate applicable at the time the expense was incurred. Send itemized bills for covered services provided by hospitals or doctors outside the United States to the address below.

Cancelled checks, cash register receipts or balance due statements are not acceptable.

After completing a claim form and attaching proper documentation, send claims except those for prescription drugs to:

SAMBA
11301 Old Georgetown Road
Rockville, MD 20852-2800

Call SAMBA at 1-800/638-6589 or 301/984-1440 if you have any questions about your claim. TDD line for hearing-impaired: 301/984-4155 (TDD equipment needed).

Prescription drug claims are addressed on pages 24 and 25.

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. The Carrier will not provide duplicate or year end statements.

Submit claims promptly

Claims for benefits should be made within 90 days after obtaining the service, or as soon thereafter as reasonably possible. Failure to file on a timely basis may invalidate your claim since this Plan will not pay benefits for claims submitted more than two (2) years from the date the expense is incurred unless timely filing was prevented by administrative operations of Government or legal incapacity, provided the claim was submitted as soon as reasonably possible.

How to Claim Benefits *continued*

Direct payment to hospital or provider of care

Benefits may be obtained by filing a claim so that this Plan can pay you, or by authorizing direct payment to the covered provider or the covered facility. You can authorize direct payment by completing the appropriate section of the claim form. The Plan reserves the right to make payment directly to you, and to decline to honor the assignment of payment of any health benefits claim to any person or party.

When more information is needed

Reply promptly when the Carrier requests information in connection with a claim. If you do not respond, the Carrier may delay processing or limit the benefits available.

Confidentiality

Medical and other information provided to the Carrier, including claim files, is kept confidential and will be used only: 1) by the Carrier and its subcontractors for internal administration of the Plan, coordination of benefit provisions with other plans, and subrogation of claims; 2) by law enforcement officials with authority to investigate and prosecute alleged civil or criminal actions; 3) by OPM to review a disputed claim or perform its contract administration functions; 4) by OPM and the General Accounting Office when conducting audits as required by the FEHB law; or 5) for bona fide medical research or education. Medical data that does not identify individual members may be disclosed as a result of the bona fide medical research or education. As part of its administration of the prescription drug benefits, the Plan may disclose information about a member's prescription drug utilization, including the names of prescribing physicians, to any treating physicians or dispensing pharmacies.

Disputed claims review

Reconsideration

If a claim for payment is denied by the Carrier, you must ask the Carrier, in writing and within six months of the date of the denial, to reconsider its decision before you request a review by OPM. (This time limit may be extended if you show you were prevented by circumstances beyond your control from making your request within the time limit.) OPM will not review your request unless you demonstrate that you gave the Carrier an opportunity to reconsider your claim. Before you ask the Carrier to reconsider, you should first check with your provider or facility to be sure that the claim was filed correctly. For instance, did they use the correct procedure code for the service(s) performed (surgery, laboratory test, X-ray, office visit, etc.)? Indicate any complications of any surgical procedure(s) performed. Include copies of an operative or procedure report, or other documentation that supports your claim. Your written request to the Carrier must state why, based on specific benefit provisions in this brochure, you believe the denied claim for payment should have been paid.

Within 30 days after receipt of your request for reconsideration, the Carrier must affirm the denial in writing to you, pay the claim, or request additional information that is reasonably necessary to make a determination. If the Carrier asks a provider for information it will send you a copy of this request at the same time. The Carrier has 30 days after receiving the information to give its decision. If this information is not supplied within 60 days, the Carrier will base its decision on the information it has on hand.

OPM review

If the Carrier affirms its denial, you have the right to request a review by OPM to determine whether the Carrier's actions are in accordance with the terms of its contract. You must request the review within 90 days after the date of the Carrier's letter affirming its initial denial.

You may also ask OPM for a review if the Carrier fails to respond within 30 days of your written request for reconsideration or 30 days after you have supplied additional information to the Carrier. In this case, OPM must receive a request for review within 120 days of your request to the Carrier for reconsideration or of the date you were notified that the Carrier needed additional information, either from you or from your doctor or hospital.

This right is available only to you or the executor of a deceased claimant's estate. Providers, legal counsel, and other interested parties may act as your representative only with your specific written consent to pursue payment of the disputed claim. OPM must receive a copy of your written consent with their request for review.

Your written request for an OPM review must state why, based on specific benefit provisions in this brochure, you believe the Carrier should have paid the denied claim. If the Carrier has reconsidered and denied more than one unrelated claim, clearly identify the documents for each claim.

How to Claim Benefits *continued*

Your request must include the following information or it will be returned by OPM:

- A copy of your letter to the Carrier requesting reconsideration;
- A copy of the Carrier's reconsideration decision (if the Carrier failed to respond, provide instead (a) the date of your request to the Carrier, or (b) the dates the Carrier requested and you provided additional information to the Carrier);
- Copies of documents that support your claim (such as doctors' letters, operative reports, bills, medical records, explanation of benefit (EOB) forms); and
- Your daytime phone number.

Medical documentation received from you or the Carrier during the review process becomes a permanent part of the disputed claim file, subject to the provisions of the Freedom of Information Act and the Privacy Act.

Send your request for review to: Office of Personnel Management, Office of Insurance Programs, Contracts Division II, P.O. Box 436, Washington, DC 20044.

You (or a person acting on your behalf) may not bring a lawsuit to recover benefits on a claim for treatment, services, supplies or drugs covered by this Plan until you have exhausted the OPM review procedure, established at section 890.105, title 5, Code of Federal Regulations (CFR). If OPM upholds the Carrier's decision on your claim, and you decide to bring a lawsuit based on the denial, the lawsuit must be brought no later than December 31 of the third year after the year in which the services or supplies upon which the claim is predicated were provided. Pursuant to section 890.107, title 5, CFR, such a lawsuit must be brought against the Office of Personnel Management in Federal court.

