SAMBA Health Benefit Plan

www.SambaPlans.com

Customer Service 800-638-6589

2027

A Fee-for-Service Plan (High and Standard Option) with a Preferred Provider Organization

This Plan's health coverage qualifies as minimum essential coverage and meets the minimum value standard for the benefits it provides. See page 7 for details. This Plan is accredited. See page 12.

IMPORTANT
- Rates: Back Cover
- Changes for 2027: Page 14
- Summary of Benefits: Page 120

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

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

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

Membership dues: There are no membership dues.

Postal Employees and Annuitants are no longer eligible for this Plan (unless currently under Temporary Continuation of Coverage).

Enrollment codes for this Plan:

441 Self Only - High Option
443 Self Plus One - High Option
442 Self and Family - High Option
444 Self Only - Standard Option
446 Self Plus One - Standard Option
445 Self and Family - Standard Option

Authorized for distribution by the:

United States
Office of Personnel Management

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

Important Notice from SAMBA About

Our Prescription Drug Coverage and Medicare

The Office of Personnel Management (OPM) has determined that the SAMBA Health Benefit Plan's prescription drug coverage meets the Centers for Medicare & Medicaid Services (CMS) requirements to be considered Creditable Coverage. This means you do not need to enroll in Medicare Part D and pay extra for prescription drug coverage. If you decide to enroll in Medicare Part D later, you will not have to pay a penalty for late enrollment as long as you keep your FEHB coverage.

However, if you choose to enroll in Medicare Part D, you can keep your FEHB coverage and your FEHB Plan will coordinate benefits with Medicare.

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

Please be advised

If you lose or drop your FEHB coverage and go 63 days or longer without prescription drug coverage that is at least as good as Medicare's prescription drug coverage, your monthly Medicare Part D premium will go up at least 1% per month for every month that you did not have that coverage. For example, if you go 19 months without Medicare Part D prescription drug coverage, your premium will always be at least 19% higher than what many other people pay. You will have to pay this higher premium as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the next Annual Coordinated Election Period (October 15 through December 7) to enroll in Medicare Part D.

Medicare's Low Income Benefits

For people with limited income and resources, extra help paying for a Medicare prescription drug plan is available. Information regarding this program is available through the Social Security Administration (SSA) online at www. socialsecurity.gov, or call the SSA at 800-772-1213, (TTY: 800-325-0778).

Additional Premium for Medicare's High Income Members
Income-Related Monthly Adjustment Amount (IRMAA)

The Medicare Income-Related Monthly Adjustment Amount (IRMAA) is an amount you may pay in addition to your FEHB premium to enroll in and maintain Medicare prescription drug coverage. **This additional premium is assessed only to those with higher incomes and is adjusted based on the income reported on your IRS tax return.** You do not make any IRMAA payments to your FEHB plan. Refer to the Part D-IRMAA section of the Medicare website: https ://www. medicare.gov/drug-coverage-part-d/costs-for-medicare-drug-coverage/monthly-premium-for-drug-plans to see if you would be subject to this additional premium.

You can get more information about Medicare prescription drug plans and the coverage offered in your area from these places:

- Visit www. medicare.gov for personalized help.
- Call 800-MEDICARE (800-633-4227), (TTY 877-486-2048).

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Introduction

This brochure describes the benefits of the SAMBA Health Benefit Plan under contract (CS 1074) between the Special Agents Mutual Benefit Association (SAMBA) and the United States Office of Personnel Management, as authorized by the Federal Employees Health Benefits law. Customer service may be reached at 800-638-6589 or 301-984-1440 or through our website: www. SambaPlans.com. If you are deaf, hearing impaired or speech impaired, you can contact our Customer Service by using our TTY service at 301-984-4155. The address for the SAMBA Health Benefit Plan administrative offices is:

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

This brochure is the official statement of benefits. No verbal statement can modify or otherwise affect the benefits, limitations, and exclusions of this brochure. It is your responsibility to be informed about your health benefits.

If you are enrolled in this Plan, you are entitled to the benefits described in this brochure. If you are enrolled in Self Plus One or Self and Family coverage, each eligible family member is also entitled to these benefits. You do not have a right to benefits that were available before January 1, 2027, unless those benefits are also shown in this brochure.

OPM negotiates benefits and rates for each plan annually. Benefit changes are effective January 1, 2027, and changes are summarized on page 14. Rates are shown at the end of this brochure.

Plain Language

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

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

Stop Healthcare Fraud!

Fraud increases the cost of healthcare for everyone and increases your Federal Employees Health Benefits Program premium.

OPM's Office of the Inspector General investigates all allegations of fraud, waste, and abuse in the FEHB Program regardless of the agency that employs you or from which you retired.

Protect Yourself From Fraud – Here are some things that you can do to prevent fraud:

- Do not give your plan identification (ID) number over the phone or to people you do not know, except for your healthcare provider, authorized health benefits plan, or OPM representative.
- Let only the appropriate medical professionals review your medical record or recommend services.
- Avoid using healthcare providers who say that an item or service is not usually covered, but they know how to bill us to get it paid.
- Carefully review explanations of benefits (EOBs) statements that you receive from us.
- Periodically review your claim history for accuracy to ensure we have not been billed for services you did not receive.
- Do not ask your doctor to make false entries on certificates, bills, or records in order to get us to pay for an item or service.
- If you suspect that a provider has charged you for services you did not receive, billed you twice for the same service, or misrepresented any information, do the following:
  - Call the provider and ask for an explanation. There may be an error.
  - If the provider does not resolve the matter, call us at 800-638-6589 or 301-984-1440 (for TTY, use 301-984-4155) and explain the situation.

- If we do not resolve the issue:

CALL — THE HEALTHCARE FRAUD HOTLINE
877-499-7295

OR go to www. opm.gov/our-inspector-general/hotline-to-report-fraud-waste-or-abuse/complaint-form/

The online reporting form is the desired method of reporting fraud in order to ensure accuracy, and a quicker response time.

You can also write to:

United States Office of Personnel Management
Office of the Inspector General Fraud Hotline
1900 E Street NW Room 6400
Washington, DC 20415-1100

- Do not maintain as a family member on your policy:
  - Your former spouse after a divorce decree or annulment is final (even if a court order stipulates otherwise); or
  - Your child age 26 or over (unless they were disabled and incapable of self-support prior to age 26).

  A carrier may request that an enrollee verify the eligibility of any or all family members listed as covered under the enrollee's FEHB enrollment.
- If you have any questions about the eligibility of a family member, check with your personnel office if you are employed, with your retirement office (such as OPM) if you are retired, or with the National Finance Center if you are enrolled under Temporary Continuation of Coverage (TCC).
- Fraud or intentional misrepresentation of material fact is prohibited under the Plan. You can be prosecuted for fraud and your agency may take action against you. Examples of fraud include falsifying a claim to obtain FEHB benefits, trying to or obtaining services or coverage for yourself or for someone who is not eligible for coverage, or enrolling in the Plan when you are no longer eligible.
- If your enrollment continues after you are no longer eligible for coverage (i.e., you have separated from Federal service) and premiums are not paid, you will be responsible for all benefits paid during the period in which premiums were not paid. You may be billed by your provider for services received. You may be prosecuted for fraud for knowingly using health insurance benefits for which you have not paid premiums. It is your responsibility to know when you or a family member is no longer eligible to use your health insurance coverage.

Discrimination is Against the Law

We comply with applicable Federal nondiscrimination laws and do not discriminate on the basis of race, color, national origin, age, disability, religion, sex, pregnancy, or genetic information. We do not exclude people or treat them differently because of race, color, national origin, age, disability, religion, sex, pregnancy, or genetic information.

The health benefits described in this brochure are consistent with applicable laws prohibiting discrimination. All coverage decisions will be based on nondiscriminatory standards and criteria. An individual's protected trait or traits will not be used to deny health benefits for items, supplies, or services that are otherwise covered and determined to be medically necessary.

Preventing Medical Mistakes

Medical mistakes continue to be a significant cause of preventable deaths within the United States. While death is the most tragic outcome, medical mistakes cause other problems such as permanent disabilities, extended hospital stays, longer recoveries, and even additional treatments. Medical mistakes and their consequences also add significantly to the overall cost of healthcare. Hospitals and healthcare providers are being held accountable for the quality of care and reduction in medical mistakes by their accrediting bodies. You can also improve the quality and safety of your own healthcare and that of your family members by learning more about and understanding your risks. Take these simple steps:

1. Ask questions if you have doubts or concerns.

- Ask questions and make sure you understand the answers.
- Choose a doctor with whom you feel comfortable talking.
- Take a relative or friend with you to help you take notes, ask questions and understand answers.

2. Keep and bring a list of all the medications you take.

- Bring the actual medications or give your doctor and pharmacist a list of all the medications and dosage that you take, including non-prescription (over-the-counter) medications and nutritional supplements.
- Tell your doctor and pharmacist about any drug, food, and other allergies you have, such as latex.
- Ask about any risks or side effects of the medication and what to avoid while taking it. Be sure to write down what your doctor or pharmacist says.
- Make sure your medication is what the doctor ordered. Ask the pharmacist about your medication if it looks different than you expected.
- Read the label and patient package insert when you get your medication, including all warnings and instructions.
- Know how to use your medication. Especially note the times and conditions when your medication should and should not be taken.
- Contact your doctor or pharmacist if you have any questions.
- Understanding both the generic and brand names for all of your medication(s) is important. This helps ensure you do not receive double dosing from taking both a generic and a brand of the same medication. It also helps you avoid taking a medication to which you are allergic.

3. Get the results of any test or procedure.

- Ask when and how you will get the results of tests or procedures. Will it be in person, by phone, mail, through the Plan or Provider's portal?
- Don’t assume the results are fine if you do not get them when expected. Contact your healthcare provider and ask for your results.
- Ask what the results mean for your care.

4. Talk to your doctor about which hospital or clinic is best for your health needs.

- Ask your doctor about which hospital or clinic has the best care and results for your condition if you have more than one hospital or clinic to choose from to get the healthcare you need.
- Be sure you understand the instructions you get about follow-up care when you leave the hospital or clinic.

5. Make sure you understand what will happen if you need surgery.

- Make sure you, your doctor, and your surgeon all agree on exactly what will be done during the operation.
- Ask your doctor, “Who will manage my care when I am in the hospital?”
- Ask your surgeon:
  - "Exactly what will you be doing?"
  - "About how long will it take?"
  - "What will happen after surgery?"
  - "How can I expect to feel during recovery?"
- Tell the surgeon, anesthesiologist, and nurses about any allergies, bad reactions to anesthesia, and any medications or nutritional supplements you are taking.

Patient Safety Links

For more information on patient safety, please visit:

- www. jointcommission.org/speakup.aspx. The Joint Commission's Speak Up™ patient safety program.

- www. jointcommission.org/topics/patient_safety.aspx. The Joint Commission helps healthcare organizations to improve the quality and safety of the care they deliver.
- www. ahrq.gov/patients-consumers/. The Agency for Healthcare Research and Quality makes available a wide-ranging list of topics not only to inform consumers about patient safety but to help choose quality healthcare providers and improve the quality of care you receive.
- https://psnet.ahrq.gov/issue/national-patient-safety-foundation. The National Patient Safety Foundation has information on how to ensure safer healthcare for you and your family.
- www. bemedwise.org. The National Council on Patient Information and Education is dedicated to improving communication about the safe, appropriate use of medications.
- www. leapfroggroup.org. The Leapfrog Group is active in promoting safe practices in hospital care.
- www. ahqa.org. The American Health Quality Association represents organizations and health care professionals working to improve patient safety.

