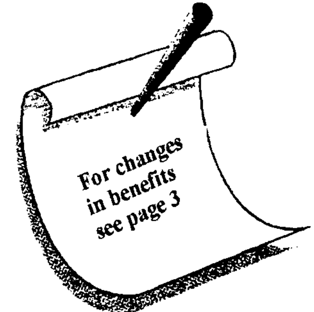
# SAMBA Health Benefit Plan 2000

**A Fee-for-Service Plan with Preferred Provider Organizations**
**Sponsored by the Special Agents Mutual Benefit Association**




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

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

**Membership dues:** There are no membership dues.

**Enrollment code for this Plan:**
**441 Self Only**
**442 Self and Family**

Visit the OPM website at http://www.opm.gov/insure
and
this Plan's website at http://www.samba-insurance.com

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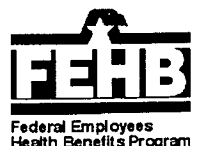


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## Introduction

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

This brochure describes the benefits you can receive from the SAMBA Health Benefit Plan, sponsored by the Special Agents Mutual Benefit Association under its contract (CS 1074) with the Office of Personnel Management (OPM), as authorized by the Federal Employees Health Benefits (FEHB) law.

This brochure is the official statement of benefits on which you can rely. A person enrolled in this Plan is entitled to the benefits described in this brochure. If you are enrolled for Self and Family coverage, each eligible family member is also entitled to these benefits. Nothing anyone says can modify or otherwise affect the benefits, limitations, and exclusions of this brochure.

Because OPM negotiates benefits and premiums annually they change each year. This brochure describes the only benefits available to you under this Plan in 2000. Benefit changes are effective January 1, 2000, and are shown on page 3. You do not have a right to benefits that were available before January 1, 2000 unless those benefits are also contained in this brochure. Premiums are listed at the end of this brochure.

## Plain language

The President and Vice President are making the Government's communication more responsive, accessible, and understandable to the public by requiring agencies to use plain language. Health plan representatives and Office of Personnel Management staff have worked cooperatively to make portions of this brochure clearer. In it you will find common, everyday words, except for necessary technical terms; "you" and other personal pronouns; active voice; and short sentences.

We refer to the SAMBA Health Benefit Plan as "this Plan" throughout this brochure even though in other legal documents, you will see a plan referred to as a carrier.

Sections one, two, four, and ten are now in plain language, as well as portions of sections three and eight. We will rewrite the remaining sections of this brochure, including the benefits section, for year 2001. Please note that the format and organization of this brochure have changed as well.

These changes do not affect the benefits or services we provide. We have rewritten this brochure only to make it more understandable.

## How to use this brochure

This brochure has ten sections. Each section has important information you should read. If you want to compare this Plan's benefits with benefits from other FEHB plans, you will find that the brochures have the same format and similar information to make comparisons easier.

1. Fee-for-Service Plan (FFS). This Plan is a FFS Plan. Turn to this section for a brief description of Fee-for-Service plans and how they work.
2. How we change for 2000. If you are a current member and want to see how we have changed, read this section.
3. How to get benefits. Make sure you read this section; it tells you how to get benefits and how we operate.
4. What if we deny your claim or request for coverage. This section tells you what to do if you disagree with our decision not to pay for your claim or deny your request for coverage.
5. Benefits. Look here to see the benefits we will provide as well as specific exclusions and limitations. You will also find information about non-FEHB benefits.
6. How to file a claim. Look here to find specific information on how to file claims with us.
7. General exclusions – Things we don't cover. Look here to see benefits that we will not provide.
8. Limitations – Rules that affect your benefits. This section describes limits that can affect your benefits.
9. Fee-for-Service Facts. This section contains information about pre-certification, protection against catastrophic expenses, and a definition section.
10. FEHB Facts. Read this for information about the Federal Employees Health Benefits (FEHB) Program.

## Section 1. Fee-for-Service Plans

Fee-for-service plans reimburse you or your provider for covered services. They do not typically provide or arrange for health care. Fee-for-service plans let you choose your own physicians, hospitals, and other health care providers.

The FFS plan reimburses you for your health care expenses, usually on a percentage basis. These percentages, as well as deductibles, methods for applying deductibles to families, and the percentage of coinsurance you must pay vary by plan. The type and extent of covered services varies by plan. There is a detailed explanation of the benefits we offer in this brochure; you should read it carefully.

This FFS plan offers a preferred provider organization (PPO) arrangement (see page 7, *This Plan's PPOs*). This arrangement with health care providers gives you enhanced benefits or limits your out-of-pocket expenses.

# Section 2. How we change for 2000

**Program-wide changes**

To keep your premium as low as possible OPM has set a copay of not less than $10 for all PPO primary care office visits for all FEHB plans. Your PPO copayment under SAMBA is $15 for office visits and consultations.

This year, you have a right to more information about this Plan, care management, our networks, facilities, and providers.

If you have a chronic or disabling condition or are in the second or third trimester of pregnancy, and your provider is leaving our PPO network at our request without cause, we will notify you. You may continue to receive our PPO level benefits for your specialist's services for up to 90 days after you receive notice. We will provide regular non-PPO benefits for the specialist's services after the 90 day period expires.

You may review and obtain copies of your medical records on request. If you want copies of your medical records, ask your health care provider for them. You may ask that a physician amend a record that is not accurate, not relevant, or incomplete. If the physician does not amend your record, you may add a brief statement to it. If they do not provide you your records, call us and we will assist you.

If you are over age 50, all FEHB plans will cover a screening sigmoidoscopy every five years. This screening is for colorectal cancer.

**Changes to this Plan**

PPO benefits for cancer diagnostic/screening tests, including mammography, have been increased from **95%**, subject to the calendar year deductible, to **100%** with no deductible (see *Additional Benefits*, page 21).

The Plan's PPO Network in the Washington, DC/Baltimore areas has changed from Prudential HealthCare to CareFirst BlueCross BlueShield.

The Plan's PPO Network in New York, New Jersey and Connecticut has changed from the UP&UP/AHP Network to First Health.

Under the PPO benefits for Mental Conditions/Substance Abuse Benefits the Plan has removed the $100 per visit/50 visits per year limitation for Outpatient care and has eliminated the lifetime maximum of two 30-day confinements in a rehabilitation facility. In addition, the catastrophic protection for mental health and substance abuse treatment will now be the same as for any other illness or injury. Preauthorization will now be required for outpatient care when treatment continues beyond 10 visits per person, per calendar year.

The PPO calendar year deductible has been increased from $200 to $300 per person, and from $400 to $600 per family, for all benefit categories except inpatient room and board, doctors' office visits and consultations.

PPO benefits have been reduced from **95%** to **90%** for all benefit categories except inpatient room and board and doctors' office visits and consultations.

Covered expenses for physical therapy are now limited to $3,000 per person, per calendar year.

The Plan no longer follows the NAIC Model Regulations regarding "benefit reserve" when administering coordination of benefits (COB) (see *Section 8. Limitations – Rules that affect your benefits*, page 30).

A $100 PPO copayment (which applies toward your catastrophic protection out-of-pocket limit) has been added to services rendered and billed by an outpatient facility under Other Medical Benefits. (The copayment is waived for those individuals with Medicare Part B primary coverage.)

The Plan's determination of reasonable and customary charges will now be based on the 75th percentile factor provided by MDR (see *Definitions* on page 34). Previously, the 80th or 90th percentile factor was used.

Your share of the SAMBA premium will increase by 15.3% for Self Only or 14.3% for Self and Family.