Federal law exclusively governs all claims for relief in a lawsuit that relates to this Plan's benefits or coverage or payments with respect to those benefits. Judicial action on such claims is limited to the record that was before OPM when it rendered its decision affirming the Carrier's denial of the benefit. The recovery in such a suit is limited to the amount of benefits in dispute.

Privacy Act statement — If you ask OPM to review a denial of a claim for payment or service, OPM is authorized by chapter 89 of title 5, U.S.C., to use the information collected from you and the Carrier to determine if the Carrier has acted properly in denying you the payment or service, and the information so collected may be disclosed to you and/or the Carrier in support of OPM's decision on the disputed claim.

Protection Against Catastrophic Costs

Catastrophic protection

For those services with coinsurance, the Plan pays **100%** of reasonable and customary charges for the remainder of the calendar year after out-of-pocket expenses for the deductibles and coinsurance in that calendar year exceed \$2,500 for one person or \$3,500 for you and any covered family members.

Out-of-pocket expenses for the purposes of this benefit are the \$300 non-PPO calendar year deductible, \$200 PPO calendar year deductible, \$200 hospital confinement deductible, \$20 copayment under PPO benefits and the coinsurance you pay for:

- Room and board and Other charges under Inpatient Hospital Benefits and Maternity Benefits;
- Surgical Benefits;
- Obstetrical and Outpatient care under Maternity Benefits; and
- Other Medical Benefits.

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

- The dental accident deductible;
- Expenses in excess of reasonable and customary charges or maximum benefit limitations;
- Coinsurance for durable medical equipment or private duty nursing not authorized (see pages 20 and 21);

Protection Against Catastrophic Costs *continued*

- Any amounts you pay because benefits have been reduced for non-compliance with this Plan's cost-containment requirements (see pages 29, 30 and 31);
- Copayments under Prescription Drug Benefits;
- The cost difference between a name brand drug and its generic equivalent;
- Any portion of the \$700 out-of-pocket expenses you pay for inpatient hospice care; and
- Coinsurance for expenses eligible under Mental Conditions/Substance Abuse Benefits.

Mental Conditions/ Substance Abuse Benefit

The Plan pays 100% of reasonable and customary charges for the remainder of the calendar year under Mental Conditions/Substance Abuse Benefits if out-of-pocket expenses for mental conditions/substance abuse treatment total \$4,000 for the covered person in that calendar year.

Carryover

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

Other Information

Precertification

Precertify before admission

Precertification does not guarantee benefit payments. Precertification of an inpatient admission is a predetermination that, based on the information given, the admission meets the medical necessity requirements of the Plan. **It is your responsibility to ensure that precertification is obtained.** If precertification is not obtained and benefits are otherwise payable, benefits for the admission will be reduced by \$500.

To precertify a scheduled admission:

- You, your representative, your doctor, or your hospital must call Prudential HealthCare (Prudential) or HealthCare COMPARE (COMPARE) prior to admission. If you live in the Washington, DC/Baltimore area, as defined on page 30, call Prudential at 1-800/648-4483 toll-free. If you live in the Tri-State area of New York, New Jersey and Connecticut, as defined on page 30, call Prudential at 1-800/422-7399 toll-free; call COMPARE from all other areas at 1-800/346-6755 toll-free. (You are not required to use Prudential or COMPARE for services received outside the United States; see page 30.)
- Provide the following information: enrollee's name and Plan identification number; patient's name, birth date and phone number; reason for hospitalization, proposed treatment or surgery; name of hospital or facility; name and phone number of admitting doctor; and number of planned days of confinement.

Prudential or COMPARE will then tell the doctor and hospital the number of approved days of confinement for the care of the patient's condition. Written confirmation of the Carrier's certification decision will be sent to you, your doctor, and the hospital.

Need additional days?

A review coordinator will contact your doctor before the certified length of stay ends to determine if you will be discharged on time or if additional inpatient days are medically necessary. If the admission is precertified but you remain confined beyond the number of days certified as medically necessary, the Plan will not pay for charges incurred on any extra days that are determined to not be medically necessary by the Carrier during the claim review.

Precertification *continued*

Prudential HealthCare PPO Service Areas

Washington, DC Metropolitan/Greater Baltimore area

Enrollees and their eligible family members who reside, work or are temporarily in the Washington, D.C. Metropolitan area, including the District of Columbia, the Maryland counties of Calvert, Charles, Frederick, Montgomery, Prince George's and St. Mary's, the Virginia counties of Arlington, Fairfax, Loudoun, Prince William, Spotsylvania and Stafford, and the cities of Alexandria, Fairfax, Falls Church, and Fredericksburg, and those in the Baltimore Metropolitan area including the city of Baltimore, and the Maryland counties of Anne Arundel, Baltimore, Carroll, Harford, and Howard, must use Prudential HealthCare, 1-800/648-4483, for precertification.

Tri-State Area of New York, New Jersey and Connecticut

Enrollees and their eligible family members who reside or work in the Tri-State area including the New York counties of Bronx, Dutchess, Kings (Brooklyn), Nassau, New York (Manhattan), Orange, Putnam, Queens, Richmond (Staten Island), Rockland, Suffolk, Ulster, and Westchester, the New Jersey counties of Atlantic, Bergen, Burlington, Camden, Cape May, Cumberland, Essex, Gloucester, Hudson, Hunterdon, Mercer, Middlesex, Monmouth, Morris, Ocean, Passaic, Salem, Somerset, Sussex, Union, Warren, and the Connecticut counties of Fairfield, Litchfield, New Haven, and New London, must use Prudential HealthCare, 1-800/422-7399 for precertification.

Affordable Networks Service Areas

Enrollees and their eligible family members (outside the Prudential HealthCare PPO Service Areas listed above) are eligible to use the Affordable Medical Networks PPOs.

Network utilization is of critical importance when securing access to managed care and the receipt of enhanced PPO Plan benefits. To maximize your benefits when Network access is available and to provide an alternative when access is not available contact the HealthCare COMPARE Managed Care InfoLine at 1-800/346-6755 and speak with a Referral Management Coordinator.