Preventable Healthcare Acquired Conditions ("Never Events")

When you enter the hospital for treatment of one medical problem, you do not expect to leave with additional injuries, infections, or other serious conditions that occur during the course of your stay. Although some of these complications may not be avoidable, patients do suffer from injuries or illnesses that could have been prevented if doctors or the hospital had taken proper precautions. Errors in medical care that are clearly identifiable, preventable and serious in their consequences for patients, can indicate a significant problem in the safety and credibility of a healthcare facility. These conditions and errors are sometimes called "Never Events" or "Serious Reportable Events."

We have a benefit payment policy that encourages hospitals to reduce the likelihood of hospital-acquired conditions such as certain infections, severe bedsores, and fractures, and to reduce medical errors that should never happen. When such an event occurs, neither you nor your FEHB Plan will incur costs to correct the medical error. You will not be billed for inpatient services related to treatment of specific hospital-acquired conditions or for inpatient services needed to correct Never Events if you use Cigna preferred providers. This policy helps to protect you from preventable medical errors and improve the quality of care you receive.

FEHB Facts

Coverage information

- **No pre-existing condition limitation**

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

- **Minimum essential coverage (MEC)**

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

- **Minimum value standard**

  Our health coverage meets the minimum value standard of 60% established by the ACA. This means that we provide benefits to cover at least 60% of the total allowed costs of essential health benefits. The 60% standard is an actuarial value; your specific out-of-pocket costs are determined as explained in this brochure.

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

  See www.opm.gov/healthcare-insurance/healthcare for enrollment information as well as:

  - Information on the FEHB Program and plans available to you
  - A health plan comparison tool
  - A list of agencies that participate in Employee Express
  - A link to Employee Express
  - Information on and links to other electronic enrollment systems

  Also, your employing or retirement office can answer your questions, give you other plans' brochures and other materials you need to make an informed decision about your FEHB coverage. These materials tell you:

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

  We do not determine who is eligible for coverage and, in most cases, cannot change your enrollment status without information from your employing or retirement office. For information on your premium deductions, you must also contact your employing or retirement office.

  Once enrolled in your FEHB Program Plan, you should contact your carrier directly for updates and questions about your benefit coverage.

- **Enrollment types available for you and your family**

  Self Only coverage is only for the enrollee. Self Plus One coverage is for the enrollee and one eligible family member. Self and Family coverage is for the enrollee and one or more eligible family members. Family members include your spouse and your children under age 26, including any foster children authorized for coverage by your employing agency or retirement office. Under certain circumstances, you may also continue coverage for a disabled child 26 years of age or older who is incapable of self-support.

If you have a Self Only enrollment, you may change to a Self Plus One or Self and Family enrollment if you marry, give birth, or add a child to your family. You may change your enrollment 31 days before to 60 days after that event. The Self Plus One or Self and Family enrollment begins on the first day of the pay period in which the child is born or becomes an eligible family member. When you change to Self Plus One or Self and Family because you marry, the change is effective on the first day of the pay period that begins after your employing office receives your enrollment form. Benefits will not be available to your spouse until you are married. A carrier may request that an enrollee verify the eligibility of any or all family members listed as covered under the enrollee's FEHB enrollment.

Contact your employing or retirement office if you want to change from Self Only to Self Plus One or Self and Family. If you have a Self and Family enrollment, you may contact us to add a family member.

Your employing or retirement office will **not** notify you when a family member is no longer eligible to receive benefits. Please tell us immediately of changes in family member status, including your marriage, divorce, annulment, or when your child reaches age 26. We will send written notice to you 60 days before we proactively disenroll your child on midnight of their 26th birthday unless your child is eligible for continued coverage because they are incapable of self-support due to a physical or mental disability that began before age 26.

If you or one of your family members is enrolled in one FEHB Plan, you or they cannot be enrolled in or covered as a family member by another enrollee in another FEHB Plan.

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

- **Family Member Coverage**

Family members covered under your Self and Family enrollment are your spouse (including your spouse by a valid common-law marriage if you reside in a state that recognizes common-law marriages) and children as described below. A Self Plus One enrollment covers you and your spouse, or one other eligible family member as described below.

Natural children, adopted children, and stepchildren
Coverage: Natural children, adopted children, and stepchildren are covered until their 26th birthday.

Foster children
Coverage: Foster children are eligible for coverage until their 26th birthday if you provide documentation of your regular and substantial support of the child and sign a certification stating that your foster child meets all the requirements. Contact your human resources office or retirement system for additional information.

Children incapable of self-support
Coverage: Children who are incapable of self-support because of a mental or physical disability that began before age 26 are eligible to continue coverage. Contact your human resources office or retirement system for additional information.

Married children
Coverage: Married children (but **NOT** their spouse or their own children) are covered until their 26th birthday.

Children with or eligible for employer-provided health insurance
Coverage: Children who are eligible for or have their own employer-provided health insurance are covered until their 26th birthday.

Newborns of covered children are insured only for routine nursery care during the covered portion of the mother's maternity stay.

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

- **Children's Equity Act**

OPM implements the Federal Employees Health Benefits Children's Equity Act of 2000. This law mandates that you be enrolled for Self Plus One or Self and Family coverage in the FEHB Program if you are an employee subject to a court or administrative order requiring you to provide health benefits for your child(ren).

If this law applies to you, you must enroll in Self Plus One or Self and Family coverage in a health plan that provides full benefits in the area where your children live or provide documentation to your employing office that you have obtained other health benefits coverage for your children. If you do not do so, your employing office will enroll you involuntarily as follows:

- If you have no FEHB coverage, your employing office will enroll you for Self Plus One or Self and Family coverage, as appropriate, in the lowest-cost nationwide plan option as determined by OPM;
- If you have a Self Only enrollment in a fee-for-service plan or in an HMO that serves the area where your children live, your employing office will change your enrollment to Self Plus One or Self and Family, as appropriate, in the same option of the same plan; or
- If you are enrolled in an HMO that does not serve the area where the children live, your employing office will change your enrollment to Self Plus One or Self and Family, as appropriate, in the lowest-cost nationwide plan option as determined by OPM.

As long as the court/administrative order is in effect, and you have at least one child identified in the order who is still eligible under the FEHB Program, you cannot cancel your enrollment, change to Self Only, or change to a plan that does not serve the area in which your children live, unless you provide documentation that you have other coverage for the children.

If the court/administrative order is still in effect when you retire, and you have at least one child still eligible for FEHB coverage, you must continue your FEHB coverage into retirement (if eligible) and cannot cancel your coverage, change to Self Only, or change to a plan that does not serve the area in which your children live as long as the court/administrative order is in effect. Similarly, you cannot change to Self Plus One if the court/administrative order identifies more than one child. Contact your employing office for further information.

- **Medicare Prescription Drug Plan (PDP) Employer Group Waiver Plan (EGWP)**

Our PDP EGWP is only available to FEHB annuitants who are Medicare Part D-eligible and their covered Medicare Part D-eligible family members. Our PDP EGWP is limited to FEHB annuitants enrolled in this plan and their eligible family members. If you are an active FEHB employee, or covered family member, and become eligible to enroll in Medicare Part D, you are not eligible to enroll in our PDP EGWP. Please contact CMS for assistance, 800-MEDICARE (800-633-4227), (TTY 877-486-2048).

- **When benefits and premiums start**

The benefits in this brochure are effective January 1. If you joined this Plan during Open Season, your coverage begins on the first day of your first pay period that starts on or after January 1. **If you changed plans or plan options during Open Season and you receive care between January 1 and the effective date of coverage under your new plan or option, your claims will be processed according to the 2027benefits of your prior plan or option.** If you have met (or pay cost-sharing that results in your meeting) the out-of-pocket maximum under the prior plan or option, you will not pay cost-sharing for services covered between January 1 and the effective date of coverage under your new plan or option. **However**, if your prior plan left the FEHB Program at the end of 2026, you are covered under that plan's 2026 benefits until the effective date of your coverage with your new plan. Annuitants' coverage and premiums begin on January 1. If you joined at any other time during the year, your employing office will tell you the effective date of coverage.

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

- **When you retire**

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

When you lose benefits

- **When FEHB coverage ends**

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

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

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

You may be eligible for spouse equity coverage or assistance with enrolling in a conversion policy (a non-FEHB individual policy).

- **Upon divorce**

If you are an enrollee and your divorce or annulment is final, your ex-spouse cannot remain covered as a family member under your Self Plus One or Self and Family enrollment. You must contact us to let us know the date of the divorce or annulment and have us remove your ex-spouse. We may ask for a copy of the divorce decree as proof. In order to change enrollment type, you must contact your employing or retirement office. A change will not automatically be made.

If you were married to an enrollee and your divorce or annulment is final, you may not remain covered as a family member under your former spouse's enrollment. This is the case even when the court has ordered your former spouse to provide health coverage to you. However, you may be eligible for your own FEHB coverage under either the spouse equity law or Temporary Continuation of Coverage (TCC). If you are recently divorced or are anticipating a divorce, contact your ex-spouse's employing or retirement office to get additional information about your coverage choices, https://www.opm.gov/healthcare-insurance/life-events/memy-family/im-separated-or-im-getting-divorced/#url=Health. We may request that you verify the eligibility of any or all family members listed as covered under the enrollee's FEHB enrollment.

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

If you leave Federal service, Tribal employment, or if you lose coverage because you no longer qualify as a family member, you may be eligible for Temporary Continuation of Coverage (TCC). For example, you can receive TCC if you are not able to continue your FEHB enrollment after you retire, if you lose your Federal or Tribal job, or if you are a covered child and you turn age 26, regardless of marital status, etc.

You may not elect TCC if you are fired from your Federal or Tribal job due to gross misconduct.

Enrolling in TCC. Get the RI 79-27, which describes TCC, from your employing or retirement office or from www.opm.gov/healthcare-insurance. It explains what you have to do to enroll.

Alternatively, you can buy coverage through the Health Insurance Marketplace where, depending on your income, you could be eligible for a tax credit that lowers your monthly premiums. Visit www.HealthCare.gov to compare plans and see what your premium, deductible, and out-of-pocket costs would be before you make a decision to enroll. Finally, if you qualify for coverage under another group health plan (such as your spouse's plan), you may be able to enroll in that plan, as long as you apply within 30 days of losing FEHB Program coverage.

- **Converting to individual coverage**

  If you leave Federal or Tribal service, your employing office will notify you of your right to convert. You must contact us in writing 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 contact us in writing 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, a waiting period will not be imposed and your coverage will not be limited due to pre-existing conditions. When you contact us, we will assist you in obtaining information about health benefits coverage inside or outside the Affordable Care Act's Health Insurance Marketplace in your state. For assistance in finding coverage, please contact us at 800-638-6589 or 301-984-1440 (for TTY, use 301-984-4155) or visit our website at www.SambaPlans.com.

- **Health Insurance Marketplace**

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

Section 1. How This Plan Works

This Plan is a fee-for-service (FFS) plan. OPM requires that FEHB Plans be accredited to validate that plan operations and/or care management meet or exceed nationally recognized standards. SAMBA holds the following accreditation: Accreditation Association for Ambulatory Health Care (AAAHC). The vendors that support SAMBA hold accreditations from URAC (Cigna Health Management, Inc. and Express Scripts) and the National Committee for Quality Assurance (Cigna's Open Access Plus Network). To learn more about this Plan's accreditations, please visit the following websites: www. aaahc.org; www. ncqa.org; www. URAC.org. You can choose your own physicians, hospitals, and other healthcare providers. We give you a choice of enrollment in a High Option or a Standard Option.