# Section 3. How to get benefits

## How do I keep my health care expenses down?

### 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 CareFirst BlueCross BlueShield (CareFirst) or First Health Group Corp. (First Health) 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 32 and 33 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.

## How much do I pay for services?

You must share the cost of some services. These cost sharing measures include deductibles, coinsurance and copayments. These and other measures are described in more detail below.

### 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 applied to the calendar year deductible for either PPO benefits or non-PPO benefits are applied toward the $300 calendar year deductible. 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, coinsurance, Prescription drug program charges, and expenses used to satisfy the dental accident deductible do not count toward the calendar year deductible.

#### Hospital confinement

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

#### Dental accident

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

**Carryover**

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

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

**If provider waives your share**

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

**Copayments**

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

## Lifetime maximums

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

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

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

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

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

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

## Do I have to submit claims?

You usually do not have to submit claims to us, if you use preferred providers. If you file a claim, please send us all of the documents for your claim as soon as possible. You must submit claims by December 31 of the year after the year you received the service. Either OPM or we can extend this deadline if you show that circumstances beyond your control prevented you from filing on time.

Please see *Section 6. How to file a claim*, for specific information you need to know before you file a claim with us.

## Who provides my health care?

In a Fee-for-Service Plan, you may choose any covered facility or provider.

## 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.

## 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.

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.

### Coverage in medically underserved areas

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 2000, the States designated as medically underserved are: Alabama, Idaho, Louisiana, Mississippi, New Mexico, North Dakota, South Carolina, South Dakota, Utah and Wyoming.

## PPO arrangements

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

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

PPO benefits apply only when you use a PPO provider. Provider networks may be more extensive in some areas than others. The availability of every specialty in all areas cannot be guaranteed. If no PPO provider is available, or you do not use a PPO provider, the standard non-PPO benefits apply.

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

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

### Overseas claims

For covered services rendered by a hospital or by a doctor outside the United States and Puerto Rico, the Plan will pay eligible charges at PPO benefit levels, limited to the Plan's reasonable and customary fee schedule established for the Washington, DC Metropolitan area. The member is responsible for the difference between the Plan's payment and the provider's charge (see page 25, *Section 6. How to file a claim*).

## This Plan's PPOs

The Plan has entered into arrangements (geographically) with CareFirst BlueCross BlueShield (CareFirst) and First Health Group Corp. (First Health) to offer Preferred Provider Organization (PPO) Networks to SAMBA enrollees (see below and *This Plan's PPO service areas* on page 32 to determine which PPO Network services your area).

Enrollees who reside in the Washington, DC Metropolitan, or Greater Baltimore areas may utilize the CareFirst PPO Network. Call CareFirst customer service toll-free, 1-877/691-5856, for information concerning the PPO.

Enrollees outside the CareFirst service areas (listed above) may utilize the First Health PPO Network. Call: Referral Management/Telephonic Provider Directory at 1-800/346-6755 to confirm provider participation and identify Network providers.

These PPO Networks offer hospitals and doctors that have agreed to provide services at negotiated rates to SAMBA enrollees and their eligible family members. Use of a participating Network doctor or hospital does not guarantee that the associated ancillary providers such as specialists, emergency room doctors, anesthesiologists, radiologists, and pathologists participate in the Network. Subject to the Plan's definitions, limitations and exclusions, the Plan pays its PPO benefits as outlined in this brochure when services are provided by a doctor or other provider participating in the Plan's PPO Network. If you elect to use a non-PPO provider, however, SAMBA will provide its usual coverage as outlined in this brochure. When you phone for an

appointment, please remember to verify that the physician is still a PPO Network provider.

**Managed Care Advisor (MCA) Program** — Enrollees (in the First Health service areas) lacking Network access (as defined) may join the Plan's Managed Care Advisor (MCA) Program offered through First Health Group 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 First Health Referral Management Coordinator at 1-800/346-6755 for a referral. Enrollees who join and comply with the requirements of the MCA Program will receive the Plan's enhanced PPO benefits (subject to the Plan's definitions, limitations, and exclusions); see page 32.

By calling First Health Group Corp. at 1-800/346-6755, you may also access Health Resource Line. Health Resource Line 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. Health Resource Line is only available to enrollees in the First Health Network 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 CareFirst and First Health Networks offer integrated organ transplant programs. See pages 13 and 14.

**What do I do if I'm in the hospital when I join this Plan?**

First, call our customer service department at 1-800/638-6589 or 301/984-1440 (for TDD, use 301/984-4155). If you are new to the FEHB Program, we will reimburse your covered expenses. If you are currently in the FEHB Program and are switching to us, your former plan will pay for the hospital stay until:

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

These provisions only apply to the person who is hospitalized.

**What if I have a serious illness and my provider leaves the Plan or this Plan leaves the Program?**

Please contact us if you believe your condition is chronic or disabling. If it is, you may be able to continue seeing your provider for up to 90 days after you receive notice that we are terminating our contract with the provider (unless the termination is for cause). If you are in the second or third trimester of pregnancy, you may continue to see your OB/GYN until the end of your postpartum care.

You may also be able to continue seeing your provider if your plan drops out of the FEHB Program and you enroll in a new FEHB plan. Contact the new plan and explain that you have a serious or chronic condition, or are in your second or third trimester. Your new plan will pay for or provide your care for up to 90 days after you receive notice that your prior plan is leaving the FEHB Program. If you are in your second or third trimester, your new plan will pay for the OB/GYN care you receive from your current provider until the end of your postpartum care.

If you continue seeing your specialist or OB/GYN under these conditions, your cost will be no more than you would normally pay for the services covered.

## Section 4. What if we deny your claim or request for coverage?

**What should I do before filing a disputed claim?**

Before you ask us to reconsider your claim, you should first check with your provider or facility to be sure that the claim was filed correctly. For instance, did the provider use the correct procedure code for the services performed (surgery, laboratory test, X-ray, office visit, etc.)? Have your provider indicate any complications of any surgical procedures performed. Your provider should also include copies of an operative or procedure report, or other documentation that supports your claim.

If we deny your request for coverage or won't pay your claim, you may ask us to reconsider our decision. Your request must:

1. Be in writing;
2. Refer to specific brochure wording explaining why you believe our decision is wrong; and
3. Be made within six months from the date of our initial denial or refusal. We may extend this time limit if you show that you were unable to make a timely request due to reasons beyond your control.

We have 30 days from the date we receive your reconsideration request to:

1. Maintain our denial in writing;
2. Pay the claim;
3. Approve your request for coverage; or
4. Ask for more information.

If we ask your medical provider for more information, we will send you a copy of our request. We must make a decision within 30 days after we receive the additional information. If we do not receive the requested information within 60 days, we will make our decision based on the information we already have.

**When may I ask OPM to review a denial?**

You may ask OPM to review the denial after you ask us to reconsider our initial denial or refusal. OPM will determine if we correctly applied the terms of our contract when we denied your claim or request for coverage.

**What if I have a serious or life threatening condition and you haven't responded to my request for coverage?**

Call us at 1-800/638-6589 or 301/984-1440 (for TDD, use 301/984-4155) and we will expedite our review.

**What if you have denied my request for coverage and my condition is serious or life threatening?**

If we expedite your review due to a serious medical condition and deny your request, we will inform OPM so that they can give your claim expedited treatment too. Alternatively, you can call OPM's health benefits Contract Division II at 202/606-3818 between 8 a.m. and 5 p.m. Serious or life-threatening conditions are ones that may cause permanent loss of bodily functions or death if they are not treated as soon as possible.

