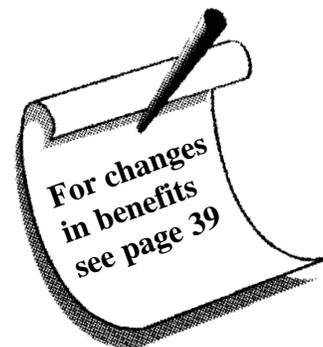




SAMBA Health Benefit Plan

1997

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), and the Offices, Boards and Divisions of the Department of Justice (OBD).

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, 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

Authorized for distribution by the:



United States
Office of
Personnel
Management



RI 72-6

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, 1997 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 1997 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 1998 or later years, and does not have a right to benefits available prior to 1997 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.

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.

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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 PPO's, 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 27, 28 and 29 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 1997, the States designated as medically underserved are: Alabama, Louisiana, Mississippi, New Mexico, North Dakota, 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 PPO’s 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.

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 HealthCareSM PPO Network. Subject to the Plan’s definitions, limitations and exclusions, the Plan pays 100% of covered charges with no deductible after a copayment of \$10 for office visits and consultations 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 28.

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 100% of covered charges with no deductible after a copayment of \$10 for office visits and consultations 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 28. 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 of 100% coverage with no deductible after a \$10 copayment for office visits and consultations (subject to the Plan's definitions, limitations, and exclusions); see page 28.

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 is \$300 per person per calendar year. 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 deductible. 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.

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 \$300 per person. 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 \$600 during a calendar year.

Coinsurance

Coinsurance is the stated percentage of covered charges you must pay after you have met any applicable deductible. For instance, when a Plan pays 80% of reasonable and customary charges for a covered service, you are responsible for 20% 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 80% of the allowance (\$76). You must pay the 20% coinsurance (\$19), plus the difference between the actual charge and the reasonable and customary allowance (\$5), for a total member responsibility of \$24. Remember, if you use a Network provider in one of the Plan's PPO Networks, benefits are available at 100% with no deductible after a copayment of \$10 per visit.

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 20% coinsurance, the actual charge is \$80. The Plan will pay \$64 (80% of the actual charge of \$80).

Copayments

A copayment is the stated amount the Plan may require you to pay for a covered service, such as \$10 per prescription by mail or \$10 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 once per lifetime.

Benefits for reconstruction of the bone that surrounds and supports the teeth under the Oral and Maxillofacial Surgery Benefit are limited to a lifetime maximum of \$5,000.

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 29 and 30 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 Program (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 1998 or later years, and does not have a right to benefits available prior to 1997 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 more for covered services than 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.

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 80% of the Medicare-approved amount. You will only be responsible for any deductible and coinsurance equal to 20% 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 that a provider who does not participate with Medicare is legally permitted to bill under Medicare law (115% of the Medicare-approved amount).

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.

General Limitations *continued*

The Carrier's explanation of benefits (EOB) will tell you how much the hospital or physician can charge you in addition to what the Plan paid. If you are billed more than the hospital or physician is allowed to charge, ask the hospital or 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, ask the Carrier for guidance.

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 page 10), doctor charges exceeding the amount specified by the Department of Health and Human Services when benefits are payable under Medicare (limiting charge) (see page 31), 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 19
- 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 35
- 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 27, 28 and 29 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 30.
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 in full.
Other charges	<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• Doctors' and hospital charges for services performed in the outpatient department of a hospital during a medical emergency• Local professional ambulance service to and from a hospital
Non-PPO benefit	The Plan pays 80% of covered Room and board and Other charges.
PPO benefit	<p>Prudential HealthCare PPO – Plan pays 100% of covered Room and board and Other charges when services are authorized by a Network primary care doctor.</p> <p>Affordable – Plan pays 100% of covered Room and board and Other charges made by the hospital 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 27, 28 and 29.
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	<ul style="list-style-type: none">• 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 <p>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 page 7).</p>

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 (chiropractist) 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 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

Charges made for the administration of anesthesia when not otherwise payable under Inpatient Hospital Benefits, or Oral and Maxillofacial surgery under Surgical 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.

Non-PPO benefit

After the \$300 calendar year deductible, the Plan pays **80%** of reasonable and customary charges for the above services and supplies.