The Referral Management Coordinator will identify a Network primary care physician, if available, and assist you in locating Network providers when specialty care or services are necessary.

The Managed Care Advisor (MCA) Program

If it is determined at the time of the initial call that you do not have access to a Network primary care physician and a Network general acute care hospital, you will be given the option to join and participate in the Plan's Managed Care Advisor (MCA) Program described below.

This phone call will ensure you of the opportunity to reduce out-of-pocket expenses by receiving SAMBA's PPO level of benefits.

To determine eligibility and to join the MCA Program, call 1-800/346-6755 and speak with a Referral Management Coordinator who will help you select a primary care physician who will manage all of your medical needs. Your primary care physician will evaluate the need to see specialists or other providers. If your primary care physician recommends specialty care, you or your provider must contact a COMPARE Referral Management Coordinator at 1-800/346-6755 for a referral. Enrollees who join and comply with the requirements of the MCA Program will receive the Plan's enhanced PPO benefits.

You don't need to certify an admission when:

- Medicare Part A, or another group health insurance policy, is the primary payer for the hospital confinement (see page 32). Precertification is required, however, when Medicare hospital benefits are exhausted prior to using lifetime reserve days.
- You are confined in a hospital outside the United States.

Precertification *continued*

Maternity or emergency admissions

When there is an unscheduled maternity admission or an emergency admission due to a condition that puts the patient's life in danger or could cause serious damage to bodily function, you, your representative, the doctor, or the hospital must telephone Prudential or COMPARE within two business days following the day of admission, even if the patient has been discharged from the hospital. Otherwise, inpatient benefits otherwise payable for the admission will be reduced by \$500.

Prenatal care management

The precertification program will also provide maternity patients and their attending doctors with information that will assist in effective management of prenatal care. This service includes monitoring of prenatal care by a nurse, identifying potential risk factors and providing literature about important prenatal topics. To obtain this service, call the precertification number for your area when your pregnancy is confirmed. (This portion of the program is **not** available to maternity patients in the Prudential Service Areas unless they utilize Prudential HealthCare's Preferred Provider Organization.)

Newborns

Newborn confinements that extend beyond the mother's discharge date must also be certified. You, your representative, the doctor or hospital must request certification for the newborn's continued confinement within two business days following the day of the mother's discharge.

Organ/tissue transplants

The precertification process for organ transplants is more extensive than the normal precertification process. See page 15.

Other considerations

An early determination of need for confinement (precertification of the medical necessity of inpatient admission) is binding on the Carrier unless Prudential or COMPARE is misled by the information given to it. After the claim is received, the Carrier will first determine whether the admission was precertified and then provide benefits according to all of the terms of this brochure.

If you do not precertify

If precertification is not obtained before admission to the hospital (or within two business days following the day of a maternity or emergency admission or, in the case of a newborn, the mother's discharge), a medical necessity determination will be made at the time the claim is filed. If the Carrier determines that the hospitalization was not medically necessary the inpatient hospital benefits will not be paid. However, medical supplies and services otherwise payable on an outpatient basis will be paid.

If the claim review determines that the admission was medically necessary, any benefits payable according to all of the terms of this brochure will be reduced by \$500 for failing to have the admission precertified.

If the admission is determined to be medically necessary, but part of the length of stay was found not to be medically necessary, inpatient hospital benefits will not be paid for the portion of the confinement that was not medically necessary. However, medical services and supplies otherwise payable on an outpatient basis will be paid.

This Plan and Medicare

Coordinating benefits

The following information applies only to enrollees and covered family members who are entitled to benefits from both this Plan and Medicare. You must disclose information about Medicare coverage, including your enrollment in a Medicare prepaid plan, to this Carrier; this applies whether or not you file a claim under Medicare. You must also give this Carrier authorization to obtain information about benefits or services denied or paid by Medicare when they request it. It is also important that you inform the Carrier about other coverage you may have as this coverage may affect the primary/secondary status of this Plan and Medicare (see page 9).

This Plan covers most of the same kinds of expenses as Medicare Part A, hospital insurance, and Part B, medical insurance, except that Medicare does not cover prescription drugs.

This Plan and Medicare *continued*

The following rules apply to enrollees and their family members who are entitled to benefits from both an FEHB plan and Medicare.

This Plan is primary if:

- 1) You are age 65 or over, have Medicare Part A (or Parts A and B), and are employed by the Federal Government;
- 2) Your covered spouse is age 65 or over and has Medicare Part A (or Parts A and B) and you are employed by the Federal Government;
- 3) The patient (you or a covered family member) is within the first 30 months of eligibility to receive Medicare Part A benefits due to End Stage Renal Disease (ESRD) except when Medicare (based on age or disability) was the patient's primary payer on the day before he or she became eligible for Medicare Part A due to ESRD; or
- 4) The patient (you or a covered family member) is under age 65 and eligible for Medicare solely on the basis of disability, and you are employed by the Federal Government.

For purposes of this section, "employed by the Federal Government" means that you are eligible for FEHB coverage based on your current employment and that you do not hold an appointment described under Rule 6 of the following "Medicare is primary" section.

Medicare is primary if:

- 1) You are an annuitant age 65 or over, covered by Medicare Part A (or Parts A and B) and are not employed by the Federal Government;
- 2) Your covered spouse is age 65 or over and has Medicare Part A (or Parts A and B) and you are not employed by the Federal Government;
- 3) You are age 65 or over and (a) you are a Federal judge who retired under title 28, U.S.C., (b) you are a Tax Court judge who retired under Section 7447 of title 26, U.S.C., or (c) you are the covered spouse of a retired judge described in (a) or (b);
- 4) You are an annuitant not employed by the Federal Government, and either you or a covered family member (who may or may not be employed by the Federal Government) is under age 65 and eligible for Medicare on the basis of disability;
- 5) You are enrolled in Part B only, regardless of your employment status;
- 6) You are age 65 or over and employed by the Federal Government in an appointment that excludes similarly appointed nonretired employees from FEHB coverage, and have Medicare Part A (or Parts A and B);
- 7) You are a former Federal employee receiving workers' compensation and the Office of Workers Compensation has determined that you are unable to return to duty;
- 8) The patient (you or a covered family member) has completed the 30-month ESRD coordination period and is still eligible for Medicare due to ESRD; or
- 9) The patient (you or a covered family member) becomes eligible for Medicare due to ESRD after Medicare assumed primary payer status for the patient under rules 1) through 7) above.