We reimburse you or your provider for your covered services, usually based on a percentage of the amount we allow. The type and extent of covered services, and the amount we allow, may be different from other plans. Read brochures carefully.

General features of our High and Standard Options

We have a Preferred Provider Organization (PPO)

Our fee-for-service plan offers services through a PPO. This means that certain hospitals and other healthcare providers are "preferred providers." We have entered into an arrangement with Cigna to offer the Cigna Open Access Plus (OAP) Network to serve as the Plan's PPO for SAMBA enrollees in all states. When you use our PPO providers, you will receive covered services at reduced cost. SAMBA is solely responsible for the selection of the OAP network in your area. Contact Evernorth Health Services (Cigna's Medical Management Team) at 800-887-9735 for the names of OAP providers and to verify their continued participation. You can also go to our Web page, which you can reach through the FEHB website, www. opm.gov/insure. Contact SAMBA at 800-638-6589 or 301-984-1440 (for TTY, use 301-984-4155) to request a PPO directory.

The Non-PPO benefits are the regular benefits of this Plan. PPO benefits apply only when you use a participating Cigna OAP Network provider. Note: Use of a participating Network doctor or hospital does not guarantee that the associated ancillary providers such as specialists, emergency room doctors, anesthesiologists, radiologists, and pathologists participate in the Network. Provider networks may be more extensive in some areas than others. We cannot guarantee the availability of every specialty in all areas and continued participation of any specific provider cannot be guaranteed. When you phone for an appointment, please remember to verify that the healthcare provider or facility is still a Cigna OAP Network provider. The nature of the services (such as urgent or emergency situations) does not affect whether benefits are paid as PPO or Non-PPO. If you reside in the PPO network area and no PPO provider is available, or you do not use a PPO provider, the regular Non-PPO benefits apply.

Other Participating Providers

The Plan offers access to certain Non-PPO healthcare providers that have agreed to discount their charges. These providers are available to you through the MultiPlan network. Covered services by these providers are considered at the negotiated rate and are subject to applicable deductibles, coinsurances, and copayments. Since these Other Participating Providers are not PPO providers, the regular Non-PPO benefits will apply.

How we pay providers

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

Non-PPO facilities and providers do not have special agreements with the Plan. When you use a Non-PPO provider to perform the service or provide the supply, our payment is based on our allowance for covered services (see *Plan allowance* in Section 10, page 115). In addition to applicable copayment, coinsurance and deductible amounts, you are responsible for the difference between the provider's charge and our allowance. Please note that your out-of-pocket costs may be higher when you use Non-PPO providers than when you use PPO providers.

When we are able to obtain discounts through negotiations with providers, we pass along the savings to you.

Preventive care services

Preventive care services are generally covered with no cost-sharing and are not subject to copayments, deductibles or annual limits when received from a network provider.

Annual deductible

The annual deductible must be met before Plan benefits are paid for care other than preventive care services.

Your rights and responsibilities

OPM requires that all FEHB plans provide certain information to their FEHB members. You may get information about us, our networks and our providers. OPM's FEHB website (www. opm.gov/insure) lists the specific types of information that we must make available to you. Some of the required information is listed below.

- SAMBA was established in 1948;
- SAMBA is a not-for-profit employee association

You are also entitled to a wide range of consumer protections and have specific responsibilities as a member of this plan. You can view the complete list of these rights and responsibilities by visiting our website, www. SambaPlans.com. You can also contact us to request that we mail a copy to you.

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

By law, you have the right to access your protected health information (PHI). For more information regarding access to PHI, visit our website at www. SambaPlans.com to obtain our Notice of Privacy Practices. You can also contact us to request that we mail you a copy of that Notice.

Your medical and claims records are confidential

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

Section 2. Changes for 2027

Do not rely only on these change descriptions; this Section is not an official statement of benefits. For that, go to Section 5 Benefits. Also, we edited and clarified language throughout the brochure; any language change not shown here is a clarification that does not change benefits.

Changes to both our High and Standard Options

- Benefits for acupuncture services as an alternative treatment of depression have been added to Section 5(e). Covered services are limited to 26 visits per person, per calendar year and will be combined with the acupuncture services described in Section 5(a). See pages 50 and 71.
- You will pay nothing for the first 5 visits per calendar year for covered Teladoc Health telehealth services. Beginning with the 6th visit, there is a $10 copayment per visit under the High Option and a $15 copayment per visit under the Standard Option. See Section 5(a), page 32 and Section 5(e), page 72.
- The calendar year deductible credit you can receive upon completion of the Health Risk Assessment (HRA) tool has increased from $25 per person, per calendar year to $50 per person, per calendar year. The benefit is still limited to two individuals per family over age 18 and allowed once per year. See Section 5(h), page 89.
- We have added an incentive for completing a Virtual Checkup through Catapult Health. We will apply a $25 credit toward the annual calendar year deductible when you complete the Virtual Checkup. See Section 5(h). Wellness and Other Special Features on page 88.
- SAMBA has added the Priority Health Coaching program under the Plan's Special Features provisions. See Section 5(h)., page 88.
- We have added the High-Cost Generic Management program under the Plan's Prescription Drug Benefits. See Section 5(f), page 77.
- PPO benefits for covered intravenous (IV)/infusion therapy, including home IV and antibiotic therapy have increased from 85% to 90% under the High Option and from 80% to 85% under the Standard Option. The non-PPO benefits are unchanged. See Section 5 (a), page 43.
- The per prescription copayments under the UnitedHealthcare Medicare Advantage (PPO) for the SAMBA Health Benefit Plan have been increased for Tier 1 and Tier 2 drug purchases. See Section 9 for more information on this voluntary program, page 105.
- Coverage for Class 2 and Class 3 dental services and the annual calendar year maximum under the dental benefits have been removed from the United Healthcare Medicare Advantage (PPO) for the SAMBA Health Benefit Plan. See Section 9, page 105 for more information on SAMBA's Medicare Advantage Plan.
- Any services for chemical or surgical modification of an individual's sex traits through medical interventions (to include "gender transition" services) are no longer covered by the Plan. Counseling services for possible or diagnosed gender dysphoria will continue to be covered when provided by a licensed mental health provider. See Section 6, page 95.
- Covered GLP-1 weight loss medications are now covered at 50% of the Plan allowance. Previously, benefits were paid at the same per prescription copayment or coinsurance as any other covered prescription drug. All existing prior authorization requirements and participation in the Plan's lifestyle management program remain in effect. See Section 5(f), page 81.

Changes to our High Option only

- Your share of the premium rate will increase for Self Only, Self Plus One, and Self and Family. See page 122.
- The per confinement copayment for covered inpatient hospital services has increased from $200 to $250 per confinement for PPO expenses and from $300 to $350 per confinement for non-PPO expenses. See Section 5(c), page 64 and Section 5(e), page 72.
- The PPO per visit copayment for covered phone consultations and online evaluation and management services (excluding Teladoc Health services) has decreased from $15 per visit to $10 per visit for primary care providers and from $25 per visit to $20 per visit for specialists. See Section 5(a), page 32 and Section 5(e), page 71.
- The copayment for covered outpatient observation services billed by a hospital has increased from $200 to $250 per confinement for PPO expenses and from $300 to $350 per confinement for non-PPO expenses. See Section 5(c), page 65.

- PPO benefits for covered medical urinalysis tests and their interpretations are now subject to the calendar year deductible. Once the deductible is met, benefits will continue to be paid at 85%. See Section 5(a), page 33.

Changes to our Standard Option only

- Your share of the premium rate will increase for Self Only, Self Plus One, and Self and Family. See page 122.
- The per confinement copayment for covered inpatient hospital services has increased from $200 to $250 per confinement for PPO expenses and from $400 to $450 per confinement for non-PPO expenses. See Section 5(c), page 64 and Section 5(e), page 72.
- The PPO per visit copayment for covered phone consultations and online evaluation and management services (excluding Teladoc Health services) has decreased from $20 per visit to $15 per visit for primary care providers and from $30 per visit to $25 per visit for specialists. See Section 5(a), page 32 and Section 5(e), page 71.
- The copayment for covered outpatient observation services billed by a hospital has increased from $200 to $250 per confinement for PPO expenses and from $400 to $450 per confinement for non-PPO expenses. See Section 5(c), page 65.

Clarifications

- We have updated brochure language to clarify the Plan's coverage for non-pharmaceutical interventions (NPIs) for stress management and mental health services. See Section 5(e), page 71.
- We have updated brochure language to better clarify the Plan's coverage for non-pharmaceutical interventions (NPIs) related to weight management and obesity care services. See Section 5(a), page 32.
- We have updated the Catapult Health's VirtualCheckup® information to make clear that this benefit is in addition to the annual routine physical covered by the plan under Section 5(a). See page 88.
- Once the annual True Out-of-Pocket (TrOOP) maximum for covered drugs under SAMBA's Medicare Advantage Plan has been met, you will continue to pay the per-prescription copayment for non–Part D medications for the remainder of the plan year. However, for Medicare-covered Part D drugs, you will have no additional costs for the rest of the plan year. See Section 9, page 105 for more information on SAMBA's Medicare Advantage Plan.
- The Medicare Part D True Out-of-Pocket (TrOOP) spending limit for covered Part D medications will increase from $2,100 to $2,400 per person, per year. This revised maximum will apply to prescription drug benefits under SAMBA's Medicare Advantage Plan and SAMBA's Medicare Prescription Drug Plan (PDP) Employer Group Waiver Plan (EGWP).

Identification cards

We will send you an identification (ID) card when you enroll. You should carry your ID card with you at all times. You must show it whenever you receive services from a Plan provider, or fill a prescription at a Plan pharmacy. Until you receive your ID card, use your copy of the Health Benefits Election Form, SF-2809, your health benefits enrollment confirmation (for annuitants), or your electronic enrollment system (such as Employee Express) confirmation letter. Note: If you are enrolled in our Medicare Part D PDP EGWP, you may receive a second ID card for your prescription drug benefits.

If you do not receive your ID card within 30 days after the effective date of your enrollment, or if you need replacement cards, call us at 800-638-6589 or 301-984-1440 (for TTY, use 301-984-4155) or write to us at SAMBA, 11301 Old Georgetown Road, Rockville, MD 20852-2800. You may also request replacement cards through our website: www.SambaPlans.com.

Where you get covered care

You can get care from any "covered provider" or "covered facility." How much we pay – and you pay – depends on the type of covered provider or facility you use and who bills for the covered services. If you use our preferred providers, you will pay less.

Balance Billing Protection

FEHB Carriers must have clauses in their in-network (participating) provider agreements. These clauses provide that, for a service that is a covered benefit in the plan brochure or for services determined not medically necessary, the in-network provider agrees to hold the covered individual harmless (and may not bill) for the difference between the billed charge and the in-network contracted amount. If an in-network provider bills you for covered services over your normal cost share (deductible, copay, coinsurance) contact your Carrier to enforce the terms of its provider contract.

- **Covered providers**

Covered providers are medical practitioners who perform covered services when acting within the scope of their license or certification under applicable state law and who furnish, bill, or are paid for their health care services in the normal course of business. Covered services must be provided in the state in which the practitioner is licensed or certified.

Benefits are provided under this Plan for the services of covered providers, in accordance with Section 2706(a) of the Public Health Service Act. Coverage of practitioners is not determined by your state's designation as a medically underserved area.

We list network-contracted covered providers in our network provider directory, which we update periodically, and make available on our website.

Benefits described in this brochure are available to all members meeting medical necessity guidelines regardless of race, color, national origin, age, disability, religion, sex, pregnancy or genetic information.