PPO benefit

Prudential HealthCare PPO — Plan pays **100%** of covered charges with no deductible when services are provided or authorized by a Network primary care doctor.

Affordable — Plan pays **100%** of covered charges with no deductible when services are provided by a Network hospital or other Network provider.

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 and lifetime maximum:

- removal of stones from salivary ducts
- removal of erupted teeth
- simple extractions
- freeing of muscle attachments
- excision of impacted teeth, bony cysts of the jaw, torus palatinus, leukoplakia, or malignant tissue

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 page 7).

Surgical Benefits *continued*

- removal of all or part of the tooth root or diseased tissue from the top of the root
- revision, removal or repositioning of soft, bony or muscle tissues
- root canal therapy (not the subsequent temporary or permanent restoration)
- reconstruction of the bone that surrounds and supports the teeth (limited to \$5,000 per person per lifetime)
- removal of inflamed or irritated tissues
- incision and drainage of abscesses
- removal of diseased gum tissue that surrounds the teeth
- scaling of teeth and root planing

Non-PPO benefit

The Plan pays **75%** of reasonable and customary charges for the above services.

PPO benefit

Prudential HealthCare PPO — Plan pays **100%** of covered charges when services listed above are provided or authorized by a Network primary care doctor

Affordable — Plan pays **100%** of covered charges when services listed above are provided by a 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 34 and 37.

Non-PPO benefit

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

PPO benefit

Prudential HealthCare PPO — Plan pays **100%** of covered charges with no deductible when services are provided or authorized by a Network Primary care doctor.

Affordable — Plan pays **100%** of covered charges with no deductible 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 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 page 7).

Surgical Benefits *continued*

- 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*).

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 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 benefits

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.

Oral and maxillofacial surgery

Reconstruction of bone that surrounds and supports the teeth is limited to \$5,000 per person per lifetime.

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.

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.

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 27, 28 and 29 for details.

Room and board

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

Plan pays **80%** of covered Room and board and Other charges.

PPO benefit

Prudential HealthCare PPO — Plan pays **100%** of covered Room and board and Other charges when services are authorized by a Network primary care doctor.

Affordable — Plan pays **100%** of covered Room and board and Other charges made by the hospital 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 **80%** of Outpatient care and Obstetrical care covered charges.

PPO benefit

Prudential HealthCare PPO — Plan pays **100%**, with no deductible, of Outpatient care covered charges and Obstetrical care when services are authorized by a Network primary care doctor.

Affordable — Plan pays **100%**, with no deductible, 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.

Prenatal monitoring

Services to monitor prenatal care and identify risk factors are available through the Plan's precertification program; see page 29.

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 page 7).

Maternity Benefits *continued*

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	<ul style="list-style-type: none">• 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.

Mental Conditions/Substance Abuse Benefits

What is covered	The Plan pays for the following services subject to a calendar year maximum of \$75,000 per person.
Inpatient care	Covered hospital and rehabilitation facility charges include: <ul style="list-style-type: none">• 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 27, 28 and 29 for details.
Non-PPO benefit	Plan pays 100% of room and board charges and 80% of covered Other charges made by the hospital or rehabilitation facility. After the \$300 calendar year deductible, Plan pays 80% of charges for doctors' inpatient visits.
PPO benefit	Prudential HealthCare PPO — Plan pays 100% of all covered charges, with no deductible, when services are authorized by a Network primary care doctor.

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 page 7).

Mental Conditions/Substance Abuse Benefits *continued*

Affordable — Plan pays **100%**, with no deductible, of Room and board and Other charges made by the hospital or rehabilitation facility and for inpatient visits when a Network provider is used. Other inpatient care must be provided by an Affordable Network provider to qualify for PPO benefits.

Catastrophic protection

After the \$300 calendar year deductible is satisfied, when eligible out-of-pocket expenses under the Mental Conditions/Substance Abuse Benefits total \$5,000 per person in a calendar year, the Plan then pays **100%** of covered expenses for the remainder of that calendar year for that person up to the \$75,000 calendar year maximum.

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 \$10 for each office visit and consultation for services provided or authorized by a Network primary care doctor.

Affordable — Plan pays **100%** of covered expenses, with no deductible, after copayment of \$10 for each office visit and consultation, for services provided by an Affordable Network provider.