When Medicare is primary

When Medicare is primary, this Plan will waive its precertification requirements. If you are enrolled in Medicare Part A and are hospitalized with the confinement covered by Medicare, you will be reimbursed for coinsurance and/or deductibles payable that calendar year under Inpatient Hospital Benefits, Surgical Benefits, Mental Conditions/Substance Abuse Benefits and Other Medical Benefits to the extent the Plan is reimbursed by Medicare for that hospitalization. If you are enrolled in Part B, your Plan deductibles and coinsurance will be waived as follows:

Inpatient Hospital Benefits: the Plan will waive the coinsurance and the \$200 per confinement deductible.

Surgical Benefits: the Plan will waive the deductibles and coinsurance.

Mental Conditions/Substance Abuse Benefits: the Plan will waive the deductibles and coinsurance.

Prescription Drugs: the prescription drug copayment is **not** waived.

Other Medical Benefits: the Plan will waive the deductibles and coinsurance.

When Medicare is the primary payer, this Plan will limit its payment to an amount that supplements the benefits that would be payable by Medicare, regardless of whether or not Medicare benefits are paid. However, the Plan will pay its 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.

When you also enroll in a Medicare prepaid plan

When you are enrolled in a Medicare prepaid plan while you are a member of this Plan, you may continue to obtain benefits from this Plan. If you submit claims for services covered by this Plan that you receive from providers that are not in the Medicare plan's network, the Plan will not waive any deductibles or coinsurance when paying these claims.

This Plan and Medicare *continued*

Medicare's payment and this Plan

If you are covered by Medicare Part B and it is primary, you should be aware that your out-of-pocket costs for services covered by both this Plan and Medicare Part B will depend on whether your doctor accepts Medicare assignment for the claim.

Doctors who participate with Medicare accept assignment; that is, they have agreed not to bill you for more than the **Medicare-approved amount** for covered services. Some doctors who do not participate with Medicare accept assignment on certain claims. If you use a doctor who accepts Medicare assignment for the claim, the doctor is permitted to bill you after the Plan has paid only when the Medicare and Plan payments combined do not total the Medicare-approved amount.

Doctors who do not participate with Medicare are not required to accept direct payment, or assignment, from Medicare. Although they can bill you for more than the amount Medicare would pay, Medicare law (the Social Security Act, 42 U.S.C.) sets a limit on how much you are obligated to pay. This amount, called the **limiting charge**, is 115 percent of the Medicare-approved amount. Under this law, if you use a doctor who does not accept assignment for the claim, the doctor is permitted to bill you after the Plan has paid **only** if the Medicare and Plan payments combined do not total the limiting charge. Neither you nor your FEHB Plan is liable for any amount in excess of the Medicare limiting charge for charges of a doctor who does not participate with Medicare. **The Medicare explanation of benefits (EOB) form will have more information about this limit.**

If your doctor does not participate with Medicare, asks you to pay more than the limiting charge **and** he or she is under contract with this Plan, call the Plan. If your doctor is **not** a Plan doctor, ask the doctor to reduce the charge or report him or her to the Medicare carrier that sent you the Medicare EOB form. In any case, a doctor who does not participate with Medicare is not entitled to payment of more than 115 percent of the Medicare-approved amount.

How to claim benefits

In most cases, when services are covered by both Medicare and this Plan, Medicare is the primary payer if you are an annuitant and this Plan is the primary payer if you are an employee. When Medicare is the primary payer, your claims should first be submitted to Medicare. The Carrier has contracted with most Medicare Part B claims processors (also known as carriers) to receive electronic copies of your claims after Medicare has paid their benefits. This means you do not need to submit your Part B claims to this Carrier. You may call the Carrier at 1-800/638-6589 (TDD, use 301/984-4155) to find out if your claims are being filed electronically. If they are not, you should initially submit your claims to Medicare. After Medicare has paid its benefits, the Carrier will consider the balance of any covered expenses. To be sure your claims are processed by this Carrier, you must submit the EOB form from Medicare and duplicates of all bills along with a completed claim form. The Carrier will not process your claim without knowing whether you have Medicare and, if you do, without receiving the Medicare EOB.

Enrollment Information

If you are a new member

Use this brochure as a guide to coverage and obtaining benefits. There may be a delay before you receive your identification card and member information from the Carrier. Until you receive your ID card, you may show your copy of the SF 2809 enrollment form or your annuitant confirmation letter from OPM to a provider as proof of enrollment in this Plan. If you do not receive your ID card within 60 days after the effective date of your enrollment, you should contact the Carrier. See "How to claim benefits" on page 26.

If you made your open season change by using Employee Express and have not received your new ID card by the effective date of your enrollment, call the Employee Express HELP number to request a confirmation letter. Use that letter to confirm your new coverage with Plan providers.

If you are a new member of this Plan, benefits and rates begin on the effective date of your enrollment, as set by your employing office or retirement system (see *Effective date* on page 37). Coverage under your new plan for a hospitalized member may be delayed if you are currently enrolled in another FEHB plan and you or a covered family member are hospitalized on the effective date of your enrollment; see *If you are hospitalized* on page 34.

No FEHB plan may refuse to provide benefits for any condition you or a covered family member may have solely on the basis that it was a condition that existed before you enrolled in a plan under the FEHB Program.