**Are there other time limits?**

You must write to OPM and ask them to review our decision within 90 days after we uphold our initial denial or refusal. You may also ask OPM to review your claim if:

1. We do not answer your request within 30 days. In this case, OPM must receive your request within 120 days of the date you asked us to reconsider your claim.
2. You provided us with additional information we asked for, and we did not answer within 30 days. In this case, OPM must receive your request within 120 days of the date we asked you for additional information.

**What do I send to OPM?**

Your request must be complete, or OPM will return it to you. You must send the following information:

1. A statement about why you believe our decision is wrong, based on specific benefit provisions in this brochure;
2. Copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms;
3. Copies of all letters you sent us about the claim;
4. Copies of all letters we sent you about the claim; and
5. Your daytime phone number and the best time to call.

If you want OPM to review different claims, you must clearly identify which documents apply to which claim.

**Who can make the request?**

Those who have a legal right to file a disputed claim with OPM are:

1. Anyone enrolled in the Plan;
2. The estate of a person once enrolled in the Plan; and
3. Medical providers, legal counsel, and other interested parties who are acting as the enrolled person's representative. They must send a copy of the person's specific written consent with the review request.

**Where should I mail my disputed claim to OPM?**

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

**What if OPM upholds the Plan's denial?**

OPM's decision is final. There are no other administrative appeals. If OPM agrees with our decision, your only recourse is to sue.

If you decide to sue, you must file the suit against OPM in Federal court by December 31 of the third year after the year in which you received the disputed services or supplies.

**What laws apply if I file a lawsuit?**

Federal law governs your lawsuit, benefits, and payment of benefits. The Federal court will base its review on the record that was before OPM when OPM made its decision on your claim. You may recover only the amount of benefits in dispute.

You (or a person acting on your behalf) may not sue to recover benefits on a claim for treatment, services, supplies, or drugs covered by us until you have completed the OPM review procedure described above (as established at section 890.105, title 5, Code of Federal Regulations (CFR)). As required by section 890.107, title 5, CFR, such a lawsuit must be brought against the Office of Personnel Management in Federal court.

**Your records and the Privacy Act**

Chapter 89 of title 5, United States Code allows OPM to use the information it collects from you and us to determine if our denial of your claim is correct. The information OPM collects during the review process becomes a permanent part of your disputed claims file, and is subject to the provisions of the Freedom of Information Act and the Privacy Act. OPM may disclose this information to support the disputed claim decision. If you file a lawsuit, this information will become part of the court record.

# Section 5. 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 32 and 33 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 29.

**Room and board**

The Plan pays covered charges for semiprivate room accommodations, including general nursing care. If a private room is used, you must pay the difference between the charge for the private room and the hospital's charge for standard semiprivate accommodations or, if it has no semiprivate rooms, the hospital's lowest rate for a private room. If the confinement is caused by an infectious or communicable disease, the private room charge will be covered.

**Other charges**

Other hospital charges include but are not limited to:

- Administration of anesthetics in a hospital by a doctor
- Blood and blood plasma to the extent not donated or otherwise replaced
- The professional services of a radiologist or pathologist
- Hospital services and supplies (other than professional services), such as use of operating, treatment, and recovery rooms; X-rays; anesthetics; laboratory and diagnostic tests; surgical dressings; and drugs and medicines for use in the hospital
- Local professional ambulance service to and from a hospital

**Non-PPO benefit**

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

**PPO benefit**

After a $200 per confinement deductible, the Plan pays **100%** of covered Room and board and **90%** of Other charges made by the hospital (including the inpatient services of an anesthesiologist, radiologist, and pathologist) when a Network hospital is used. Other services listed must be provided by a Network provider to qualify for PPO benefits.

**Limited benefits**

**Hospitalization for dental work**

Medically necessary hospitalization for dental procedures requires precertification as indicated on pages 32 and 33.

**Related benefits**

**Outpatient hospital benefits**

Services rendered in and billed by the outpatient department of a hospital are covered under Other Medical Benefits (see page 19).

**Private duty nursing services**

Private duty nursing care is covered under Other Medical Benefits.

**Professional charges**

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

**What is not covered**

- Room and board expenses in any place that is not a covered facility as defined on pages 6 and 7 or in any facility used principally for convalescence, for rest, for a nursing home, for the aged, for domiciliary or custodial care, or as a school
- Personal comfort services, such as radio, telephone, television, beauty and barber services

**The non-PPO benefits are the standard benefits of this Plan. PPO benefits apply only when you use a PPO provider. When no PPO provider is available, non-PPO benefits apply (except as noted on pages 7 and 8).**

## 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 (chiropodist) for:
  - — An open cutting operation
  - — Removal of a nail root
  - — Treatment (including cutting or removal) of corns, calluses, or toenails when the individual is under treatment by a doctor for a metabolic disease, such as diabetes mellitus, or a peripheral-vascular disease such as arteriosclerosis.

**Multiple surgical procedures**

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

**Incidental procedures**

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

**Anesthesia**

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

**Services related to outpatient surgery**

Services rendered in and billed by the outpatient department of a hospital or ambulatory surgical center are covered under Other Medical Benefits (see page 19).

**Second opinion (voluntary)**

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

**Oral and maxillofacial surgery**

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

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

**Mastectomy surgery**

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

Benefits will be provided for breast reconstruction surgery following a mastectomy, including surgery to produce a symmetrical appearance on the other breast. Benefits will be provided for all stages of breast reconstruction following a mastectomy, including treatment of any physical complications, including lymphedemas, and for breast prostheses, including surgical bras and replacements.

**Non-PPO benefit**

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

**PPO benefit**

After the $300 calendar year deductible, the Plan pays **90%** of covered charges when services are provided by a Network hospital or other Network provider.

**The non-PPO benefits are the standard benefits of this Plan. PPO benefits apply only when you use a PPO provider. When no PPO provider is available, non-PPO benefits apply (except as noted on pages 7 and 8).**

## Surgical Benefits *continued*

**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**

After a $100 deductible per accident, the Plan pays **90%** of covered charges when services are provided by a Network provider.

**Organ/tissue transplants and donor expenses**

All reasonable and customary charges incurred for a covered surgical transplant, whether incurred by the recipient or donor, will be considered expenses of the recipient and will be covered the same as for any other illness or injury. Surgical transplants must be authorized by the Plan's precertification 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 National Transplant Program/Centers of Excellence** — The Plan pays **100%** of covered expenses for the organ transplants listed above (except cornea and pancreas) when performed through the First Health National Transplant Program or CareFirst's Centers of Excellence. Covered expenses are:

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

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

**Transplant Precertification** — As a potential candidate for an organ transplant procedure, you or your doctor must contact the First Health National Transplant Program at 1-800/346-6755 or CareFirst's Centers of Excellence (Washington, DC and Baltimore area) at 1-800/553-8700 to initiate the pretransplant evaluation. The clinical results of the evaluation will be reviewed to determine if the proposed procedure meets the Plan's definition of medically necessary. A case manager will assist the patient in accessing the appropriate transplant facility. This includes providing information to facilitate travel and lodging arrangements and coordinating the pretransplant evaluation.

**The non-PPO benefits are the standard benefits of this Plan. PPO benefits apply only when you use a PPO provider. When no PPO provider is available, non-PPO benefits apply (except as noted on pages 7 and 8).**

## Surgical Benefits *continued*

**Limitations**

If you do not use either the First Health National Transplant Program or a CareFirst Centers of Excellence facility, standard Plan benefits will be applied to your expenses. Total benefit payments, including donor expenses, the transplant procedure itself (hospital and doctor fees), transplant-related follow-up care for one year, and pharmacy costs for immunosuppressant and other transplant-related medication will be limited to a maximum payment of $100,000 per transplant. The travel and lodging allowance will not be available.