Calendar year maximum

Benefits for the inpatient and outpatient treatment of mental conditions and/or substance abuse are limited to a maximum Plan payment of \$75,000 per person per calendar year.

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 page 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 **80%** of the remaining covered expenses incurred in that calendar year for the services and supplies listed below.

PPO benefit

The Plan pays **100%** of covered charges with no deductible after a copayment of \$10 for office visits and consultations when services listed below are 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 20), 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
- 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

Durable medical equipment

Rental of durable medical equipment, such as a 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 reduced to 80% of the benefit otherwise payable under Other Medical Benefits (i.e., 64% of covered charges after satisfaction of the deductible).

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:

- From age 35 through 39, one mammogram screening during this five year period.
- From age 40 through 49, one mammogram screening every two consecutive 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.

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 page 7).

Other Medical Benefits *continued*

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 for 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:

- 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.

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 35
- 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 17 and 18).

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 36, 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.

Radiation and chemotherapy

Plan pays **100%** of covered expenses for treatment by chemotherapy and by X-ray, radium, or other radioactive substance when not otherwise payable under Inpatient Hospital Benefits.

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** 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 5 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 \$15 copay.

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 National Rx Services Program. National Rx Services will fill your prescription. All drugs and supplies listed above are covered under this Program.

Under the National 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 **\$10** copayment for each prescription drug, supply, or refill you purchase through the National Rx Services Program.

Prescription Drug Benefits *continued*

To claim benefits

The Plan will send you information on the National 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 a \$10 copayment for each prescription or refill to:

National Rx Services, Inc. of Pennsylvania
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, National 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 a.m. to 8 p.m. or Saturday, from 8 a.m. to 12 noon, Eastern Time.

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, National Rx Services, Inc., will bill you directly for the full discounted cost of the covered medication. Pay National Rx Services, Inc. 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 19 and 20.
- 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 22 and 23.

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.

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 relate 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 the calendar year deductible is met when out-of-pocket expenses for the coinsurance in that calendar year exceed \$1,000 for one person or \$2,000 for you and any covered family members.

Out-of-pocket expenses for the purposes of this benefit are the \$10 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;
- The \$300 calendar year 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 19 and 20);

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 27, 28 and 29);
- 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 up to the \$75,000 per person calendar year maximum after the \$300 calendar year deductible is met, if out-of-pocket expenses for mental conditions/substance abuse treatment total \$5,000 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 28, 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 28, 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 28.)
- 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, DC Metropolitan area, including the District of Columbia, the Maryland counties of Calvert, Charles, Frederick, Montgomery, Prince George's and St. Mary's, the Virginia counties of Arlington, Fairfax, Loudoun, Prince William, Spotsylvania and Stafford, and the cities of Alexandria, Fairfax, Falls Church, and Fredericksburg, and those in the Baltimore Metropolitan area including the city of Baltimore, and the Maryland counties of Anne Arundel, Baltimore, Carroll, Harford, and Howard, 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, Columbia, Dutchess, Greene, 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.

The Managed Care Advisor Service Areas

Enrollees and their eligible family members who reside in the Zip Code areas listed below may be eligible to participate in the Managed Care Advisor (MCA) Program by calling HealthCare COMPARE Corp. at 1-800/346-6755.