Enrollment Information *continued*

If you are hospitalized

If you change plans or options, benefits under your prior plan or option cease on the effective date of your enrollment in your new plan or option, unless you or a covered family member are confined in a hospital or other covered facility or are receiving medical care in an alternative care setting on the last day of your enrollment under the prior plan or option. In that case, the confined person will continue to receive benefits under the former plan or option until the earliest of (1) the day the person is discharged from the hospital or other covered facility (a move to an alternative care setting does not constitute a discharge under this provision), or (2) the day after the day all inpatient benefits have been exhausted under the prior plan or option, or (3) the 92nd day after the last day of coverage under the prior plan or option. However, benefits for other family members under the new plan will begin on the effective date. If your plan terminates participation in the FEHB Program in whole or in part, or if the Associate Director for Retirement and Insurance orders an enrollment change, this continuation of coverage provision does not apply; in such case, the hospitalized family member's benefits under the new plan begin on the effective date of enrollment.

Your responsibility

It is your responsibility to be informed about your health benefits. Your employing office or retirement system can provide information about when you may change your enrollment; who "family members" are; what happens when you transfer, go on leave without pay, enter military service, or retire; when your enrollment terminates; and the next open season for enrollment. Your employing office or retirement system will also make available to you an FEHB Guide, brochures and other materials you need to make an informed decision.

Things to keep in mind

- The benefits in this brochure are effective on January 1 for those already enrolled in this Plan. If you changed plans or plan options, see "If you are a new member" on page 33. In both cases, however, the Plan's new rates are effective the first day of the enrollee's first full pay period that begins on or after January 1 (January 1 for all annuitants).
- Generally, you must be continuously enrolled in the FEHB Program for the last five years before you retire to continue your enrollment for you and any eligible family members after you retire.
- The FEHB Program provides Self Only coverage for the enrollee alone or Self and Family coverage for the enrollee, his or her spouse, and unmarried dependent children under age 22. Under certain circumstances, coverage will also be provided under a family enrollment for a disabled child 22 years of age or older who is incapable of self-support.
- An enrollee with Self Only coverage who is expecting a baby or the addition of a child may change to a Self and Family enrollment up to 60 days after the birth or addition. The effective date of the enrollment change is the first day of the pay period in which the child was born or became an eligible family member. The enrollee is responsible for his or her share of the Self and Family premium for that time period.
- You will not be informed by your employing office (or your retirement system) or your Carrier when a family member loses eligibility.
- You must direct questions about enrollment and eligibility, including whether a dependent age 22 or older is eligible for coverage, to your employing office or retirement system. The Carrier does not determine eligibility and cannot change an enrollment status without the necessary information from the employing agency or retirement system.
- An employee, annuitant, or family member enrolled in one FEHB plan is not entitled to receive benefits under any other FEHB plan.
- Report additions and deletions (including divorces) of covered family members to the Carrier promptly.
- If you are an annuitant or former spouse with FEHB coverage and you are also covered by Medicare Part B, you may drop your FEHB coverage and enroll in a Medicare prepaid plan when one is available in your area. If you later change your mind and want to reenroll in FEHB, you may do so at the next open season, or whenever you involuntarily lose coverage in the Medicare prepaid plan or move out of the area it serves.
Most Federal annuitants have Medicare Part A. If you do not have Medicare Part A, you may enroll in a Medicare prepaid plan, but you will probably have to pay for hospital coverage in addition to the Part B premium. **Before** you join the plan, ask whether they will provide hospital benefits and, if so, what you will have to pay.

Enrollment Information *continued*

You may also remain enrolled in this Plan when you join a Medicare prepaid plan. See page 32 for how this Plan's benefits are affected when you are enrolled in a Medicare prepaid plan.

Contact your local Social Security Administration (SSA) office for information on local Medicare plans (also known as Coordinated Care Plans or Medicare HMOs) or request it from SSA at 1-800-638-6833. Contact your retirement system for information on dropping your FEHB enrollment and changing to a Medicare prepaid plan.

- Federal annuitants are not required to enroll in Medicare Part B (or Part A) in order to be covered under the FEHB Program nor are their FEHB benefits reduced if they do not have Medicare Part B (or Part A).

Coverage after enrollment ends

When an employee's enrollment terminates because of separation from Federal service or when a family member is no longer eligible for coverage under an employee or annuitant enrollment, and the person is not otherwise eligible for FEHB coverage, he or she will generally be eligible for a free 31-day extension of coverage. The employee or family member may also be eligible for one of the following:

Former spouse coverage

When a Federal employee or annuitant divorces, the former spouse may be eligible to elect coverage under the spouse equity law. If you are recently divorced or anticipate divorcing, contact the employee's employing office (personnel office) or retiree's retirement system to get more facts about electing coverage.

Temporary continuation of coverage (TCC)

If you are an employee whose enrollment is terminated because you separate from service, you may be eligible to temporarily continue your health benefits coverage under the FEHB Program in any plan for which you are eligible. Ask your employing office for RI 79-27, which describes TCC, and for RI 70-5, the FEHB Guide for individuals eligible for TCC. Unless you are separated for gross misconduct, TCC is available to you if you are not otherwise eligible for continued coverage under the Program. For example, you are eligible for TCC when you retire if you are unable to meet the five-year enrollment requirement for continuation of enrollment after retirement.

Your TCC begins after the initial free 31-day extension of coverage ends and continues for up to 18 months after your separation from service (that is, if you use TCC until it expires 18 months following separation, you will only pay for 17 months of coverage). Generally, you must pay the total premium (both the Government and employee shares) plus a 2 percent administrative charge. If you use your TCC until it expires, you are entitled to another free 31-day extension of coverage when you may convert to nongroup coverage. If you cancel your TCC or stop paying premiums, the free 31-day extension of coverage and conversion option are not available.

Children or former spouses who lose eligibility for coverage because they no longer qualify as family members (and who are not eligible for benefits under the FEHB Program as employees or under the spouse equity law) also may qualify for TCC. They also must pay the total premium plus the 2 percent administrative charge. TCC for former family members continues for up to 36 months after the qualifying event occurs, for example the child reaches age 22 or the date of the divorce. This includes the free 31-day extension of coverage. When their TCC ends (except by cancellation or nonpayment of premium), they are entitled to another free 31-day extension of coverage when they may convert to nongroup coverage.