This Plan provides Care Coordinators for complex conditions and can be reached by contacting Cigna Healthcare and Evernorth Health Services at 800-887-9735 for assistance.

We consider the following to be covered providers when they perform services within the scope of their license or certification:

- doctor of medicine (M.D.)
- doctor of osteopathy (D.O.)
- doctor of podiatry (D.P.M.)
- dentist (D.D.S., D.M.D.)
- chiropractor
- licensed registered physical therapist
- licensed occupational therapist
- licensed speech therapist
- qualified clinical psychologist

- clinical social worker
- optometrist
- audiologist
- respiratory therapist
- physician's assistant
- nurse midwife
- nurse practitioner/clinical specialist
- nursing school-administered clinic
- certified registered nurse anesthetist (C.R.N.A.)
- licensed acupuncturist (LAC)
- licensed naturopathic doctor (ND)

- **Covered facilities**

Covered facilities include:

- Ambulatory surgical center:

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

- Birthing center — a licensed or certified facility approved by the Plan, that provides services for nurse midwifery and related maternity services.
- Hospital:

1. An institution that is accredited under the hospital accreditation program of the Joint Commission on Accreditation of Healthcare Organizations, or
2. Any other institution that is operated pursuant to law, under the supervision of a staff of doctors and with 24-hour-a-day nursing service by a registered graduate nurse (R.N.) or a licensed practical nurse (L.P.N.), and primarily engaged in providing acute inpatient care and treatment of sick and injured persons through medical, diagnostic and major surgical facilities, all of which must be provided on its premises or under its control.

   In no event shall the term "hospital" include a skilled nursing facility, a convalescent nursing home, or any institution or part thereof which: a) is used principally as a convalescent facility, nursing facility, or facility for the aged; b) furnishes primarily domiciliary or custodial care, including training in the routines of daily living; or c) is operated as a school or residential treatment facility (except as listed in *Section 5(e). Mental Health and Substance Use Disorder Benefits*).

- Residential Treatment Center:

1. Is accredited by nationally recognized organizations.
2. Is licensed by the state, district or territory to provide residential treatment for medical conditions, mental health conditions and/or substance use disorders.
3. An accredited healthcare facility (excluding hospitals, skilled nursing facilities, group homes, halfway houses, and similar types of facilities) that provides 24 hour residential evaluation, treatment, and comprehensive specialized services relating to the individual's medical, physical, mental health, and/or substance use disorder therapy needs.

- Rehabilitation facility — an institution specifically engaged in the rehabilitation of persons suffering from alcoholism or drug addiction which meets all of these requirements:

1. It is operated pursuant to law.
2. It mainly provides services for persons receiving treatment for alcoholism or drug addiction. The services are provided for a fee from its patients, and include both: (a) room and board; and (b) 24-hour-a-day nursing service.
3. It provides the services under the full-time supervision of a doctor or registered graduate nurse (R.N.).
4. It keeps adequate patient records which include: (a) the course of treatment; and (b) the person's progress; and (c) discharge summary; and (d) follow-up programs.

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

- **Transitional care**

Specialty care: You may continue seeing your specialist and receiving any PPO benefits for up to 90 days if you are undergoing treatment for a chronic or disabling condition and you lose access to your specialist because:

- we drop out of the Federal Employees Health Benefits (FEHB) Program and you enroll in another FEHB Plan, or
- we terminate our contract with your specialist for reasons other than for cause,

Contact us at 800-638-6589 or 301-984-1440 (for TTY, use 301-984-4155) or, if we drop out of the Program, contact your new plan.

If you are in the second or third trimester of pregnancy and you lose access to your specialist based on the above circumstances, you can continue to see your specialist and your PPO benefits continue until the end of your postpartum care, even if it is beyond the 90 days.

Note: If you lose access to your specialist because you changed your carrier or plan option enrollment, contact your new plan.

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

We pay for covered services from the effective date of your enrollment. However, if you are in the hospital when your enrollment in our Plan begins, call our customer service department immediately at 800-638-6589 or 301-984-1440 (for TTY, use 301-984-4155). If you are new to the FEHB Program, we will reimburse you for your covered services while you are in the hospital beginning on the effective date of your coverage.

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

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

These provisions apply only to the benefits of the hospitalized person. If your plan terminates participation in the FEHB in whole or in part, or if OPM orders an enrollment change, this continuation of coverage provision does not apply. In such cases, the hospitalized family member's benefits under the new plan begin on the effective date of enrollment.

You need prior Plan approval for certain services

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

"You must get prior approval for certain services. Failure to do so will result in a minimum $500 penalty for inpatient hospital admissions or 20% penalty for all other services."

- **Inpatient hospital admission**

Precertification is the process by which – prior to your inpatient hospital admission – we evaluate the medical necessity of your proposed stay and the number of days required to treat your condition. Unless we are misled by the information given to us, we won't change our decision on medical necessity.

In most cases, your physician or hospital will take care of requesting precertification. Because you are still responsible for ensuring that your care is precertified, you should always ask your physician or hospital whether or not they have contacted us.

Warning: We will reduce our benefits for the inpatient hospital stay by $500 if no one contacts us for precertification. If the stay is not medically necessary, we will only pay for any covered medical services and supplies that are otherwise payable on an outpatient basis.

- **Other services**

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

- Certain drugs; see Section 5(f) on pages 74 and 78. Contact Express Scripts at 855-315-8527 for additional information and prior authorization.
- Select drugs that are excluded from the Plan's prescription drug formulary (visit www.SambaPlans.com/health-benefit-plan/ for a list of these drugs). Prior authorization for medical necessity is required for these excluded drugs. Contact Express Scripts at 855-315-8527. See S*ection 5(f). Prescription Drug Benefits* for additional information.
- Surgical treatment of morbid obesity (bariatric surgery). Contact Cigna Healthcare and Evernorth Health Services at 800-887-9735.
- Organ/tissue transplants. The prior authorization process for organ/tissue transplants is more extensive than the normal authorization process. Before your initial evaluation as a potential candidate for a transplant procedure, you or your doctor must contact the Cigna Lifesource Transplant Unit at 800-668-9682 to initiate the pretransplant evaluation. See Section 5(b) on page 61.
- Services for genetic testing. Call SAMBA at 800-638-6589 or 301-984-1440 (for TTY, use 301-984-4155).
- Certain outpatient procedures, including services such as: skin removal or enhancement; treatment of varicose veins; and eye, ear, nose and throat procedures. Contact Cigna Healthcare and Evernorth Health Services at 800-887-9735.
- Unlisted outpatient procedures. Contact Cigna Healthcare and Evernorth Health Services at 800-887-9735.
- Outpatient spinal procedures. Call Cigna Healthcare and Evernorth Health Services at 800-887-9735

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

Exceptions: You do not need precertification, prior authorization, or prior approval in these cases:

- If you have other group health insurance, including Medicare, that is the primary payer.
- The procedure is performed outside the United States.

- **Radiology/Imaging procedures**

The following outpatient radiology/imaging services require precertification.

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

For these outpatient procedures, you, your representative, your doctor or facility must call Cigna Healthcare and Evernorth Health Services at 800-887-9735 before scheduling the procedure. We will reduce our Plan allowance for these procedures by 20% if no one contacts us for precertification. If the procedure is not medically necessary, we will not pay any benefits. Refer to *Lab, X-ray and other diagnostic tests* on page 33 for additional information.

How to request precertification for an admission or get prior authorization for Other services

First, you, your representative, your physician, or your hospital must call Cigna Healthcare and Evernorth Health Services at 800-887-9735 before admission or services requiring prior authorization are rendered.

Next, provide the following information:

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

- **Non-urgent care claims**

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

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

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

- **Urgent care claims**

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

If you fail to provide sufficient information, we will contact you within 24 hours after we receive the claim to let you know what information we need to complete our review of the claim. You will then have up to 48 hours to provide the required information. We will make our decision on the claim within 48 hours of (1) the time we received the additional information or (2) the end of the time frame, whichever is earlier.

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

You may request that your urgent care claim on appeal be reviewed simultaneously by us and OPM. Please let us know that you would like a simultaneous review of your urgent care claim by OPM either in writing at the time you appeal our initial decision, or by calling us at 800-638-6589 or 301-984-1440 (for TTY, use 301-984-4155). You may also call OPM's FEHB 2 at 202-606-3818 between 8 a.m. and 5 p.m. Eastern Time to ask for the simultaneous review. We will cooperate with OPM so they can quickly review your claim on appeal. In addition, if you did not indicate that your claim was a claim for urgent care, call us at 800-638-6589 or 301-984-1440 (for TTY, use 301-984-4155). If it is determined that your claim is an urgent care claim, we will expedite our review (if we have not yet responded to your claim).

- **Concurrent care claims**

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

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

- **Emergency inpatient admission**

If you have an emergency admission due to a condition that you reasonably believe puts your life in danger or could cause serious damage to bodily function, you, your representative, the physician, or the hospital must telephone us within two business days following the day of the emergency admission, even if you have been discharged from the hospital. If you do not telephone the Plan within two business days, penalties may apply — see *Warning* under *Inpatient hospital admissions* earlier in this Section and *If your hospital stay needs to be extended* below.

- **Maternity care**

You do not need precertification of a maternity admission for a routine delivery. However, if your medical condition requires you to stay more than 48 hours after a vaginal delivery or 96 hours after a cesarean section, then you, your representative, your physician, or the hospital must contact us for precertification of additional days. Further, if your baby stays after you are discharged, you, your representative, your physician, or the hospital must contact us for precertification of additional days for your baby.

Note: When a newborn requires definitive treatment during or after the mother's hospital stay, the newborn is considered a patient in their own right. If the newborn is eligible for coverage, regular medical or surgical benefits apply rather than maternity benefits.

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

If your hospital stay – including for maternity care – needs to be extended, you, your representative, your doctor, or the hospital must ask us to approve the additional days. If you remain in the hospital beyond the number of days we approved and did not get the additional days precertified, then:

- for the part of the admission that was medically necessary, we will pay inpatient benefits, but
- for the part of the admission that was not medically necessary, we will pay only medical services and supplies otherwise payable on an outpatient basis and will not pay inpatient benefits.

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

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

If you disagree with our pre-service claim decision

If you have a **pre-service claim** and you do not agree with our decision regarding precertification of an inpatient admission or prior approval of other services, you may request a review in accord with the procedures detailed below. If your claim is in reference to a contraceptive, call Express Scripts at 855-315-8527.

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

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

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

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

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

2. Ask you or your provider for more information.

   You or your provider must send the information so that we receive it within 60 days of our request. We will then decide within 30 more days.

   If we do not receive the information within 60 days, we will decide within 30 days of the date the information was due. We will base our decision on the information we already have. We will write to you with our decision.

3. Write to you and maintain our denial.

- **To reconsider an urgent care claim**

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

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

- **To file an appeal with OPM**

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

Section 4. Your Costs for Covered Services

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

Cost-sharing

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

Copayment

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

Example: When you see your PPO primary care provider you pay a copayment of $15 per visit under the High Option or $20 per visit under the Standard Option.

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

Other separate copayments include, but are not limited to:

- High Option inpatient hospital confinement; PPO: $250 per confinement; Non-PPO: $350 per confinement
- Standard Option inpatient hospital confinement; PPO: $250 per confinement; Non-PPO: $450 per confinement

Deductible

A deductible is a fixed amount of covered expenses you must incur for certain covered services and supplies before we start paying benefits for them. Copayments and coinsurance amounts do not count toward any deductible. When a covered service or supply is subject to a deductible, only the Plan allowance for the service or supply counts toward the deductible. Covered expenses are applied to the deductible in the order in which they are processed, which may differ from when services were actually rendered.