MCA Program locations in Zip Codes beginning with—

010	052	187	257	306	378	421	490	539	582	635	687	744	808	856	960
012	053	188	258	307	380	422	491	540	583	636	688	745	810	859	961
013	054	189	261	308	382	423	492	541	584	637	689	746	811	860	967
014	056	193	262	310	383	424	493	542	585	638	690	747	812	863	970
015	057	195	266	313	384	425	494	543	586	639	691	748	813	864	971
020	058	196	267	315	385	426	496	544	587	640	692	749	814	865	973
023	059	197	268	316	386	427	497	545	588	644	693	754	815	870	974
025	153	199	270	317	387	431	498	546	590	645	705	756	816	873	975
026	154	215	271	318	388	433	499	547	592	646	706	759	820	874	976
027	155	216	272	320	389	434	500	548	593	653	707	763	821	875	977
028	156	218	273	321	390	435	501	549	594	654	710	764	822	877	978
029	157	226	275	323	391	440	502	550	595	655	712	765	823	878	979
030	160	227	278	324	392	446	504	553	596	656	714	766	824	879	982
031	162	228	279	326	393	448	505	555	597	657	716	767	825	880	983
032	163	229	280	335	394	449	508	556	598	660	717	768	826	881	985
033	164	230	281	342	395	451	510	557	599	664	718	769	827	882	986
034	167	231	283	344	396	456	511	559	610	665	719	776	828	883	988
035	168	233	284	349	397	457	512	560	614	666	720	779	829	884	989
036	169	234	285	350	400	458	513	561	615	667	721	780	830	890	990
037	170	239	286	351	401	461	514	562	617	668	723	781	831	893	991
038	171	241	287	354	403	463	515	563	618	669	724	783	832	894	993
039	172	242	288	355	404	465	516	564	619	670	725	786	833	897	994
040	173	243	289	356	407	467	520	565	620	671	726	788	834	898	995
041	174	244	290	357	408	469	521	566	622	673	727	789	835	922	996
042	175	245	291	359	409	472	522	567	623	674	728	790	836	923	997
043	176	246	293	360	411	473	523	570	624	675	729	792	837	932	998
044	177	248	294	362	412	474	524	571	625	676	730	793	838	935	999
045	178	250	295	363	413	475	525	572	626	677	734	795	840	936	
046	179	251	296	364	414	476	526	573	627	678	735	796	843	939	
047	180	252	298	365	415	481	530	574	628	679	736	797	845	952	
048	182	253	299	367	416	484	534	575	629	680	737	798	846	954	
049	183	254	301	368	417	486	535	576	630	683	739	801	847	955	
050	184	255	304	373	418	487	537	577	633	684	740	804	853	956	
051	186	256	305	377	420	488	538	580	634	686	743	807	855	957	

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 30). 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 18 months of eligibility to receive Medicare Part A benefits due to End Stage Renal Disease (ESRD) except when Medicare 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 18-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 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.

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

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

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

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

When Medicare is the primary payer, this Plan will pay the lesser of (1) its benefits in full, or (2) a reduced amount that, when added to the benefits payable by Medicare, will not exceed 100% of reasonable and customary expenses or, for doctor services, the amount specified by Medicare, as described on page 31.

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.

Medicare-participating doctors accept assignment; that is, they have agreed not to bill you for more than the Medicare-approved amount for covered services. Some non-Medicare-participating doctors 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 in those instances where the Medicare and Plan payments combined do not total the Medicare-approved amount.

Non-Medicare-participating doctors do not need to accept assignment. When they do not accept assignment on a claim, they can bill you for more than the Medicare approved amount – up to a limit set by the Medicare law (the Social Security Act, 42 U.S.C.) called the limiting charge. The limiting charge is 115 percent of the Medicare-approved amount. 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 set by the Medicare law for non-Medicare-participating doctors. Neither you nor your FEHB Plan is liable for any amount in excess of the Medicare limiting charge for charges of a non-participating Medicare doctor. The Medicare explanation of benefits (EOB) form will have more information about this limit.

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. Call the Carrier at 1-800/638-6589 (for 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 24.

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 35). 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 32.

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 except as stated in any cosmetic surgery or dental benefits description in this brochure.

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 31. 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.
- You may also remain enrolled in this Plan when you join a Medicare prepaid plan. See page 30 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.

Enrollment Information *continued*

- 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.
- **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

Enrollment Information *continued*

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.

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.

Definitions *continued*

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.

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

Definitions *continued*

- 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.

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 Carrier knows how much other providers in your area charge for the procedure. The Carrier 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

Definitions *continued*

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 who are 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 Group Term Life

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 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 Dental/Vision

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.

SAMBA offers a Dental/Vision Care Plan covering many services that are coordinated with the health 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 1997

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

Benefit Changes

SAMBA now offers a Managed Care Advisor (MCA) Program which is available to members who do not have access to PPO providers. Members who choose to participate under the MCA Program will receive the Plan's enhanced PPO benefits. See page 7 for additional information.

The calendar year deductible has been increased from \$200 to \$300 per person and from \$500 to \$600 per family.

Non-PPO benefits for Room and board have been reduced from 100% of covered charges to 80% under "Inpatient Hospital Benefits" and "Maternity Benefits". In addition, the "Protection Against Catastrophic Costs" provision has been changed to include the out-of-pocket coinsurance expenses you pay related to Room and board under "Inpatient Hospital Benefits" and "Maternity Benefits".