NOTE: If there is a delay in processing the TCC enrollment, the effective date of the enrollment is still the 32nd day after regular coverage ends. The TCC enrollee is responsible for premium payments retroactive to the effective date and coverage may not exceed the 18 or 36 month period noted above.

Notification and election requirements:

- **Separating employees** — Within 61 days after an employee's enrollment terminates because of separation from service, his or her employing office must notify the employee of the opportunity to elect TCC. The employee has 60 days after separation (or after receiving the notice from the employing office, if later) to elect TCC.

Enrollment Information *continued*

- **Children** — You must notify your employing office or retirement system when a child becomes eligible for TCC within 60 days after the qualifying event occurs, for example the child reaches age 22 or marries.
- **Former spouses** — You or your former spouse must notify the employing office or retirement system of the former spouse's eligibility for TCC within 60 days after the termination of the marriage. A former spouse may also qualify for TCC if, during the 36-month period of TCC eligibility, he or she loses spouse equity eligibility because of remarriage before age 55 or loss of the qualifying court order. This applies even if he or she did not elect TCC while waiting for spouse equity coverage to begin. The former spouse must contact the employing office within 60 days of losing spouse equity eligibility to apply for the remaining months of TCC to which he or she is entitled.

The employing office or retirement system has 14 days after receiving notice from you or the former spouse to notify the child or the former spouse of his or her rights under TCC. If a child wants TCC, he or she must elect it within 60 days after the date of the qualifying event (or after receiving the notice, if later). If a former spouse wants TCC, he or she must elect it within 60 days after any of the following events: the date of the qualifying event or the date he or she receives the notice, whichever is later; or the date he or she loses coverage under the spouse equity law because of remarriage before age 55 or loss of the qualifying court order.

Important: The employing office or retirement system must be notified of a child's or former spouse's eligibility for TCC within the 60-day time limit. If the employing office or retirement system is not notified, the opportunity to elect TCC ends 60 days after the qualifying event in the case of a child and 60 days after the change in status in the case of a former spouse.

Conversion to individual coverage

When none of the above choices is available — or chosen — when coverage as an employee or family member ends, or when TCC coverage ends (except by cancellation or nonpayment of premium), you may be eligible to convert to an individual, nongroup contract. You will not be required to provide evidence of good health and the plan is not permitted to impose a waiting period or limit coverage for preexisting conditions. If you wish to convert to an individual contract, you must apply in writing to the carrier of the plan in which you are enrolled within 31 days after receiving notice of the conversion right from your employing agency. A family member must apply to convert within the 31-day free extension of coverage that follows the event that terminates coverage, e.g., divorce or reaching age 22. Benefits and rates under the individual contract may differ from those under the FEHB Program.

Definitions

Accidental injury

An injury caused by an external force or element such as a blow or fall and that requires immediate medical attention. Also included are animal bites and poisonings. Dental care required as a result of an accidental bodily injury is dental treatment necessary to repair an accidental injury to sound, natural teeth. An injury to the 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 the Carrier to issue payment of benefits directly to the provider. The Carrier reserves the right to pay the member directly for all covered services.

Calendar year

January 1 through December 31 of the same year. For new enrollees, the calendar year begins on the effective date of their enrollment and ends on December 31 of the same year.

Confinement

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

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

Definitions *continued*

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 Other Medical Benefits (see page 20).

Cosmetic surgery

Any operative procedure or any portion of a procedure performed primarily to improve physical appearance and/or treat a mental condition through change in bodily form.

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 special diets;
- 3) moving the patient;
- 4) acting as companion or sitter;
- 5) supervising medication that can usually be self administered; or
- 6) treatment or services that any person may be able to perform with minimal instruction, including but not limited to recording temperature, pulse, and respirations, or administration and monitoring of feeding systems.

The Carrier determines which services are custodial care.

Durable medical equipment

Equipment and supplies that:

- 1) are prescribed by your attending doctor;
- 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.

Effective date

The date the benefits described in this brochure are effective:

- 1) January 1 for continuing enrollments and for all annuitant enrollments;
- 2) the first day of the first full pay period of the new year for enrollees who change plans or options or elect FEHB coverage during the open season for the first time; or
- 3) for new enrollees during the calendar year, but not during the open season, the effective date of enrollment as determined by the employing office or retirement system.

Experimental or investigational drug, device and medical treatment or procedure

A drug, device or medical treatment or procedure is experimental or investigational:

- 1) if the drug or device cannot be lawfully marketed without approval of the U.S. Food and Drug Administration and approval for marketing has not been given at the time the drug or device is furnished; or
- 2) if reliable evidence shows that the drug, device or medical treatment or procedure 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
- 3) if reliable evidence shows that the consensus of opinion among experts regarding the drug, device 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.

Definitions *continued*

Group health coverage

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

Home health care agency

An agency or organization that provides a program of home health care which meets all of the following requirements:

- 1) it is certified by the patient's doctor as an appropriate provider of home health services
- 2) it has a full-time administrator
- 3) it maintains written records of services provided to the patient; and
- 4) either its staff includes at least one registered graduate nurse (R.N.) or nursing care by a registered graduate nurse (R.N.) is available to it.

Home health care plan

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

Hospice care program

A formal program directed by a doctor to help care for a terminally ill person. This may be through either:

- 1) a centrally administered, medically directed and nurse-coordinated program that provides a coherent system primarily of home care, uses a hospice team of professional and volunteer workers and is available 24 hours a day, 7 days a week; or
- 2) confinement in a facility that operates as an integral part of the program to provide short periods of stay in a homelike setting for direct care or respite.

Terminally ill person

A covered family member whose life expectancy is six months or less, as certified by the primary attending doctor.