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

**What is not covered**

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

### Limited benefit

**Cosmetic surgery**

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

### What is not covered

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

**The non-PPO benefits are the standard benefits of this Plan. PPO benefits apply only when you use a PPO provider. When no PPO provider is available, non-PPO benefits apply (except as noted on pages 7 and 8).**

# Maternity Benefits

**What is covered**

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

**Inpatient hospital**

**Precertification**

The medical necessity of your hospital admission must be precertified for you to receive full Plan benefits. Unscheduled or emergency admissions not precertified must be reported within two business days following the day of admission even if you have been discharged. Newborn confinements that extend beyond the mother's discharge must also be precertified. If any of the above are not done, the benefits payable will be reduced by $500. See pages 32 and 33 for details.

**Room and board**

The Plan pays covered semiprivate room and board charges (see *Inpatient Hospital Benefits* on page 11 for coverage of private room). Routine nursery care of the infant is considered a hospital expense of the mother and not an expense of the child.

**Other charges**

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

**Non-PPO benefit**

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

**PPO benefit**

After a $200 per confinement deductible, the Plan pays **100%** of covered Room and board and **90%** of Other charges made by the hospital (including the inpatient services of an anesthesiologist, radiologist, and pathologist), when a Network hospital is used. Other services listed must be provided by a Network provider/facility to qualify for PPO benefits.

**Outpatient care**

Eligible charges for services provided by a covered birthing center are covered under Other Medical Benefits.

**Obstetrical care**

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

**Non-PPO benefit**

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

**PPO benefit**

After the $300 calendar year deductible, the Plan pays **90%** of Outpatient care covered charges and Obstetrical care from a Network provider. The services listed must be provided by a 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 33.

**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 12.

**The non-PPO benefits are the standard benefits of this Plan. PPO benefits apply only when you use a PPO provider. When no PPO provider is available, non-PPO benefits apply (except as noted on pages 7 and 8).**

## Maternity Benefits *continued*

**For whom**

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

**What is not covered**

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

**The non-PPO benefits are the standard benefits of this Plan. PPO benefits apply only when you use a PPO provider. When no PPO provider is available, non-PPO benefits apply (except as noted on pages 7 and 8).**

# Mental Conditions/Substance Abuse Benefits

**What is covered**

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

**Inpatient care**

Covered hospital and rehabilitation facility charges include:

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

**Rehabilitation facility**

When a covered person is admitted to an approved rehabilitation facility as an inpatient for a prescribed course of treatment of alcoholism or substance abuse upon recommendation of a doctor, the Plan will provide benefits subject to precertification. The following limitations apply for non-PPO benefits: (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 32 and 33 for details.

**Non-PPO benefit**

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

**PPO benefit**

After a $200 per confinement deductible, the Plan pays **100%** of Room and board and **90%** of Other charges made by the hospital or rehabilitation facility when a Network provider is used. After the $300 calendar year deductible, Plan pays **90%** of charges for doctors' inpatient visits. Other inpatient care must be provided by a Network provider to qualify for PPO benefits.

**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. Preauthorization is required when treatment continues beyond 10 visits per person, per calendar year. Call 1-800/999-9849 in the Washington, DC and Baltimore Metropolitan areas, in all other areas call 1-800/346-6755 to obtain preauthorization. If preauthorization is not obtained, benefits will be reduced to **80%** of the benefit otherwise payable under Mental Conditions/Substance Abuse Benefits.

**Non-PPO benefit**

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

**PPO benefit**

Plan pays **100%** of covered expenses, with no deductible, after a copayment of $15 for each office visit and consultation. After the $300 calendar year deductible the Plan pays **90%** of covered day or after-care (partial hospitalization) in a hospital. Services must be provided by a Network provider.

**Lifetime maximum**

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

**What is not covered**

- Marital counseling
- Treatment of learning disabilities

**The non-PPO benefits are the standard benefits of this Plan. PPO benefits apply only when you use a PPO provider. When no PPO provider is available, non-PPO benefits apply (except as noted on pages 7 and 8).**

# Other Medical Benefits

**What is covered**

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

**Non-PPO benefit**

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

**PPO benefit**

After the $300 calendar year deductible, the Plan pays **90%** of covered charges for the services listed below except:

The Plan pays **100%** of covered charges after a copayment of $15 for the doctor's office visits and consultations, including the services rendered by the doctor in conjunction with the office visit and consultation such as X-ray and laboratory tests.

Services rendered on a different date than the office visit or by any other provider will be payable at **90%** and subject to the $300 calendar year deductible.

Listed services must be provided by a Network provider. (Network 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, and Routine screening services (see page 19)
- Doctors' services for home, office and hospital calls, and for consultations, except for those covered under Surgical Benefits and Maternity Benefits
- Treatment by chemotherapy and by X-ray, radium, or other radioactive substance
- Initial in-hospital examination of a newborn covered under a Self and Family enrollment
- Use of freestanding professional medical treatment centers, such as dialysis, cancer, or emergency or immediate-care facilities
- Surgical dressings, splints, casts, crutches, and similar supplies
- 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 occupational therapist or licensed medical social worker
- Transparenteral nutrition (TPN)
- Doctors examination including related X-rays and laboratory tests for second (or third) surgical opinion
- 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
- Operating room charges, surgical supplies and related X-rays and tests performed on the day of surgery, when surgery is performed in a doctor's office
- One routine physical examination (and one routine gynecologic exam for women age 18 and older) per calendar year including related X-rays and laboratory tests
- Home health care; reasonable and customary charges of a home health aide provided through a home health care agency. 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 (see *Limited benefits* on page 20)
- Breast prostheses, including surgical bras and replacements following mastectomy

**The non-PPO benefits are the standard benefits of this Plan. PPO benefits apply only when you use a PPO provider. When no PPO provider is available, non-PPO benefits apply (except as noted on pages 7 and 8).**

## Other Medical Benefits *continued*

**Other services**

The Plan provides coverage for physical therapy, private duty nursing and durable medical equipment at the following benefit levels:

**Non-PPO benefit**

After the $300 calendar year deductible, the Plan pays **50%** of covered services and supplies listed below.

**PPO benefit**

After the $300 calendar year deductible, the Plan pays **90%** of covered services and supplies listed below. Services and supplies must be provided by a Network provider to qualify for PPO benefits. (Network providers are not available in all areas for all services.)

- Private duty nursing care (see *Limited benefits*, page 20)
- Physical therapy (see *Limited benefits*, page 20)
- Rental or purchase (at the Plan's option) of covered durable medical equipment, such as wheelchair, hospital bed, oxygen equipment and oxygen, artificial limbs, eyes, larynges and braces 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.

**Outpatient facility care**

After satisfaction of the $300 calendar year deductible the Plan provides coverage at the benefit levels listed below.

**Non-PPO benefit**

After a $100 copayment per outpatient facility service (applied per facility, per day), the Plan pays **70%** of covered services and supplies listed below (subject to the calendar year deductible).

**PPO benefit**

After a $100 copayment per outpatient facility service (applied per facility, per day), the Plan pays **90%** of covered services and supplies listed below (subject to the calendar year deductible). Services must be provided by a Network facility to qualify for PPO benefits.