- The High Option PPO and Non-PPO calendar year deductibles are as follows:
  - PPO: $300 per person, limited to $600 for a Self Plus One or a Self and Family enrollment. The PPO deductible applies only to services received from PPO providers or when the Plan pays PPO benefits.
  - Non-PPO: $300 per person, limited to $600 for a Self Plus One or a Self and Family enrollment. The Non-PPO deductible applies only to services received from Non-PPO providers.

    The calendar year deductible will not exceed the per person limit for any covered individual. Under a Self and Family enrollment, the deductible is satisfied for all family members when the combined covered expenses applied to the calendar year deductible for family members reach $600.
- The Standard Option PPO and Non-PPO calendar year deductibles are as follows:
  - PPO: $350 per person, limited to $700 for a Self Plus One enrollment or $900 for a Self and Family enrollment. The PPO deductible applies only to services received from PPO providers or when the Plan pays PPO benefits.
  - Non-PPO: $350 per person, limited to $700 for a Self Plus One enrollment or $900 for a Self and Family enrollment. The Non-PPO deductible applies only to services received from Non-PPO providers.

    The calendar year deductible will not exceed the per person limit for any covered individual. Under a Self and Family enrollment, the deductible is satisfied for all family members when the combined covered expenses applied to the calendar year deductible for family members reach $900.

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

Example: If the billed amount is $100 and the provider has an agreement with us to accept $80, and you have not paid any amount toward meeting your calendar year deductible, you must pay $80. We will apply $80 to your deductible. We will begin paying benefits once the remaining portion of your calendar year deductible ($220 under High Option or $270 under Standard Option) has been satisfied.

Note: If you change plans during Open Season and the effective date of your new plan is after January 1 of the next year, you do not have to start a new deductible under your prior plan between January 1 and the effective date of your new plan. If you change plans at another time during the year, you must begin a new deductible under your new plan.

If you change options in this Plan during the year, we will credit the amount of covered expenses already applied toward the deductible of your old option to the deductible of your new option.

Coinsurance

Coinsurance is the percentage of our allowance that you must pay for your care. In most cases, coinsurance does not begin until you have met your calendar year deductible.

Example: You pay 15% of the Plan allowance for in-network surgical services under High Option or 20% of the Plan allowance under Standard Option.

If your provider routinely waives your cost

If your provider routinely waives (does not require you to pay) your copayments, deductibles, or coinsurance, the provider is misstating the fee and may be violating the law. In this case, when we calculate our share, we will reduce the provider's fee by the amount waived.

For example, if your physician ordinarily charges $100 for a service but routinely waives your 35% High Option out-of-network coinsurance, the actual charge is $65. We will pay $42.25 (65% of the actual charge of $65).

Waivers

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

Differences between our allowance and the bill

Our "Plan allowance" is the amount we use to calculate our payment for covered services. Fee-for-service plans arrive at their allowances in different ways, so their allowances vary. For more information about how we determine our Plan allowance, see the definition of Plan allowance in Section 10.

Often, the provider's bill is more than a fee-for-service plan's allowance. Whether or not you have to pay the difference between our allowance and the bill will depend on the provider you use.

- **PPO providers** agree to limit what they will bill you. Because of that, when you use a preferred provider, your share of covered charges consists only of your deductible and coinsurance or copayment. Here is an example about coinsurance: You see a PPO surgeon who charges $150, but our allowance is $100. If you have met your deductible, you are only responsible for your coinsurance. That is, under High Option, you pay just 15% of our $100 allowance ($15). Because of the agreement, your PPO physician will not bill you for the $50 difference between our allowance and the bill.
- **Non-PPO providers**, on the other hand, have no agreement to limit what they will bill you. When you use a Non-PPO provider, you will pay your deductible and coinsurance – plus any difference between our allowance and charges on the bill. Here is an example: You see a Non-PPO physician who charges $150 and our allowance is again $100. Because you've met your deductible, you are responsible for your coinsurance, so under High Option, you pay 35% of our $100 allowance ($35). Plus, because there is no agreement between the Non-PPO physician and us, the physician can bill you for the $50 difference between our allowance and the bill.

The following illustrates the examples of how much you have to pay out-of-pocket under High Option for services from a PPO physician vs. a Non-PPO physician. We use our example of a service for which the physician charges $150 and our allowance is $100. The example below shows the amount you pay if you have met your calendar year deductible.

EXAMPLE

PPO provider

Surgical charge: $150
Our allowance: We set it at: $100
We pay: 85% of our allowance: $85
You owe: Coinsurance: 15% of our allowance: $15
+Difference up to charge?: No: 0
TOTAL YOU PAY: $15

Non-PPO provider

Surgical charge: $150
Our allowance: We set it at: $100
We pay: 65% of our allowance: $65
You owe: Coinsurance: 35% of our allowance: $35
+Difference up to charge?: Yes: $50
TOTAL YOU PAY: $85

Your catastrophic protection out-of-pocket maximum for deductibles, coinsurance, and copayments

After your (deductible, copayments and coinsurance) reaches the out-of-pocket maximum you do not have to pay any more for covered services, with the exception of certain cost sharing for the services below which do not count toward your catastrophic protection out-of-pocket maximum.

Your out-of-pocket maximum for services rendered during the 2027 calendar year is:

High Option

Self Only $5,000 ($6,000 out of network)
Self Plus One $10,000 ($12,000 out of network)
Self and Family $10,000 ($14,000 out of network)

Only eligible out-of-pocket expenses from PPO providers, in-network pharmacies, or when the Plan pays PPO benefits count toward the PPO limit. Only eligible expenses from Non-PPO providers and out of network pharmacies count toward the out of network limit.

Note: Professional care provided by the following Non-PPO providers are paid according to PPO benefits when services are rendered in a PPO facility: Anesthesiologists, Assistant Surgeons, Emergency Room Physicians, Pathologists, and Radiologists.

Your out-of-pocket maximum may differ if you changed plans at Open Season.

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

- expenses in excess of the Plan allowance or maximum benefit limitations;
- amounts you pay for non-compliance with this Plan's prior authorization requirements; and
- the cost difference between a brand name drug and its generic equivalent.

Standard Option

Self Only $6,000 ($8,500 out of network)
Self Plus One $12,000 ($14,000 out of network)
Self and Family $12,000 ($14,000 out of network)

Only eligible out-of-pocket expenses from PPO providers, in-network pharmacies, or when the Plan pays PPO benefits count toward the PPO limit. Only eligible expenses from Non-PPO providers and out of network pharmacies count toward the out of network limit.

Note: Professional care provided by the following Non-PPO providers are paid according to PPO benefits when services are rendered in a PPO facility: Anesthesiologists, Assistant Surgeons, Emergency Room Physicians, Pathologists, and Radiologists.

Your out-of-pocket maximum may differ if you changed plans at Open Season.

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

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

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 prior plan if they are for care you received in January before your effective date of coverage in this Plan. If you have already met your prior plan's catastrophic protection benefit level in full, it will continue to apply until the effective date of your coverage in this Plan. If you have not met this expense level in full, your prior plan will first apply your covered out-of-pocket expenses until the prior year's catastrophic level is reached and then apply the catastrophic protection benefit to covered out-of-pocket expenses incurred from that point until the effective date of your coverage in this Plan. Your prior plan will pay these covered expenses according to this year's benefits; benefit changes are effective January 1.

Note: If you change options in this Plan during the year, we will credit the amount of covered expenses already accumulated toward the catastrophic out-of-pocket limit of your old option to the catastrophic protection limit of your new option.

If we overpay you

We will make diligent efforts to recover benefit payments we made in error but in good faith. We may reduce subsequent benefit payments to offset overpayments.

Note: We will generally first seek recovery from the provider if we paid the provider directly or from the person (covered family member, guardian, custodial parent, etc.) to whom we sent our payment. You are obligated to notify us if you receive an overpayment from us.

When Government facilities bill us

Facilities of the Department of Veteran Affairs, the Department of Defense, and the Indian Health Service are entitled to seek reimbursement from us for certain services and supplies they provide to you or a family member. They may not seek more than their governing laws allow. You may be responsible for certain services and charges. Contact the government facility directly for more information.

Important Notice About Surprise Billing - Know Your Rights

The No Surprises Act (NSA) is a federal law that provides you with protections against "surprise billing" and "balance billing" for out-of-network emergency services; out-of-network non-emergency services provided with respect to a visit to a participating health care facility; and out-of-network air ambulance services.

A surprise bill is an unexpected bill you receive for:

- emergency care - when you have little or no say in the facility or provider from whom you receive care, or for
- non-emergency services furnished by nonparticipating providers with respect to patient visits to participating health care facilities, or for
- air ambulance services furnished by nonparticipating providers of air ambulance services.

Balance billing happens when you receive a bill from the nonparticipating provider, facility, or air ambulance service for the difference between the nonparticipating provider's charge and the amount payable by your health plan.

Your health plan must comply with the NSA protections that hold you harmless from surprise bills.

For specific information on surprise billing, the rights and protections you have, and your responsibilities go to www.SambaPlans.com or contact the health plan at 800-638-6589 or 301-984-1440 (for TTY, use 301-984-4155).

The Federal Flexible Spending Account Program – *FSAFEDS*

Healthcare FSA (HCFSA) – Reimburses an FSA participant for eligible out-of-pocket healthcare expenses (such as copayments, deductibles, over-the-counter drugs and medications, vision and dental expenses, and much more) for their tax dependents, and their adult children (through the end of the calendar year in which they turn 26).

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

Section 5. High and Standard Option Benefits

See page 14 for how our benefits changed this year. Page 120 and page 121 are a benefits summary of each option. Make sure that you review the benefits that are available under the option in which you are enrolled.

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High and Standard Option Overview

This Plan offers both a High and Standard Option. Both benefit packages are described in Section 5. Make sure that you review the benefits that are available under the option in which you are enrolled.

The High and Standard Option Section 5 is divided into subsections. Please read *Important things you should keep in mind* at the beginning of the subsections. Also read the general exclusions in Section 6; they apply to the benefits in the following subsections. To obtain claim forms, claims filing advice, or more information about High and Standard Option benefits, contact us at 800-638-6589 or 301-984-1440 (TTY, use 301-984-4155) or on our website at www. SambaPlans.com.

Each option offers unique features.

- **High Option**
  - Extensive PPO network
  - No referral needed to see a specialist
  - $15 per office visit copayment when PPO primary care providers are used
  - $25 per office visit copayment when PPO specialists are used
  - $10 copayment for generic drugs purchased at a retail pharmacy
  - $15 copayment for generic drugs purchased through the Mail Order Program
  - 100% coverage for room and board and 85% for other hospital charges after the $250 per confinement copayment when a PPO facility is used
  - 65% of the Plan allowance coverage for most eligible out-of-network expenses
- **Standard Option**
  - Extensive PPO network
  - Affordable premiums
  - No referral needed to see a specialist
  - $20 per office visit copayment when PPO primary care providers are used
  - $30 per office visit copayment when PPO specialists are used
  - $12 copayment for generic drugs purchased at a retail pharmacy
  - $20 copayment for generic drugs purchased through the Mail Order Program
  - 100% coverage for room and board and 80% for other hospital charges after the $250 per confinement copayment when a PPO facility is used
  - 55% of the Plan allowance coverage for most eligible out-of-network expenses

Enhanced Benefit Opportunity

We offer an Enhanced Benefit Opportunity through UnitedHealthcare Medicare Advantage (PPO) for the SAMBA Health Benefit Plan to annuitants with primary Medicare Part A and Part B. Membership is voluntary and members may opt-in or opt-out of this Plan at any time. Members have access to a nationwide PPO network and may seek care within the network or out-of-network. Members that opt-in will have access to certain benefit enhancements that are noted in Section 9, page 105.