Hospice team

A team of professionals and volunteer workers who provide care to: (1) reduce or abate pain or other symptoms of mental or physical distress; (2) meet the special needs arising out of the stresses of the terminal illness, dying and bereavement. The team must include at least a doctor and registered graduate nurse. The team may include one or more of the following: a social worker; a clergyman/counselor; volunteers; a clinical psychologist; a physiotherapist; an occupational-therapist.

Medical emergency

The sudden and unexpected onset of a condition requiring immediate non-surgical medical care in a hospital emergency room. The severity of the condition, as revealed by the doctor's diagnosis, must be such as would normally require emergency care. Medical emergencies include heart attacks, cardiovascular accidents, poisonings, loss of consciousness or respiration, convulsions, and such other similarly acute conditions as may be determined by the Plan to be medical emergencies.

Medically necessary

Services, drugs, supplies or equipment provided by a hospital or covered provider of health care services that the Carrier determines:

- 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.

Definitions *continued*

Mental conditions/ substance abuse

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

Reasonable and customary

This Plan's payment of your claim begins with determining the reasonable and customary charge appropriate for the procedure covered by your claim. Claims data and fee information are gathered for specific geographic areas by Medical Data Research (MDR) and updated semi-annually. By analyzing the fee information the Plan knows how much other providers in your area charge for the procedure. The Plan then sets a benchmark or "percentile" at the highest dollar amount it considers reasonable and customary for the procedure. An 80th percentile factor means that at least 80 percent of the fee information that was analyzed was at or below the benchmark charge. The Carrier determines reasonable and customary charges for surgery, anesthesia, X-ray and laboratory tests, doctors' visits and other professional services. Surgery and anesthesia charges are reimbursed at the 80th percentile. X-ray and laboratory tests, doctors' visits and other professional services are reimbursed based on the 90th percentile provided by MDR. Prudential HealthCare, acting in its capacity as medical consultant to the Plan, may rely on claims data and fee information gathered and analyzed independently of MDR.

Sound, natural tooth

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.

Surgical procedure

Cutting, suturing, treating burns, correcting a fracture, reducing a dislocation, manipulating a joint under general anesthesia, electrocauterizing, tapping (paracentesis), applying plaster casts, administering pneumothorax, endoscopy or injecting sclerosing solution.

Non-FEHB Benefits Available to Plan Members

The benefits described on this page are neither offered nor guaranteed under the contract with the FEHB Program, but are made available to all enrollees and family members of this Plan. The cost of the benefits described on this page is not included in the FEHB premium and any charges for these services do not count toward any FEHB deductibles, out-of-pocket maximum copay charges, etc. These benefits are not subject to the FEHB disputed claims review procedure.

SAMBA Supplemental Insurance Plans

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

Group Term Life

Group Term Life Insurance protection is available for all SAMBA members, their spouses, and dependent children. The basic Group Term Life Insurance protection for members is based upon the GS classification, ranging from \$75,000 for GS 5 and below to \$230,000 for SES. Premiums are based strictly on the member's grade classification rather than age. The benefit doubles in the event of a covered accidental death plus an additional **50%** of the original amount if the member is killed in the line of duty.

Supplemental Group Term Life

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

Direct Recognition Life Plan

SAMBA offers a group-rated, individually issued policy issued in units of \$100,000. The policy provides permanent coverage and is available to active and retired members ages 40 through 60. A similar policy in the amount of \$50,000 is also available to a surviving spouse or the spouse of a member who has been issued a Direct Recognition Life Policy.

Disability Income Protection

The Disability Income Protection Plan, specially designed to fill in the gaps that exist in both the CSRS and FERS, provides four types of coverage.

Hospital Income Protection

For each covered day hospitalized, the member or spouse will receive **70%** of the member's insured daily earnings. Thirty-five percent (**35%**) is paid for dependent children. Benefit payment continues for up to 60 days of each covered hospital confinement.

Long Term Disability

If a member becomes totally disabled and cannot work for more than 60 days, the Plan will pay up to **65%** of the insured monthly salary until age 62 if covered under FERS or age 65 if covered under CSRS. Of course, this will be in combination with any disability awards from certain other sources including CSRS or FERS.

Pension Supplement

SAMBA's Disability Income Protection Plan offers a unique benefit that replaces the pension credits lost because of disability. This benefit credit is equal to **2%** of the insured salary for each year disabled.

Survivor's Benefit

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

Personal Accident Insurance

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

Long Term Care

Unique to SAMBA's benefit package is a program to provide long term care coverage for members, spouses, parents, and parents-in-law. Benefits are payable for nursing homes, home health care, adult day care, and respite care.

Professional Liability and Legal Services

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

Dental/Vision

SAMBA offers a very comprehensive Dental/Vision Care Plan.

Dependent Children Health Benefit Plan

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

Benefits on this page are not part of the FEHB Contract

How SAMBA Changes January 1998

Do not rely on this page; it is not an official statement of benefits.

Program-wide changes

This year, the Office of Personnel Management (OPM) instituted minimum benefit levels in all plans for normal deliveries (48 hours of inpatient care), caesarean sections (96 hours of inpatient care), and mastectomies (48 hours of inpatient care). See pages 13 and 16 for this Plan's benefits.

North Dakota will not be included among the states designated as medically underserved in 1998. If you live in North Dakota this may affect your choice of provider. See page 6 for information on medically underserved areas.

Members who are eligible for Medicare Part A benefits for the treatment of End Stage Renal Disease (ESRD) will now be covered by this Plan for the first 30 months of eligibility before Medicare coverage begins. Prior to enactment of the Balanced Budget Act of 1997, Medicare picked up these benefits after 18 months.

Changes to this Plan

Non-PPO benefits have been reduced from **80%** to **70%** for Other Medical Benefits, Surgical Benefits, Maternity Benefits, Inpatient Hospital Benefits, and Mental Conditions/Substance Abuse Benefits, and from **100%** to **70%** for Room and board charges under Mental Conditions/Substance Abuse Benefits.