Under "Oral and maxillofacial surgery" in the "Surgical Benefits" provision, benefits are limited to \$5,000 per person per lifetime for reconstruction surgery of the bone that surrounds and supports the teeth. Previously, there was no limitation on this benefit.

The copayment under the "Prescription Drug Benefits" has been increased from \$8 to \$10 per mail order prescription and from \$12 to \$15 per retail pharmacy prescription.

Under "Outpatient care" in the "Mental Conditions/Substance Abuse Benefits" provisions, Non-PPO benefits have been changed from 80% to 50% of covered charges. The Plan's PPO reimbursement is increased to 100% (previously 80%) with a \$10 copayment and no deductible for outpatient physicians services in the Prudential Networks in the Washington, DC/Baltimore and Tri-State areas of New Jersey, Southern New York and Southern Connecticut.

Under the "Oral and maxillofacial surgery" in the "Surgical Benefits" provision, PPO benefits are now available in the Prudential HealthCare PPO and Affordable Networks. PPO benefits will be paid at 100% of covered charges; Non-PPO benefits will be paid at 75% of reasonable and customary charges. Previously, PPO benefits were not available.

Under "Accidental injury to sound, natural teeth" in the "Surgical Benefits" provision, PPO benefits are now available in the Prudential HealthCare PPO and Affordable Networks. PPO benefits will be paid at 100% of covered charges and Non-PPO benefits will be paid at 75% of reasonable and customary charges, after a \$100 deductible per accident. Previously, PPO benefits were not available.

Clarifications

Procedures, services, drugs and supplies related to abortions are excluded 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.

The "Diagnosis and treatment of infertility" in the "Maternity Benefits" provision shows that prescription drugs are included under the \$5,000 lifetime maximum for covered expenses.

The use of a Plan identification card to obtain benefits after you are no longer enrolled in the Plan is a fraudulent action subject to review by the Inspector General.

Medical data that does not identify individual members may be disclosed as a result of bona fide medical research or education.

PPO arrangement – This section has been clarified to show that while PPO providers agree with the Plan to provide covered services, final decisions about health care from PPO providers are the sole responsibility of the doctor and patient and are independent of the terms of the insurance contract.

General Information – When a family member is hospitalized on the effective date of an enrollment change and continues to receive benefits under the **old** plan, benefits under the **new** plan will begin for other family members on the effective date of the new enrollment.

How SAMBA Changes January 1997 *continued*

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.

Annuitants and former spouses with FEHB coverage, and who are covered by Medicare Part B, may join a Medicare prepaid plan if they do not have Medicare Part A, but they will probably have to pay for hospital coverage. They may also remain enrolled under an FEHB plan when they enroll in 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).

Temporary continuation of coverage (TCC) for employees or family members who lose eligibility for FEHB coverage includes one free 31-day extension of coverage and may include a second. How these are coordinated has been clarified; notification and election requirements have also been clarified.

“Conversion to individual coverage” does not require evidence of good health and the plan is not permitted to impose a waiting period or limit coverage for preexisting conditions; benefits and rates under the individual contract may differ from those under the FEHB Program.

The rules concerning whether this Plan or Medicare pays your claim first when you are entitled to benefits under both this Plan and Medicare have been clarified (see page 30):

- This Plan is primary if you, the enrollee, are age 65 or over, have Medicare, and are employed by the Federal Government. If your covered spouse is age 65 or over, has Medicare, and is employed by the Federal Government and you, the enrollee, are not, Medicare is primary.
- Medicare is primary, if 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.

The language concerning “Group health insurance and automobile insurance” has been amended to show that the Plan’s double coverage provision is administered in accordance with the National Association of Insurance Commissioners’ Group Coordination of Benefits Model Regulation.

This Plan’s type of delivery system is now identified on the brochure cover: A Managed Fee-for-Service Plan with Preferred Provider Organizations.

Other Changes

The “Flexible services option” is now known as the “Flexible benefits option.”

Enrollees who change their FEHB enrollments using Employee Express may call the Employee Express HELP number to obtain a letter confirming that change if their ID cards do not arrive by the effective date of the enrollment change.