To learn more about the Enhanced Benefits Opportunity through UnitedHealthcare Medicare Advantage (PPO) for the SAMBA Health Benefit Plan and how to enroll, call us at 866-794-6791, TTY 711, 8 a.m. to 8 p.m., local time, 7 days a week, or go to www. retiree.uhc.com/SAMBA.

Section 5(a). Medical Services and Supplies Provided by Physicians and Other Healthcare Professionals

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- The calendar year deductible applies to almost all benefits in this Section. We added "(No deductible)" to show when the calendar year deductible does not apply.
  - The High Option calendar year deductibles are $300 per person (limited to $600 per Self Plus One or a Self and Family enrollment) for services of PPO providers and $300 per person (limited to $600 per Self Plus One or a Self and Family enrollment) for services of Non-PPO providers.
  - The Standard Option calendar year deductibles are $350 per person (limited to $700 per Self Plus One enrollment or $900 per Self and Family enrollment) for services of PPO providers and $350 per person (limited to $700 per Self Plus One enrollment or $900 per Self and Family enrollment) for services of Non-PPO providers.
- The Non-PPO benefits are the regular benefits of this Plan. PPO benefits apply only when you use a PPO provider. When no PPO provider is available, Non-PPO benefits apply.
- When you use a PPO hospital or ambulatory surgical center facility, some of the professionals that provide related services may not be PPO network providers. We determine how to pay these providers based on their specialty. For the following specialties we pay PPO benefits: Emergency Room Physicians, Pathologists and Radiologists. PPO benefits for these providers include PPO deductible, copay, coinsurance, and out-of-pocket maximum amounts. For all other provider specialties, we will pay Non-PPO benefits. For all Non-PPO providers, you will be responsible for any difference between the Plan allowance and billed amount for these out of network providers.
- Be sure to read Section 4, *Your Costs for Covered Services*, for valuable information about how cost sharing works. Also, read Section 9 for information about how we pay if you have other coverage, or if you are age 65 or over.
- If you are enrolled in the SAMBA Health Benefit Plan and have Medicare Part A and Part B and it is primary, we offer the UnitedHealthcare Medicare Advantage (PPO) for the SAMBA Health Benefit Plan to our members. This plan enhances your SAMBA coverage by reducing or eliminating cost-sharing for services and adding benefits at no additional cost. **It includes a Medicare Part B subsidy of $100 per month for High Option and $75 per month for Standard Option.** The UnitedHealthcare Medicare Advantage (PPO) for the SAMBA Health Benefit Plan is subject to Medicare rules. (See Section 9 for additional details.)
- The coverage and cost-sharing listed below are for services provided by physicians and other health care professionals for your medical care. See Section 5(c) for cost-sharing associated with the facility (i.e., hospital, surgical center, etc.)
- **YOU MUST GET PRIOR AUTHORIZATION FOR SOME SERVICES. Please refer to *Other services* in Section 3 to be sure which services require prior authorization.**

Benefit Description	You Pay After the calendar year deductible...	
Note: The calendar year deductible applies to almost all benefits in this Section. We say "(No deductible)" when it does not apply.		
Diagnostic and treatment services	**High Option**	**Standard Option**
Professional services of physicians • Office visits and consultations, including second surgical opinion • Visits and consultation services provided in a convenient care clinic or an urgent care center	PPO: $15 copayment per office visit to primary care providers; $25 copayment per office visit to specialists (No deductible) Non-PPO: 35% of the Plan allowance and any difference between our allowance and the billed amount	PPO: $20 copayment per office visit to primary care providers; $30 copayment per office visit to specialists (No deductible) Non-PPO: 45% of the Plan allowance and any difference between our allowance and the billed amount
• Phone consultations and online medical evaluation and management services (telehealth) other than through Teladoc Health. Note: For additional telehealth benefits, see *Telehealth with Teladoc Health* below.	PPO: $10 copayment per office visit to primary care providers; $20 copayment per office visit to specialists (No deductible) Non-PPO: 35% of the Plan allowance and any difference between our allowance and the billed amount	PPO: $15 copayment per office visit to primary care providers; $25 copayment per office visit to specialists (No deductible) Non-PPO: 45% of the Plan allowance and any difference between our allowance and the billed amount
• Same day services performed and billed by the doctor in conjunction with the office visit or consultation rendered in an office, convenient care or urgent care setting Note: Specialty drugs purchased from and billed by the doctor, home health agency, or outpatient facility are covered under *Specialty drugs*; see page 44.	PPO: 15% of the Plan allowance Non-PPO: 35% of the Plan allowance and any difference between our allowance and the billed amount	PPO: 20% of the Plan allowance Non-PPO: 45% of the Plan allowance and any difference between our allowance and the billed amount
Professional services of physicians • During a hospital stay • In a skilled nursing facility • Emergency room physician care • Initial examination of a newborn child	PPO: 15% of the Plan allowance Non-PPO: 35% of the Plan allowance and any difference between our allowance and the billed amount	PPO: 20% of the Plan allowance Non-PPO: 45% of the Plan allowance and any difference between our allowance and the billed amount
Remote Monitoring and Digital Health (see definitions in Section 10, page 116) • Remote Physiologic Monitoring (RPM) • Remote Therapeutic Monitoring (RTM)	PPO: 15% of the Plan allowance Non-PPO: 35% of the Plan allowance and any difference between our allowance and the billed amount	PPO: 20% of the Plan allowance Non-PPO: 45% of the Plan allowance and any difference between our allowance and the billed amount
Telehealth services	**High Option**	**Standard Option**
Telehealth with Teladoc Health You can receive treatment from board-certified doctors for your non-emergency conditions such as the flu, strep throat, eye infections, bronchitis, and much more. Covered services include visits through the web or your mobile device to obtain a consultation, diagnosis and prescriptions (when appropriate). The service is available 24 hours a day, 7 days a week. Note: Benefits are combined with telehealth services listed in Section 5(e), see page 72.	Teladoc Health Providers: Nothing (No deductible) for the first 5 visits per calendar year for any covered telehealth service; $10 copayment per telehealth service beginning with the 6th visit (No deductible)	Teladoc Health Providers: Nothing (No deductible) for the first 5 visits per calendar year for any covered telehealth service; $15 copayment per telehealth service beginning with the 6th visit (No deductible)

Telehealth services - continued on next page

Benefit Description	You Pay After the calendar year deductible...	
Telehealth services (cont.)	**High Option**	**Standard Option**
Refer to *Section 5(h). Wellness and Other Special Features* for additional information.	Teladoc Health Providers: Nothing (No deductible) for the first 5 visits per calendar year for any covered telehealth service; $10 copayment per telehealth service beginning with the 6th visit (No deductible)	Teladoc Health Providers: Nothing (No deductible) for the first 5 visits per calendar year for any covered telehealth service; $15 copayment per telehealth service beginning with the 6th visit (No deductible)
Lab, X-ray and other diagnostic tests	**High Option**	**Standard Option**
Tests and their interpretations, such as: • Blood tests • Non-routine Pap test • Pathology • X-ray • Non-routine mammogram • Ultrasound • Electrocardiogram and EEG • CT/CAT; MRI; MRA; NC; PET (Outpatient requires precertification. Contact Cigna Healthcare and Evernorth Health Services at 800-887-9735 before scheduling the procedure. See *Radiology/Imaging procedures* under *You need prior Plan approval for certain services* on page 20.)	PPO:15% of the Plan allowance (No deductible) Non-PPO: 35% of the Plan allowance and any difference between our allowance and the billed amount Note: If your PPO provider uses a Non-PPO lab or radiologist, we will pay Non-PPO benefits for any lab and X-ray charges.	PPO: 20% of the Plan allowance Non-PPO: 45% of the Plan allowance and any difference between our allowance and the billed amount If your PPO provider uses a Non-PPO lab or radiologist, we will pay Non-PPO benefits for any lab and X-ray charges.
• Urinalysis	PPO:15% of the Plan allowance Non-PPO: 35% of the Plan allowance and any difference between our allowance and the billed amount Note: If your PPO provider uses a Non-PPO lab or radiologist, we will pay Non-PPO benefits for any lab and X-ray charges.	PPO: 20% of the Plan allowance Non-PPO: 45% of the Plan allowance and any difference between our allowance and the billed amount Note: If your PPO provider uses a Non-PPO lab or radiologist, we will pay Non-PPO benefits for any lab and X-ray charges.
• Specialized diagnostic genetic testing as well as counseling services related to the approved tests. (Prior authorization is required. See *You need prior Plan approval for certain services* on page 19.) Note: Benefits are only available when it is medically necessary to diagnose and/or manage a patient's existing medical condition. Benefits are not provided for genetic panels when some or all of the tests included in the panel are experimental or investigational or are not medically necessary.	PPO:15% of the Plan allowance (No deductible) Non-PPO: 35% of the Plan allowance and any difference between our allowance and the billed amount Note: If your PPO provider uses a Non-PPO lab or radiologist, we will pay Non-PPO benefits for any lab and X-ray charges.	PPO: 20% of the Plan allowance Non-PPO: 45% of the Plan allowance and any difference between our allowance and the billed amount Note: If your PPO provider uses a Non-PPO lab or radiologist, we will pay Non-PPO benefits for any lab and X-ray charges.

Lab, X-ray and other diagnostic tests - continued on next page

Benefit Description	You Pay After the calendar year deductible...	
Lab, X-ray and other diagnostic tests (cont.)	**High Option**	**Standard Option**
Lab Program — You can use this voluntary program for covered lab services. Testing must be performed by a Quest Diagnostics laboratory or a LabCorp laboratory. Ask your doctor to use Quest or LabCorp for lab processing. To find a Quest or LabCorp laboratory location near you, visit our website at www. SambaPlans.com. Note: This benefit applies to expenses for laboratory tests performed by Quest Diagnostics or LabCorp only. Related expenses or laboratory tests referred to and/or performed by an associated laboratory (not participating in the Lab Program) are subject to applicable deductible, copayments and coinsurance.	Nothing for services obtained through the Lab Program (No deductible)	Nothing for services obtained through the Lab Program (No deductible)
Physician ordered outpatient drug testing/screening is covered only when: • medically necessary; • is performed in a physician-supervised treatment setting; and • the results of the testing will impact treatment planning Presumptive (screening) drug testing is covered when there is a suspicion of drug misuse by the individual being tested. Definitive (confirmatory) drug testing is covered when presumptive test results are inconsistent with the individual's condition or history and examination or a presumptive drug test is not available for the drug for which there is a suspicions of abuse or misuse.	PPO: 15% of the Plan allowance Non-PPO: 35% of the Plan allowance and any difference between our allowance and the billed amount. Note: If your PPO provider uses a Non-PPO lab or radiologist, we will pay Non-PPO benefits for any lab and X-ray charges.	PPO: 20% of the Plan allowance Non-PPO: 45% of the Plan allowance and any difference between our allowance and the billed amount. Note: If your PPO provider uses a Non-PPO lab or radiologist, we will pay Non-PPO benefits for any lab and X-ray charges.
Not covered • *Hair analysis* • *Routine tests for confirmation of specimen integrity* • *Testing ordered by or on behalf of third parties (e.g., school, courts, employers)* • *Drug testing billed by an entity that did not perform the service*	*All Charges*	*All Charges*
Preventive care, adult	**High Option**	**Standard Option**
• Routine physical every year **The following preventive services are covered at the patient age and time interval recommended at each of the links below.** • U.S. Preventive Services Task Force (USPSTF) A and B recommended screenings such as cancer, osteoporosis, depression, diabetes, high blood pressure, total blood cholesterol, HIV, and colorectal cancer. For a complete list of screenings go to the website at https ://www.uspreventiveservicestaskforce.org/uspstf/recommendation-topics/uspstf-a-and-b-recommendations	PPO: Nothing (No deductible) Non-PPO: 35% of the Plan allowance and any difference between our allowance and the billed amount	PPO: Nothing (No deductible) Non-PPO: 45% of the Plan allowance and any difference between our allowance and the billed amount