- Hospital services and supplies (other than professional services), such as use of operating, treatment, recovery, and emergency rooms; X-rays; anesthetics; laboratory and machine diagnostic tests (e.g., Magnetic Resonance Imaging-MRI); surgical dressings; and drugs and medicines for use in the hospital when such services and supplies are rendered in and billed by the outpatient department of a hospital.
- Covered charges for services provided by a birthing center (see page 6).
- Covered charges for services provided by an ambulatory surgical center for use of the facility (see page 6).

**Routine services**

The following routine screening services are paid as described on page 18. These services are covered differently when performed by a PPO Network provider; see *Additional Benefits*, page 21.

**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 one or two calendar years.
- From age 50 through 64, one mammogram screening every calendar year.
- At age 65 or over, one mammogram screening every two consecutive calendar years.

**Cervical cancer screening**

Annual coverage of one pap smear for women age 18 and older.

**Colorectal cancer screening**

Annual coverage of one fecal occult blood test for members age 40 and older.

**Prostate cancer screening**

Annual coverage of one PSA (Prostate Specific Antigen) test for men 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 pages 7 and 8).**

## Other Medical Benefits *continued*

**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 7 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.

**Home health care**

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.

**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

**Physical therapy**

Covered expenses for physical therapy are limited to $3,000 per person, per calendar year.

**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 page 17).
- Charges covered by the Inpatient Hospital, Maternity, Surgical, Mental Conditions/Substance Abuse or Additional Benefits of this Plan.

**The non-PPO benefits are the standard benefits of this Plan. PPO benefits apply only when you use a PPO provider. When no PPO provider is available, non-PPO benefits apply (except as noted on pages 7 and 8).**

## 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 13).

**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.

**Cancer tests (diagnostic/screening) provided by PPO Network providers**

Plan pays **100%** of covered charges for the following diagnostic and screening cancer tests. Services must be rendered by a PPO Network provider, and are limited to the applicable schedules indicated on page 19 under Routine services.

- Mammogram
- Pap Smear
- Fecal occult blood test
- PSA (Prostate Specific Antigen) test

**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.

**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.

**The non-PPO benefits are the standard benefits of this Plan. PPO benefits apply only when you use a PPO provider. When no PPO provider is available, non-PPO benefits apply (except as noted on pages 7 and 8).**

# 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

**Coverage of FDA — Approved Drugs, Devices, and Biological Products**: When the FDA has approved a drug, device or biological product and by federal law of the United States the drug, device or biological product requires a doctor's written prescription for purchase, this Plan will provide coverage when the product is used for its intended purposes and labeled indications as approved by FDA if those purposes and indications would otherwise be eligible for benefits under this Plan's benefit structure. This includes coverage for related injection, infusion, surgery, or other services necessary for administration or utilization of the drug, device or biological product in the manner for which it was approved. However, as with all other covered benefits, the services must be medically necessary and appropriate for the patient's condition.

### What is not covered

- 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 for sexual dysfunction, e.g., Viagra, Muse, Caverject, etc.

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

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

## From a pharmacy

You may purchase up to a 30-day supply of covered drugs or supplies through the PAID system available at most pharmacies. Call 1-800/222-7186 to locate a Plan network pharmacy in your area. Your SAMBA health insurance identification card serves as a PAID identification card. In most cases, you simply present the card, together with the prescription, to the pharmacist. A $15 generic and name brand single source (no generic substitute), $25 multisource name brand drug copayment is required for each prescription. You may fill your prescription at any PAID Prescriptions pharmacy participating in the SAMBA Program that transmits claim information via the PAID system.

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

### To claim benefits

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

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

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

# Prescription Drug Benefits *continued*

**By mail**

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

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

You pay a $15 generic and name brand single source (no generic substitute), $25 multisource name brand drug copayment for each prescription drug, supply or refill you purchase through the Merck-Medco Rx Services Program.

**To claim benefits**

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

1) ask your doctor to give you a new prescription for up to a 90-day supply of your regular medication plus refills, if appropriate;
2) complete the patient profile questionnaire the first time you order under the program; and
3) complete a mail order envelope, enclose your prescriptions, and mail them along with the required copayment ($15 generic and name brand single source (no generic substitute), $25 multisource name brand drug) for each prescription or refill to:

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

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

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

**Prescription Drug Formulary**: Your prescription drug program includes a "formulary" feature. A formulary is a list of commonly prescribed FDA approved medications that have been selected based on their effectiveness and cost savings. By asking your doctor to prescribe formulary medications, you can help control rising costs while maintaining high-quality care. Use of a formulary drug is voluntary; there is no financial penalty if your physician does not prescribe a formulary drug. For information about the formulary, call Merck-Medco Member Services at 1-800/222-7186.

**Coordinating with other drug coverage**

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

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

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

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

## *Non-FEHB Benefits Available to Plan Members*

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

**Terrorism Coverage**

SAMBA provides all its members, without charge, a $100,000 accident policy payable upon death caused by an act of terrorism within the United States and $50,000 if overseas.

**SAMBA Supplemental Insurance Plans**

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

**Group Term Life**

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

**Supplemental Group Term Life**

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

**Disability Income Protection**

For active members, 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 adjusted disability payment under the plan.

**Personal Accident Insurance**

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

**Long Term Care**

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

**Professional Liability and Legal Services**

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

**Dental/Vision**

SAMBA offers a very comprehensive Dental/Vision Care Plan.

**Dependent Children Health Benefit Plan**

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

***Benefits on this page are not part of the FEHB Contract***

# Section 6. How to File a Claim

**Claim forms, identification cards and questions**

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 have a question concerning Plan benefits, contact the Carrier at 301/984-1440 or 1-800/638-6589 or you may write to the Carrier at 11301 Old Georgetown Road, Rockville, MD 20852-2800. You may also contact the Carrier at its website at http://www.samba-insurance.com or by e-mail at feedback@samba-insurance.com.

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.

Canceled 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.

Once benefits have been paid, there is a three year limitation on the reissuance of uncashed checks.

**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.

## Section 7. General exclusions – Things we don't cover

The exclusions in this section apply to all benefits. Although we may list a specific service as a benefit, we will not cover it unless we determine it is medically necessary to prevent, diagnose, or treat your illness or condition. The fact that one of our covered providers has prescribed, recommended, or approved a service or supply does not make it medically necessary or eligible for coverage under this Plan.

We do not cover the following:

- Services, drugs or supplies that are not medically necessary;
- Services not required according to accepted standards of medical, dental, or psychiatric practice in the United States;
- Experimental or investigational procedures, treatments, drugs or devices;
- 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;
- Procedures, services, drugs and supplies related to sex transformations, sexual dysfunction or sexual inadequacy;
- Services or supplies you receive from a provider or facility barred from the FEHB Program;
- Expenses you incurred while you were not enrolled in this Plan;
- Services when no charge would be made if the covered individual had no health insurance coverage;
- Services furnished without charge (except as described on page 31); 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;
- Services and supplies furnished by immediate relatives or household members, such as your parents, your spouse, and your own and your spouse's children, brothers and sisters by blood, marriage or adoption;
- Noncovered facilities, except that medically necessary prescription drugs are covered;
- Services and supplies not specifically listed as covered;
- Any portion of a provider's fee or charge ordinarily due from the enrollee but that has been waived. If a provider routinely waives (does not require the enrollee to pay) a deductible, copayment or coinsurance, the Carrier will calculate the actual provider fee or charge by reducing the fee or charge by the amount waived;
- Charges the enrollee or Plan has no legal obligation to pay, such as: excess charges for an annuitant age 65 or older who is not covered by Medicare Parts A and/or B (see page 31), doctor charges exceeding the amount specified by the Department of Health and Human Services when benefits are payable under Medicare (limiting charge)(see page 29), 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 12 and 13;
- Dental appliances, study models, splints and other devices or services associated with the treatment of temporomandibular joint (TMJ) dysfunction;
- Eyeglasses or hearing aids, or examinations for them, except as shown on page 18;
- Marital counseling;
- Practitioners who do not meet the definition of covered provider on page 7;
- 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 12;
- Services by a massage therapist;
- Services by a naturopathic practitioner;
- Services and supplies for cosmetic purposes, e.g., Retin A, Minoxidil, Rogaine;
- Services and supplies for sexual dysfunction, e.g., Viagra, Muse, Caverject; and
- Fees for medical records not requested by the Plan.