The annual catastrophic protection out-of-pocket limit has been increased from \$1,000 to \$2,500 per person and from \$2,000 to \$3,500 per family. The Plan's deductibles (\$300 non-PPO calendar year deductible, \$200 PPO calendar year deductible, and the \$200 per confinement deductible) are now included in the out-of-pocket expenses used to satisfy the catastrophic protection limit.

PPO benefits have been reduced from **100%** to **95%** and include a \$200 per person, \$400 per family calendar year deductible (which may also be used to satisfy the \$300 per person, \$600 per family non-PPO deductible) in all benefit categories, except Hospital Room and board, office visits and consultations, and accidental injury to sound natural teeth (which is subject to a \$100 per person, per accident deductible).

The PPO copayment for office visits and consultations under Other Medical Benefits and Mental Conditions/Substance Abuse Benefits has been increased from \$10 to \$20. (After the \$20 copayment, services rendered by the doctor in conjunction with an office visit remains payable at **100%**.)

There is now a \$200 deductible per hospital confinement (which applies toward your catastrophic protection out-of-pocket limit).

Radiation and chemotherapy is now covered under Other Medical Benefits. After satisfaction of the calendar year deductible, the Plan pays **95%** PPO benefits and **70%** non-PPO benefits. Previously, Radiation and chemotherapy was covered under Additional Benefits at **100%** with no deductible.

Under Mental Conditions/Substance Abuse Benefits the \$75,000 calendar year maximum has been eliminated.

Under Mental Conditions/Substance Abuse Benefits the annual catastrophic protection out-of-pocket has been reduced from \$5,000 to \$4,000.

Benefits have been increased from **80%** to **95%** for the inpatient services of non-PPO anesthesiologists, radiologists or pathologists when an Affordable Network hospital is used.

Under the Prescription Drug Benefits you pay a \$15 generic, \$25 name brand drug copayment for each prescription purchased at a retail pharmacy and through the mail order program. Previously you paid a copayment of \$15 at a retail pharmacy and \$10 through the mail order program.

Oral and maxillofacial surgery benefits under Surgical Benefits has been reduced to include only those procedures listed on page 13. Benefits have been reduced from **75%** to **70%** for non-PPO benefits and from **100%** to **95%** for PPO benefits, subject to the calendar year deductibles.

Summary of Benefits for SAMBA Health Benefit Plan - 1998

Do not rely on this chart alone. All benefits are subject to the definitions, limitations, and exclusions set forth in the brochure. This chart merely summarizes certain important expenses covered by the Plan. If you wish to enroll or change your enrollment in this Plan, be sure to indicate the correct enrollment code on your enrollment form (codes appear on the cover of this brochure). All items below with an asterisk (*) are subject to the \$300 non-PPO calendar year deductible. Those items designated with a (+) are subject to the \$200 PPO calendar year deductible.

Benefits		Plan pays/provides	Page
Inpatient care	Hospital	Non-PPO benefit: After a \$200 per confinement deductible, 70% for semiprivate Room and board and Other hospital charges.....	12
		PPO benefit: After a \$200 per confinement deductible, 100% of Room and board and 95% of Other hospital charges	
	Surgical	Non-PPO benefit: 70%* of reasonable and customary charges.....	13, 14 and 15
		PPO benefit: 95%+ of covered surgical charges	
	Medical	Non-PPO benefit: 70%* of reasonable and customary charges.....	20, 21 and 22
	PPO benefit: 95%+ of covered charges		
	Maternity	Same as for illness or injury.....	16
	Mental Conditions/ Substance Abuse	Non-PPO benefit: After a \$200 per confinement deductible, 70% for semiprivate Room and board and Other hospital charges, and inpatient visits (deductible applies).....	18 and 19
		PPO benefit: After a \$200 per confinement deductible, 100% for semiprivate Room and board and 95% of Other hospital charges. Inpatient visits 95%+	
Outpatient care	Hospital	Non-PPO benefit: 70%* of reasonable and customary charges for charges not covered or not fully covered under Inpatient Hospital Benefits.....	20 and 21
		PPO benefit: 95%+ of covered charges	
	Surgical	Non-PPO benefit: 70%* of reasonable and customary charges.....	13, 14 and 15
		PPO benefit: 95%+ of covered surgical charges	
	Medical	Non-PPO benefit: 70%* of reasonable and customary charges.....	20, 21 and 22
		PPO benefit: 95%+ , (100% after a \$20 copayment for doctor visits and consultations)	
	Maternity	Same as for illness or injury.....	16 and 17
	Home Health Care	100% of reasonable and customary charges for up to 100 visits per calendar year	23
	Mental Conditions/ Substance Abuse	Non-PPO benefit: 50%* of covered charges up to a maximum of \$100 per visit and up to 50 visits per calendar year.....	18 and 19
		PPO benefit: Plan pays 95% of covered expenses	
Emergency care (accidental injury)		100% of reasonable and customary charges for covered expenses for accidental injury treatment within 72 hours of an accident.....	23
Prescription drugs		Mail order and prescription card program: After a \$15 (generic) \$25 (name brand) copayment through the mail order service, or at the local participating pharmacy, Plan pays 100% of covered charges in excess of copayment per prescription except when a name brand drug is requested when a generic equivalent is available. Then you pay the difference in cost plus the copayment.....	24 and 25
Dental care		After a \$100 deductible per person, per accident, 75% of reasonable and customary charges for treatment of accidental injury to sound, natural teeth.....	14
Additional benefits		Hospice care; skilled nursing facility; childhood immunizations.....	23
Protection against catastrophic costs		100% of covered charges after out-of-pocket expenses for Surgical, Maternity, Other Medical Benefits and Room and board, and Other charges under Inpatient Hospital Benefits, exceed \$2,500 per person (\$3,500 per family) per calendar year	28 and 29
	Mental Conditions/ Substance Abuse	After the \$300 calendar year deductible when eligible out-of-pocket expenses under the Mental Condition/Substance Abuse Benefits total \$4,000 in a calendar year, the Plan then pays 100% of such covered expenses for the remainder of that calendar year.....	18 and 19