Preventive care, adult - continued on next page

Benefit Description	You Pay After the calendar year deductible...	
Preventive care, adult (cont.)	**High Option**	**Standard Option**
• Individual counseling on prevention and reducing health risks • Preventive care benefits for women such as Pap smears, gonorrhea prophylactic medication to protect newborns, annual counseling for sexually transmitted infections, contraceptive methods, and screening for interpersonal and domestic violence. For a complete list of preventive care benefits for women go to the Health and Human Services (HHS) website at https ://www. hrsa.gov/ womens-guidelines. • To build your personalized list of preventive services go to https://health.gov/myhealthfinder Note: Contact us for information on the specific tests covered under this benefit. Other medically necessary laboratory and diagnostic tests and X-rays not included in the above list that are during a routine exam are subject to the benefits under *Diagnostic and treatment services*. Note: Your physician's bill must clearly state "routine physical exam." If a medical diagnosis is provided on the bill, those services will be paid under the medical benefit.	PPO: Nothing (No deductible) Non-PPO: 35% of the Plan allowance and any difference between our allowance and the billed amount	PPO: Nothing (No deductible) Non-PPO: 45% of the Plan allowance and any difference between our allowance and the billed amount
• Colorectal cancer screening, including - Fecal occult blood test - Sigmoidoscopy screening - Routine screening colonoscopy, including facility and anesthesia charges related to the colonoscopy exam Note: See *Surgical procedures* on page 52 for benefits for colonoscopies performed by a physician to diagnose or treat a specific condition.	PPO: Nothing (No deductible) Non-PPO: 35% of the Plan allowance and any difference between our allowance and the billed amount	PPO: Nothing (No deductible) Non-PPO: 45% of the Plan allowance and any difference between our allowance and the billed amount
Routine Prostate Specific Antigen (PSA) test	PPO: 15% of the Plan allowance Non-PPO: 35% of the Plan allowance and any difference between our allowance and the billed amount	PPO: 20% of the Plan allowance Non-PPO: 45% of the Plan allowance and any difference between our allowance and the billed amount
• Routine mammogram • BRCA screening for women whose family history is associated with an increased risk for deleterious mutations in BRCA1 or BRCA2 genes Note: Contact Cigna Healthcare and Evernorth Health Services for prior authorization at 800-887-9735.	PPO: Nothing (No deductible) Non-PPO: 35% of the Plan allowance and any difference between our allowance and the billed amount Note: When billed by a facility, such as the outpatient department of a hospital, we provide benefits as shown here.	PPO: Nothing (No deductible) Non-PPO: 45% of the Plan allowance and any difference between our allowance and the billed amount Note: When billed by a facility, such as the outpatient department of a hospital, we provide benefits as shown here.

Preventive care, adult - continued on next page

Benefit Description	You Pay After the calendar year deductible...	
Preventive care, adult (cont.)	**High Option**	**Standard Option**
Routine use of adult immunizations recommended by the Advisory Committee on Immunization Practices (ACIP) and adopted by the Centers for Disease Control and Prevention (CDC) are covered. A recommendation is considered to be for routine use if it is listed on the Immunization Schedules of the Centers for Disease Control and Prevention. For the current immunization schedule, visit https ://www. cdc.gov/ vaccines/imz-schedules/index.html.	PPO: Nothing (No deductible) Non-PPO: Any difference between our allowance and the billed amount (No deductible)	PPO: Nothing (No deductible) Non-PPO: Any difference between our allowance and the billed amount (No deductible)
Note: Any procedure, injection, diagnostic service, laboratory, or X-ray service done in conjunction with a routine examination and is not included in the preventive recommended listing of services will be subject to the applicable member copayments, coinsurance, and deductible.	PPO: 15% of the Plan allowance Non-PPO: 35% of the Plan allowance and any difference between our allowance and the billed amount	PPO: 20% of the Plan allowance Non-PPO: 45% of the Plan allowance and any difference between our allowance and the billed amount
Obesity counseling, screening and referral, for those persons at or above the USPSTF obesity prevention risk factor level, to intensive nutrition and behavioral weight-loss therapy, counseling, or family centered programs under the USPSTF A and B recommendations are covered as part of prevention and treatment of obesity as follows: • Intensive nutrition and behavioral weight-loss counseling therapy • Family centered programs when medically identified to support obesity prevention and management by an in-network provider Note: Also see *Section 5(h). Wellness and Other Special Features*, pages 90 and 91. • When anti-obesity medication is prescribed, see Section 5(f). • When Bariatric or Metabolic surgical treatment or intervention is indicated for severe obesity, see Section 5(b).	PPO: Nothing (No deductible) Non-PPO: 35% of the Plan allowance and any difference between our allowance and the billed amount	PPO: Nothing (No deductible) Non-PPO: 45% of the Plan allowance and any difference between our allowance and the billed amount
Not covered • *Routine immunizations not endorsed by the Centers for Disease Control and Prevention (CDC)* • *Physical exams required for obtaining or continuing employment or insurance, attending schools or camp, athletic exams, or travel* • *Immunizations, boosters, and medications for travel or work-related exposure*	*All charges*	*All charges*

Benefit Description	You Pay After the calendar year deductible...	
Preventive care, children	**High Option**	**Standard Option**
• Routine use of children's immunizations recommended by the Advisory Committee on Immunization Practices (ACIP) schedule and adopted by the Centers for Disease Control and Prevention (CDC) are covered. A recommendation is considered to be for routine use if it is listed on the Immunization Schedules of the Centers for Disease Control and Prevention. For the current immunization schedule, visit https ://www. cdc.gov/ vaccines/imz-schedules/index.html.	PPO: Nothing (No deductible) Non-PPO: Any difference between our allowance and the billed amount (No deductible)	PPO: Nothing (No deductible) Non-PPO: Any difference between our allowance and the billed amount (No deductible)
• Well-child (up to age 18) visits, examinations and other preventive services as described in the Bright Future Guidelines provided by the American Academy of Pediatrics. For a complete list of the American Academy of Pediatrics Bright Futures Guidelines go to https://brightfutures.aap.org. For preventive immunizations, see guidance above. • You may also find a complete list of U.S. Preventive Services Task Force (USPSTF) A and B recommendations online at https ://www. uspreventiveservicestaskforce.org/uspstf/ recommendation-topics/uspstf-a-and-b-recommendations • To build your personalized list of preventive services go to https://health.gov/myhealthfinder Note: Your physician's bill must clearly state "routine well-child exam." If a medical diagnosis is provided on the bill, those services will be paid under the medical benefit.	PPO: Nothing (No deductible) Non-PPO: 35% of the Plan allowance and any difference between our allowance and the billed amount	PPO: Nothing (No deductible) Non-PPO: 45% of the Plan allowance and any difference between our allowance and the billed amount
Note: Any procedure, injection, diagnostic service, laboratory, or X-ray service done in conjunction with a routine examination and is not included in the preventive recommended listing of services will be subject to the applicable member copayments, coinsurance, and deductible.	PPO: 15% of the Plan allowance Non-PPO: 35% of the Plan allowance and any difference between our allowance and the billed amount	PPO: 20% of the Plan allowance Non-PPO: 45% of the Plan allowance and any difference between our allowance and the billed amount
Obesity counseling, screening and referral, for those persons at or above the USPSTF obesity prevention risk factor level, to intensive nutrition and behavioral weight-loss therapy, counseling, or family centered programs under the USPSTF A and B recommendations are covered as part of prevention and treatment of obesity as follows: • Intensive nutrition and behavioral weight-loss counseling therapy • Family centered programs when medically identified to support obesity prevention and management by an in-network provider Note: Also see *Section 5(h). Wellness and Other Special Features*, pages 90 and 91. • When anti-obesity medication is prescribed, see Section 5(f).	PPO: Nothing (No deductible) Non-PPO: 35% of the Plan allowance and any difference between our allowance and the billed amount	PPO: Nothing (No deductible) Non-PPO: 45% of the Plan allowance and any difference between our allowance and the billed amount

Preventive care, children - continued on next page

Benefit Description	You Pay After the calendar year deductible...	
Preventive care, children (cont.)	**High Option**	**Standard Option**
• When Bariatric or Metabolic surgical treatment or intervention is indicated for severe obesity, see Section 5(b).	PPO: Nothing (No deductible) Non-PPO: 35% of the Plan allowance and any difference between our allowance and the billed amount	PPO: Nothing (No deductible) Non-PPO: 45% of the Plan allowance and any difference between our allowance and the billed amount
Not covered • *Physical exams required for obtaining or continuing employment or insurance, attending schools or camp, athletic exams, or travel* • *Immunizations, boosters, and medications for travel or work-related exposure*	*All charges*	*All charges*
Maternity care	**High Option**	**Standard Option**
Complete maternity (obstetrical) care, such as: • Prenatal and Postpartum care • Delivery • Prenatal sonograms • Stand-by doctor for cesarean section Notes: • As part of your coverage, you have access to in-network Certified Nurse Midwives (CNM), Certified Midwives (CM) (in states where they are licensed), and home nurse visits during the prenatal and post-partum period. • You do not need to precertify your vaginal delivery; see Section 3, page 21 for other circumstances, such as extended stays for you or your baby. • You may remain in the hospital up to 48 hours after admission for a vaginal delivery and 96 hours after admission for a cesarean delivery. We will cover an extended stay if medically necessary, but you, your representative, your doctor, or your hospital must precertify. • We cover routine nursery care of the newborn child during the covered portion of the parent's stay. We will cover other care of an infant who requires non-routine treatment if we cover the infant under a Self Plus One or Self and Family enrollment. • We pay hospitalization and surgeon services for non-maternity care the same as for illness and injury.	PPO: 15% of the Plan allowance Note: For facility care related to maternity, see Section 5(c). Non-PPO: 35% of the Plan allowance and any difference between our allowance and the billed amount	PPO: Nothing (No deductible) Note: For facility care related to maternity, see Section 5(c). Non-PPO: 45% of the Plan allowance and any difference between our allowance and the billed amount