# Section 8. Limitations – Rules that affect your benefits

## Medicare

Tell us if you or a family member is enrolled in Medicare Part A or B. Medicare will determine who is responsible for paying for medical services and we will coordinate the payments. On occasion, you may need to file a Medicare claim form.

If you are eligible for Medicare, you may enroll in a Medicare+Choice plan and also remain enrolled with us.

If you are an annuitant or former spouse, you can suspend your FEHB coverage and enroll in a Medicare+Choice plan when one is available in your area. For information on suspending your FEHB enrollment and changing to a Medicare+Choice plan, contact your retirement office. If you later want to re-enroll in the FEHB Program, generally you may do so only at the next Open Season.

If you involuntarily lose coverage, or move out of the Medicare+Choice service area, you may re-enroll in the FEHB Program at any time.

If you do not have Medicare Part A or B, you can still be covered under the FEHB Program and your benefits will not be reduced. We cannot require you to enroll in Medicare.

For information on Medicare+Choice plans, contact your local Social Security Administration (SSA) office, or call SSA at 1-800/638-6833.

### 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 30).

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.

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

### This Plan is primary if:

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

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

### Medicare is primary if:

1) You are an annuitant age 65 or over, covered by Medicare Part A (or Parts A and B) and are not employed by the Federal Government;
2) Your covered spouse is age 65 or over and has Medicare Part A (or Parts A and B) and you are not employed by the Federal Government;
3) You are age 65 or over and (a) you are a Federal judge who retired under title 28, U.S.C., (b) you are a Tax Court judge who retired under Section 7447 of title 26, U.S.C., or (c) you are the covered spouse of a retired judge described in (a) or (b);
4) You are an annuitant not employed by the Federal Government, and either you or a covered family member (who may or may not be employed by the Federal Government) is under age 65 and eligible for Medicare on the basis of disability;
5) You are enrolled in Part B only, regardless of your employment status;

6) You are age 65 or over and employed by the Federal Government in an appointment that excludes similarly appointed nonretired employees from FEHB coverage, and have Medicare Part A (or Parts A and B);
7) You are a former Federal employee receiving workers' compensation and the Office of Workers Compensation has determined that you are unable to return to duty;
8) The patient (you or a covered family member) has completed the 30-month ESRD coordination period and is still eligible for Medicare due to ESRD; or
9) The patient (you or a covered family member) becomes eligible for Medicare due to ESRD after Medicare assumed primary payer status for the patient under rules 1) through 7) above.

**When Medicare is primary**

When Medicare is primary, all or part of your Plan deductibles and coinsurance will be waived as follows:
**Inpatient Hospital Benefits**: If you are enrolled in Medicare Part A, the Plan will waive the deductible and coinsurance.
**Surgical Benefits**: If you are enrolled in Medicare Part B, the Plan will waive the deductibles and coinsurance.
**Mental Conditions/Substance Abuse Benefits**: If you are enrolled in Medicare Part A, the Plan will waive the inpatient deductible and coinsurance for hospital charges. If you are enrolled in Medicare Part B, the Plan will waive the deductibles and coinsurance for doctors' inpatient services and outpatient care.
**Prescription Drugs**: the prescription drug copayment is **not** waived.
**Other Medical Benefits**: If you are enrolled in Medicare Part B, the Plan will waive the deductibles, coinsurance, and the $100 copayment per outpatient facility service.

When Medicare is the primary payer, this Plan will limit its payment to an amount that supplements the benefits that would be payable by Medicare, regardless of whether or not Medicare benefits are paid. However, the Plan will pay its regular benefits for emergency services to an institutional provider, such as a hospital, that does not participate with Medicare and is not reimbursed by Medicare.

If you are enrolled in Medicare, you may be asked by a physician to sign a private contract agreeing that you can be billed directly for services that would ordinarily be covered by Medicare. Should you sign such an agreement, Medicare will not pay any portion of the charges, and you may receive less or no payment for those services under this Plan.

**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.

**Medicare's payment and this Plan**

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

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

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

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

**How to claim benefits**

In most cases, when services are covered by both Medicare and this Plan, Medicare is the primary payer if you are an annuitant and this Plan is the primary payer if you are an employee. When Medicare is the primary payer, your claims should first be submitted to Medicare. The Carrier has contracted with most Medicare Part B claims processors (also known as carriers) to receive electronic copies of your claims after Medicare has paid their benefits. This means you do not need to submit your Part B claims to this Carrier. You may call the Carrier at 1-800/638-6589 (TDD, use 301/984-4155) to find out if your claims are being filed electronically. If they are not, you should initially submit your claims to Medicare. After Medicare has paid its benefits, the Carrier will consider the balance of any covered expenses. To be sure your claims are processed by this Carrier, you must submit the MSN 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 Summary Notice (MSN).

**Other group insurance coverage**

When anyone has coverage with us and with another group health plan it is called double coverage. You must tell us if you or a family member has double coverage. You must also send us documents about other insurance if we ask for them.

When you have double coverage, one plan is the primary payer; it pays benefits first. The other plan is secondary; it pays benefits next. We decide which insurance is primary according to the National Association of Insurance Commissioners' Guidelines.

If we pay second, we will determine how much of the charge we will pay for. After the first plan pays, we will pay either what is left of the covered expense or our regular benefit, whichever is less. We will not pay more than the covered expense. The combined payments from both plans may not equal the entire amount billed by the provider.

Remember: Even if you do not file a claim with your other plan, you must still tell us that you have double coverage.

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.

**When others are responsible for injuries**

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.

**TRICARE**

TRICARE is the health care program for members, eligible dependents, and retirees of the military. TRICARE includes the CHAMPUS program. If both TRICARE and this Plan cover you, we are the primary payer. See your TRICARE Health Benefits Advisor if you have questions about TRICARE coverage.

**Workers' compensation**

We do not cover services that:

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

Once the OWCP or similar agency has paid its maximum benefits for your treatment, we will provide your benefits.

The Plan is entitled to be reimbursed by OWCP (or similar agency) for benefits paid by the Plan that were later found to be payable by OWCP (or the agency).

**Medicaid**

We pay first if both Medicaid and this Plan cover you.

**DVA facilities, DoD facilities, and Indian Health Service**

Facilities of the Department of Veterans Affairs, the 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**

We do not cover services and supplies that a local, State, or Federal Government agency directly or indirectly pays for.

## 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.

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

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

**Inpatient hospital care**

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

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

**Physician services**

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

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

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

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

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

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

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

# Section 9. FFS Facts

## 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 CareFirst or First Health prior to admission. If you live in the Washington, DC/Baltimore area, as defined below, call CareFirst at 1-800/553-8700 toll-free. Call First Health from all other areas at
- 1-800/346-6755 toll-free. (You are not required to precertify hospital admissions for services received outside the United States; see page 33.)
- 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.