If you are eligible for Medicare, the information about Medicare coverage that you must disclose to the Carrier now includes your enrollment in a Medicare prepaid plan.

When you are enrolled in both this Plan and a Medicare prepaid plan, this Plan will not waive any deductibles or coinsurance when paying claims for covered services that you receive from providers that are not in the Medicare plans network.

The fact that an enrollee does not have a vested right to receive the benefits in this brochure in 1998 or later years, nor to benefits for years prior to 1997 unless those benefits are in this brochure, is now stated under “General Limitations” as well as on page 2.

The Plan will not pay for 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 or by a similar agency under another Federal or State law. The Carrier is entitled to be reimbursed by OWCP (or the similar agency) for services it paid that were later found to be payable by OWCP (or the agency).

How SAMBA Changes January 1997 *continued*

Disputed claims – If your claim for payment or services is denied by the Carrier, and you decide to ask OPM to review that denial, you must first ask the Carrier to reconsider their decision. You must now request their reconsideration within six months of the denial (previously, you had one year to do this). 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.

Providers, legal counsel, and other interested parties may act as your representative in pursuing payment of a disputed claim **only** with your written consent. Any lawsuit to recover benefits on a claim for treatment, services, supplies or drugs covered by this Plan must be brought against the Office of Personnel Management in Federal court and only after you have exhausted the OPM review procedure.

Language referencing “The Prudential Insurance Company of America (The Prudential)” has been changed to reflect the company’s new name, “Prudential HealthCareSM PPO (Prudential HealthCare).”

The address to submit claims for retail prescription drugs has been changed. See page 22.

The states designated as medically underserved have changed for 1997. Arkansas and Idaho are no longer underserved.

Summary of Benefits for SAMBA Health Benefit Plan - 1997

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 calendar year deductible.

Benefits		Plan pays/provides	Page
Inpatient care	Hospital	Non-PPO benefit: 80% for semiprivate room and board and Other hospital charges	12
		PPO benefit: 100% of Room and board and Other hospital charges	
	Surgical	Non-PPO benefit: 80%* of reasonable and customary charges.....	13, 14 and 15
		PPO benefit: 100% of covered surgical charges	
	Medical	Non-PPO benefit: 80%* of reasonable and customary charges.....	19 and 20
	PPO benefit: 100% of covered charges		
Maternity	Same as for illness or injury.....	16	
Mental Conditions/ Substance Abuse	Non-PPO benefit: 100% for semiprivate room and board and 80% of Other hospital charges, and inpatient visits (deductible applies) subject to a \$75,000 calendar year maximum per person for all inpatient and outpatient expenses due to Mental Conditions/Substance Abuse	17 and 18	
	PPO benefit: 100% of Other hospital charges; and inpatient visits		
Outpatient care	Hospital	Non-PPO benefit: 80%* of reasonable and customary charges for charges not covered or not fully covered under Inpatient Hospital Benefits.....	19 and 20
		PPO benefit: 100% of covered charges	
	Surgical	Non-PPO benefit: 80%* of reasonable and customary charges.....	13, 14 and 15
		PPO benefit: 100% of covered surgical charges	
	Medical	Non-PPO benefit: 80%* of reasonable and customary charges.....	19 and 20
		PPO benefit: \$10 copay but no deductible or coinsurance 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.....	21	
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 subject to a \$75,000 calendar year maximum per person for all inpatient and out-patient expenses due to Mental Conditions/Substance Abuse	17 and 18	
	PPO benefit: deductible is waived and Plan pays 100% of some expenses.		
Emergency care (accidental injury)	100% of reasonable and customary charges for covered expenses for accidental injury treatment within 72 hours of an accident.....	21	
Prescription drugs	Mail order and prescription card program: After a \$10 copayment through the mail order service or a \$15 copayment 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.....	22 and 23	
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; radiation and chemotherapy; skilled nursing facility; childhood immunizations	21	
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, excluding deductibles, exceed \$1,000 per person (\$2,000 per family) per calendar year.....	26 and 27
	Mental Conditions/ Substance Abuse	After the \$300 calendar year deductible when eligible out-of-pocket expenses under the Mental Condition/Substance Abuse Benefits total \$5,000 in a calendar year, the Plan then pays 100% of such covered expenses for the remainder of that calendar year up to the \$75,000 calendar year maximum	17 and 18