CareFirst or First Health 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.

**This Plan's PPO Service Areas**

**CareFirst PPO Service Area**

Enrollees and their eligible family members who reside 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 call CareFirst, 1-800/553-8700, for precertification.

**First Health PPO Network Service Areas**

Enrollees and their eligible family members (outside the CareFirst PPO Service Area listed above) are eligible to use the First Health Network PPOs, and must call First Health at 1-800/346-6755 for precertification.

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

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

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

**You don't need to certify an admission when:**

- Medicare Part A, or another group health insurance policy, is the primary payer for the hospital confinement (see pages 28 and 29). 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.

**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 CareFirst or First Health 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 CareFirst Service Area.)

**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 13.

**Other considerations**

An early determination of need for confinement (precertification of the medical necessity of inpatient admission) is binding on the Carrier unless CareFirst or First Health 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.

## Protection Against Catastrophic Costs

**Catastrophic protection**

For those services with coinsurance, the Plan pays **100%** of reasonable and customary charges for the remainder of the calendar year after out-of-pocket expenses for the deductibles and coinsurance in that calendar year exceed $1,500 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 $300 calendar year deductible, $200 hospital confinement deductible, $100 outpatient facility services copayment, $15 copayment under PPO benefits and the coinsurance you pay for:

- Room and board and Other charges under Inpatient Hospital Benefits, Maternity Benefits and Mental Conditions/Substance Abuse Benefits;
- Surgical Benefits;
- Obstetrical and Outpatient care under Maternity Benefits;
- Outpatient care under Mental Conditions/Substance Abuse Benefits; and
- Other Medical Benefits.

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

- The dental accident deductible;
- Expenses in excess of reasonable and customary charges or maximum benefit limitations;
- Coinsurance for durable medical equipment or private duty nursing not authorized (see pages 19 and 20);
- Any amounts you pay because benefits have been reduced for non-compliance with this Plan's cost-containment requirements (see pages 32 and 33);
- Copayments under Prescription Drug Benefits;
- The cost difference between a name brand drug and its generic equivalent; and
- Any portion of the $700 out-of-pocket expenses you pay for inpatient hospice care;

**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.

## 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.

**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**

A drug, device, or biological product is experimental or investigational if the drug, device, or biological product cannot be lawfully marketed without approval of the U.S. Food and Drug Administration (FDA) and approval for marketing has not been given at the time it is furnished. Approval means all forms of acceptance by the FDA.

A medical treatment or procedure, or a drug, device, or biological product is experimental or investigational if 1) reliable evidence shows that it is the subject of ongoing phase I, II, or III clinical trials or under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with the standard means of treatment or diagnosis; or 2) reliable evidence shows that the consensus of opinion among experts regarding the drug, device, or biological product or medical treatment or procedure is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with the standard means of treatment or diagnosis.

Reliable evidence shall mean only published reports and articles in the authoritative medical and scientific literature; the written protocol or protocols used by the treating facility or the protocol(s) of another facility studying substantially the same drug, device or medical treatment or procedure; or the written informed consent used by the treating facility or by another facility studying substantially the same drug, device or medical treatment or procedure.

**Group health coverage**

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

**Home health care agency**

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

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

**Home health care plan**

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

**Hospice care program**

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

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

**Terminally ill person**

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

**Hospice team**

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

**Medical emergency**

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

**Medically necessary**

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

1) are appropriate to diagnose or treat the patient's condition, illness or injury;
2) are consistent with standards of good medical practice in the United States;
3) are not primarily for the personal comfort or convenience of the patient, the family, or the provider;
4) are not a part of or associated with the scholastic education or vocational training of the patient; and
5) in the case of inpatient care, cannot be provided safely on an outpatient basis.

The fact that a covered provider has prescribed, recommended, or approved a service, supply, drug or equipment does not, in itself, make it medically necessary.

**Mental conditions/ substance abuse**

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

**Reasonable and customary**

This Plan's payment of your claim begins with determining the reasonable and customary charge appropriate for the procedure covered by your claim. Claims data and fee information are gathered for specific geographic areas by Medical Data Research (MDR) and updated semi-annually. By analyzing the fee information the Plan knows how much other providers in your area charge for the procedure. The Plan then sets a benchmark or "percentile" at the highest dollar amount it considers reasonable and customary for the procedure. A 75th percentile factor means that at least 75 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, and X-ray and laboratory tests, doctors' visits and other professional services. These services are reimbursed at the 75th percentile provided by MDR. The Plan and it's medical consultants 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.

## Section 10. FEHB Facts

**You have a right to the following information.**

OPM requires that all FEHB plans comply with the Patient's Bill of Rights, which gives you the right to information about your health plan, its networks, providers and facilities. You can also find out about care management, which includes medical practice guidelines, disease management programs and how we determine if procedures are experimental or investigational. OPM's website (www.opm.gov) lists the specific types of information that we must make available to you.

If you want specific information about us, call 1-800/638-6589 or 301/984-1440 (TDD, use 301/984-4155), or write to 11301 Old Georgetown Road, Rockville, MD 20852-2800. You may also contact us by fax at 301/984-6224, or visit our website at www.samba-insurance.com.

**Where do I get information about enrolling in the FEHB Program?**

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

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

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

**When are my benefits and premiums effective?**

The benefits in this brochure are effective on January 1. If you are new to this plan, your coverage and premiums begin on the first day of your first pay period that starts on or after January 1. Annuitants' premiums begin January 1.

**What happens when I retire?**

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

**What types of coverage are available for me and my family?**

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

If you have a Self Only enrollment, you may change to a Self and Family enrollment if you marry, give birth or add a child to your family. You may change your enrollment 31 days before to 60 days after you give birth or add the child to your family. The benefits and premiums for your Self and Family enrollment begin on the first day of the pay period in which the child is born or becomes an eligible family member.

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

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

**Are my medical and claims records confidential?**

We will keep your medical and claims information confidential. Only the following will have access to it:

- OPM, this Plan, and our subcontractors when they administer this contract,
- This plan, and appropriate third parties, such as other insurance plans and the Office of Workers' Compensation Programs (OWCP), when coordinating benefit payments and subrogating claims,
- Law enforcement officials when investigating and/or prosecuting alleged civil or criminal actions,
- OPM and the General Accounting Office when conducting audits,
- Individuals involved in bona fide medical research or education that does not disclose your identity,
- OPM, when reviewing a disputed claim or defending litigation about a claim,
- This Plan and appropriate third parties when administering coordination of benefit provisions with other plans, and subrogation of claims, or
- As part of its administration of the prescription drug benefits, the Plan may disclose information about a member's prescription drug utilization, including the names of prescribing physicians, to any treating physicians or dispensing pharmacies.

## Information for new members

**Identification cards**

We will send you an Identification (ID) card. Use your copy of the Health Benefits Election Form, SF-2809, or the OPM annuitant confirmation letter until you receive your ID card. You can also use an Employee Express confirmation letter.

**What if I paid a deductible under my old plan?**

Your old plan's deductible continues until our coverage begins.

**Pre-existing conditions**

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

## When you lose benefits

**What happens if my enrollment in this Plan ends?**

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

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

You may be eligible for former spouse coverage or Temporary Continuation of Coverage.

**What is former spouse coverage?**

If you are divorced from a Federal employee or annuitant, you may not continue to get benefits under your spouse's enrollment. But, you may be eligible for your own FEHB coverage under the spouse equity law. If you are recently divorced or are anticipating a divorce, contact your ex-spouse's employing or retirement office to get more information about your coverage choices.

## What is TCC?

Temporary Continuation of Coverage (TCC). If you leave Federal service or if you lose coverage because you no longer qualify as a family member, you may be eligible for TCC. For example, you can receive TCC if you are not able to continue your FEHB enrollment after you retire. You may not elect TCC if you are fired from your Federal job due to gross misconduct.

Get the RI 79-27, which describes TCC, and the RI 70-5, the Guide to Federal Employees Health Benefits Plans for Temporary Continuation of Coverage and Former Spouse Enrollees from your employing or retirement office.

Key points about TCC:

- You can pick a new plan;
- If you leave Federal service, you can receive TCC for up to 18 months after you separate;
- If you no longer qualify as a family member, you can receive TCC for up to 36 months;
- Your TCC enrollment starts after regular coverage ends.
- If you or your employing office delay processing your request, you still have to pay premiums from the 32nd day after your regular coverage ends, even if several months have passed.
- You pay the total premium, and generally a 2-percent administrative charge. The government does not share your costs.
- You receive another 31-day extension of coverage when your TCC enrollment ends, unless you cancel your TCC or stop paying the premium.
- You are not eligible for TCC if you can receive regular FEHB Program benefits.

## How do I enroll in TCC?

If you leave Federal service your employing office will notify you of your right to enroll under TCC. You must enroll within 60 days of leaving, or receiving this notice, whichever is later.

**Children**: You must notify your employing or retirement office within 60 days after your child is no longer an eligible family member. That office will send you information about enrolling in TCC. You must enroll your child within 60 days after they become eligible for TCC, or receive this notice, whichever is later.

**Former spouses**: You or your former spouse must notify your employing or retirement office within 60 days of one of these qualifying events:

- Divorce
- Loss of spouse equity coverage within 36 months after the divorce.

Your employing or retirement office will then send your former spouse information about enrolling in TCC. Your former spouse must enroll within 60 days after the event, which qualifies them for coverage, or receiving the information, whichever is later.

**Note**: Your child or former spouse loses TCC eligibility unless you or your former spouse notify your employing or retirement office within the 60-day deadline.

## How can I convert to individual coverage?

You may convert to an individual policy if:

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

If you leave Federal service, your employing office will notify you if individual coverage is available. You must apply in writing to us within 31 days after you receive this notice.

However, if you are a family member who is losing coverage, the employing or retirement office will not notify you. You must apply in writing to us within 31 days after you are no longer eligible for coverage.

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

**How can I get a Certificate of Group Health Plan Coverage?**

If you leave the FEHB Program, we will give you a Certificate of Group Health Plan Coverage that indicates how long you have been enrolled with us. You can use this certificate when getting health insurance or other health care coverage. You must arrange for the other coverage within 63 days of leaving this Plan. Your new plan must reduce or eliminate waiting periods, limitations or exclusions for health related conditions based on the information in the certificate.

If you have been enrolled with us for less than 12 months, but were previously enrolled in other FEHB plans, you may request a certificate from them, as well.

## Inspector General Advisory: Stop Health Care Fraud!

Fraud increases the cost of health care for everyone. If you suspect that a physician, pharmacy, or hospital has charged you for services you did not receive, billed you twice for the same service, or misrepresented any information, do the following:

- Call the provider and ask for an explanation. There may be an error.
- If the provider does not resolve the matter, call us at 1-800/638-6589 or 301/984-1440 (for TDD, use 301/984-4155) and explain the situation.
- If we do not resolve the issue, call or write:

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

U.S. Office of Personnel Management
Office of the Inspector General Fraud Hotline
1900 E Street, NW, Room 6400
Washington, D.C. 20415

**Penalties for Fraud**

Anyone who falsifies a claim to obtain FEHB Program benefits can be prosecuted for fraud. Also, the Inspector General may investigate anyone who uses an ID card if they:

- Try to obtain services for a person who is not an eligible family member; or
- Are no longer enrolled in the Plan and try to obtain benefits.

Your agency may also take administrative action against you.

## Summary of Benefits for SAMBA Health Benefit Plan – 2000

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: After a $200 per confinement deductible, **70%** for semiprivate Room and board and Other hospital charges<br>**PPO** benefit: After a $200 per confinement deductible, **100%** of Room and board and **90%** of Other hospital charges | 11 |
| | **Surgical** | **Non-PPO** benefit: **70%*** of reasonable and customary charges<br>**PPO** benefit: **90%*** of covered surgical charges | 12, 13 and 14 |
| | **Medical** | **Non-PPO** benefit: **70%*** of reasonable and customary charges<br>**PPO** benefit: **90%*** of covered charges | 18, 19 and 20 |
| | **Maternity** | Same as for illness or injury | 15 |
| | **Mental Conditions/ Substance Abuse** | **Non-PPO** benefit: After a $200 per confinement deductible, **70%** for semiprivate Room and board and Other hospital charges, and inpatient visits (deductible applies)<br>**PPO** benefit: After a $200 per confinement deductible, **100%** for semiprivate Room and board and **90%** of Other hospital charges. Inpatient visits **90%*** | 17 |
| **Outpatient care** | **Hospital** | **Non-PPO** benefit: **70%*** of reasonable and customary charges for charges not covered or not fully covered under Inpatient Hospital Benefits after a $100 copayment per outpatient hospital service<br>**PPO** benefit: **90%*** of covered charges after a $100 copayment per outpatient hospital service | 19 |
| | **Surgical** | **Non-PPO** benefit: **70%*** of reasonable and customary charges<br>**PPO** benefit: **90%*** of covered surgical charges | 12, 13 and 14 |
| | **Medical** | **Non-PPO** benefit: **70%*** of reasonable and customary charges<br>**PPO** benefit: **90%*** (**100%** after a $15 copayment for doctor visits and consultations) | 18, 19 and 20 |
| | **Maternity** | Same as for illness or injury | 15 |
| | **Home health care** | **Non-PPO** benefit: **70%*** of reasonable and customary charges for up to 100 visits per calendar year<br>**PPO** benefit: **90%*** of reasonable and customary charges for up to 100 visits per calendar year | 20 |
| | **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.<br>**PPO** benefit: Plan pays **90%** of covered expenses. | 17 |
| **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 $15 (generic or name brand single source, no generic substitute) $25 (name brand) copayment through the mail order service, or at the local participating pharmacy, Plan pays **100%** of covered charges in excess of copayment per prescription except when a name brand drug is requested when a generic equivalent is available. Then you pay the difference in cost plus the copayment | 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 | 13 |
| **Additional Benefits** | | Hospice care; skilled nursing facility; childhood immunizations; cancer tests (diagnostic/screening) | 24 |
| **Out-of-Pocket Maximum** | | **100%** of covered charges after out-of-pocket expenses for Surgical, Maternity, Other Medical Benefits and Room and board and Other charges under Inpatient Hospital Benefits, exceed $1,500 per person ($2,000 per family) per calendar year | 38 |

# 2000 Rate Information for SAMBA Health Benefit Plan

FEHB Benefits of the Plan are described in this brochure.

The 2000 rates for this Plan follow. If you are in a special enrollment category, refer to an FEHB Guide or contact the agency that maintains your health benefits enrollment.

| | | Biweekly Premium | | Monthly Premium | |
|---|---|---|---|---|---|
| Type of Enrollment | Code | Gov't Share | Your Share | Gov't Share | Your Share |
| Self Only | 441 | $78.83 | $45.80 | $170.80 | $99.23 |
| Self and Family | 442 | $175.97 | $117.55 | $381.27 | $254.69 |