Maternity care - continued on next page

Benefit Description	You Pay After the calendar year deductible...	
Maternity care (cont.)	**High Option**	**Standard Option**
Notes: • Hospital services are covered under Section 5(c) and Surgical benefits 5(b). Note: When a newborn requires definitive treatment during or after the parent's hospital stay, the newborn is considered a patient in their own right. If the newborn is eligible for coverage, regular medical or surgical benefits apply rather than maternity benefits. In addition, circumcision is covered at the same rate as for regular medical or surgical benefits. • Sonograms and other related tests that are not included in your routine prenatal or postnatal care are covered under *Lab, X-ray, and other diagnostic tests*, see page 33. • See *Section 5(h). Wellness and Other Special Features* (page 90) for information on our Healthy Pregnancies, Healthy Babies® Program and Maven, a maternity management program designed to provide support for expectant and new parents.	PPO: 15% of the Plan allowance Note: For facility care related to maternity, see Section 5(c). Non-PPO: 35% of the Plan allowance and any difference between our allowance and the billed amount	PPO: Nothing (No deductible) Note: For facility care related to maternity, see Section 5(c). Non-PPO: 45% of the Plan allowance and any difference between our allowance and the billed amount
• Screening for gestational diabetes • Screening and counseling for prenatal and postpartum depression • Breastfeeding and lactation support and counseling for each birth • Breastfeeding equipment rental or purchase • Breastfeeding supplies limited to tubing, adapters and cap replacements for breast pumps, breast shield and splash protector replacements Note: Benefits for the rental of breastfeeding equipment are limited to an amount no greater than what we would have paid if the equipment had been purchased. We will only cover the cost of standard equipment.	PPO: Nothing (No deductible) Non-PPO: 35% of the Plan allowance and any difference between our allowance and the billed amount	PPO: Nothing (No deductible) Non-PPO: 45% of the Plan allowance and any difference between our allowance and the billed amount
Physical and emotional support provided during pregnancy, childbirth and postpartum by a doula certified in birth and postpartum services. (See *Section 10. Definitions of Terms We Use in This Brochure*.) Note: Benefits are limited to $1,000 per person, per calendar year under the **High Option** and $800 per person, per calendar year under the **Standard Option**.	PPO and Non-PPO: Nothing (No deductible) and all charges in excess of the $1,000 benefit maximum	PPO and Non-PPO: Nothing (No deductible) and all charges in excess of the $800 benefit maximum
Not covered: • *Routine sonograms to determine fetal age, size or sex* • *Services before enrollment in the Plan begins or after enrollment ends*	*All charges*	*All charges*

Benefit Description	You Pay After the calendar year deductible...	
Family planning	**High Option**	**Standard Option**
Contraceptive counseling on an annual basis	PPO: Nothing (No deductible) Non-PPO: 35% of the Plan allowance and any difference between our allowance and the billed amount	PPO: Nothing (No deductible) Non-PPO: 45% of the Plan allowance and any difference between our allowance and the billed amount
A range of voluntary family planning services, without cost sharing, that includes a least one form of contraception in each of the categories in the HRSA supported guidelines. This list includes: • Voluntary female sterilization (including related expenses for anesthesia and outpatient facility services, if necessary) • Surgically implanted contraceptives (including related expenses for anesthesia and outpatient facility services, if necessary) • Injectable contraceptive drugs (such as Depo Provera) • Intrauterine devices (IUDs) • Diaphragms • Over-the-counter (OTC) FDA approved contraceptive drugs and devices for women (written prescription is required) Note: See additional Family Planning and Prescription drug coverage in Section 5(f), page 82. Note: Your plan offers some type of voluntary female sterilization surgery coverage at no cost to members. The contraceptive benefit includes at least one option in each of the HRSA-supported categories of contraception (as well as the screening, education, counseling, and follow-up care). Any type of voluntary female sterilization surgery that is not already available without cost sharing can be accessed through the contraceptive exceptions process described below. Exceptions are available by contacting the Plan at 800-638-6589 or 301-984-1440 (for TTY, use 301-984-4155), 8 a.m. to 5 p.m. ET. Reviews can be initiated by the member or provider. Once we have been contacted with exception request information sufficient for us to make a determination, you will receive a response within 24 hours or the next business day. Contraceptive exception requests are not subject to *Section 8. The Disputed Claim Process*. If you have difficulty accessing contraceptive coverage or other reproductive healthcare, you can contact contraception@opm.gov.	PPO: Nothing (No deductible) Non-PPO: 35% of the Plan allowance and any difference between our allowance and the billed amount	PPO: Nothing (No deductible) Non-PPO: 45% of the Plan allowance and any difference between our allowance and the billed amount

Family planning - continued on next page

Benefit Description	You Pay After the calendar year deductible...	
Family planning (cont.)	**High Option**	**Standard Option**
Voluntary male sterilization	PPO: 15% of the Plan allowance Non-PPO: 35% of the Plan allowance and any difference between our allowance and the billed amount	PPO: 20% of the Plan allowance Non-PPO: 45% of the Plan allowance and any difference between our allowance and the billed amount
Not covered: • *Reversal of voluntary surgical sterilization* • *Genetic counseling, except as indicated under Lab, X-ray and other diagnostic tests on page 33* • *Genetic screening* • *Expenses for sperm collection and storage*	*All charges*	*All charges*
Infertility services	**High Option**	**Standard Option**
Diagnosis and treatment of infertility (see definition in Section 10, page 114), limited to: • Initial diagnostic tests and procedures rendered only to identify the cause of infertility • Medical or surgical procedures rendered to create or enhance fertility, except as shown in *Not covered* • Artificial insemination (AI) procedures, limited to the following: - Intravaginal insemination (IVI) - Intracervical insemination (ICI) - Intrauterine insemination (IUI) Note: Fertility drugs, including IVF-related drugs up to three (3) cycles per year, are covered under *Section 5(f). Prescription Drug Benefits*. See page 82.	PPO: 15% of the Plan allowance Non-PPO: 35% of the Plan allowance and any difference between our allowance and the billed amount	PPO: 20% of the Plan allowance Non-PPO: 45% of the Plan allowance and any difference between our allowance and the billed amount
Fertility preservation for iatrogenic infertility: • Procurement of sperm or eggs including medical, surgical, and pharmacy claims associated with retrieval; • Cryopreservation of sperm and mature oocytes; and • Cryopreservation storage costs for one year. Note: Benefits are limited to $5,000 per person, per calendar year under the **High Option** and $3,500 per person, per calendar year under the **Standard Option**. Prior approval is required. If prior authorization is not obtained, no benefits will be payable and claims for these services will be denied. Contact Cigna Healthcare and Evernorth Health Services at 800-887-9735.	PPO: 15% of the Plan allowance Non-PPO: 35% of the Plan allowance and any difference between our allowance and the billed amount	PPO: 20% of the Plan allowance Non-PPO: 45% of the Plan allowance and any difference between our allowance and the billed amount

Infertility services - continued on next page

Benefit Description	You Pay After the calendar year deductible...	
Infertility services (cont.)	**High Option**	**Standard Option**
Not covered: • *Infertility services after voluntary sterilization* • *Assisted reproductive technology (ART) procedures and related services and supplies related to any fertility treatments in which eggs or embryos are manipulated. These treatments include:* - *In vitro fertilization (IVF) (see Section 5(f). Prescription Drug Benefits on page 82 for coverage of IVF-related drugs up to three (3) cycles per year)* - *Embryo transfer and gamete intra-fallopian transfer (GIFT)* - *Zygote intra-fallopian transfer (ZIFT)* - *Any procedure, service or supply involving the handling of eggs or embryos* • *Cost of donor sperm or egg* • *Expenses for sperm collection and storage, except as listed above* • *Elective preservation for reasons other than listed above* • *Surrogacy (host uterus/gestational carrier)* • *Preimplantation genetic diagnosis (PGD)* • *Commercially available over-the-counter home ovulation prediction test kits or pregnancy test kits*	*All charges*	*All charges*
Allergy care	**High Option**	**Standard Option**
Allergy injections, testing and treatment, including materials (such as allergy serum)	PPO: 15% of the Plan allowance Non-PPO: 35% of the Plan allowance and any difference between our allowance and the billed amount	PPO: 20% of the Plan allowance Non-PPO: 45% of the Plan allowance and any difference between our allowance and the billed amount
Not covered: • *Provocative food testing and sublingual allergy desensitization* • *Clinical ecology and environmental medicine*	*All charges*	*All charges*
Treatment therapies	**High Option**	**Standard Option**
• Chemotherapy and radiation therapy Note: High dose chemotherapy in association with autologous bone marrow transplants is limited to those transplants listed in Section 5(b) on pages 56 through 60. • Dialysis - Renal dialysis, hemodialysis and peritoneal dialysis • Transparenteral nutrition (TPN)	PPO: 15% of the Plan allowance Non-PPO: 35% of the Plan allowance and any difference between our allowance and the billed amount	PPO: 20% of the Plan allowance Non-PPO: 45% of the Plan allowance and any difference between our allowance and the billed amount

Treatment therapies - continued on next page

Benefit Description	You Pay After the calendar year deductible...	
Treatment therapies (cont.)	**High Option**	**Standard Option**
• Medical food formulas ordered by a healthcare provider that are medically necessary to treat specific nutritional risks, including Phenylketonuria (PKU) and other Inborn Errors of Metabolism. Note: Medical foods for conditions other than permanent inborn errors of metabolism are not considered a covered benefit. • Medical foods and nutritional supplements when administered by catheter or nasogastric tubes • Respiratory and inhalation therapies • Cardiac rehabilitation • Hyperbaric oxygen therapy Note: Contact the Plan at 800-638-6589 or 301-984-1440 (For TTY, use 301-984-4155) for details about coverage and information about hyperbaric oxygen therapy. • Growth hormone therapy (GHT) Note: Some medications, such as specialty drugs, oral oncology drugs, and growth hormones, require prior authorization. See *Specialty drugs* on page 75. Additionally, certain specialty drugs can be dispensed by your doctor or by Accredo, our specialty pharmacy. See *Specialty drugs* on page 44.	PPO: 15% of the Plan allowance Non-PPO: 35% of the Plan allowance and any difference between our allowance and the billed amount	PPO: 20% of the Plan allowance Non-PPO: 45% of the Plan allowance and any difference between our allowance and the billed amount
• Intravenous (IV)/Infusion Therapy - Home IV and antibiotic therapy	PPO: 10% of the Plan allowance Non-PPO: 35% of the Plan allowance and any difference between our allowance and the billed amount	PPO: 15% of the Plan allowance Non-PPO: 45% of the Plan allowance and any difference between our allowance and the billed amount
Applied Behavior Analysis (ABA) therapy for children up to age 18 with autism spectrum disorder.	PPO: 15% of the Plan allowance Non-PPO: 35% of the Plan allowance and any difference between our allowance and the billed amount	PPO: 20% of Plan allowance Non-PPO: 45% of the Plan allowance and any difference between our allowance and the billed amount
Not covered: • *Chelation therapy except for acute arsenic, gold or lead poisoning* • *Topical hyperbaric oxygen therapy* • *Prolotherapy* • *Infant formulas used as a substitute for breastfeeding* • *Medical foods administered orally except as described above*	*All charges*	*All charges*

Benefit Description	You Pay After the calendar year deductible...	
Specialty drugs	**High Option**	**Standard Option**
Specialty drugs are those used to treat some severe, chronic medical conditions. The drugs listed below, by category, when dispensed by some other source than through the Express Scripts Network of Pharmacies (Accredo) are subject to the *Specialty drugs* benefit on this page. Prior authorization may be required for certain medications. These include, but are not limited to, the medications listed below. Please call Express Scripts for details at 855-315-8527. • Oral cancer medications: Afinitor, Hycamtin Oral, Nexavar, Revlimid, Sprycel, Sutent, Tarceva, Temodar (oral), Thalomid, Tykerb, Votrient, and Zolinza • Growth stimulating agents: Genotropin, Increlex, Norditropin (all forms), Serostim, Somatropin, and Zorbtive • Hemophilia medications: Advate (all forms), Alphanate, Alphanine SD, Bebulin VH, Benefix, Corifact, Feiba VH, Helixate FS, Hemofil M, Humate-P, Koate DVI, Kogenate FS, Mononine, Novoseven (all forms), Profilnine SD, Riastap, Stimate, and Wilate • Hepatitis medications: Copegus, Infergen, Pegasys, Peg-Intron (all forms), Rebetol, and Ribavirin • Immune deficiency medications: Actimmune and Adagen • Metabolic disorder medications: Carbaglu, Cystadane, Kuvan, and Orfadin • Multiple Sclerosis medications: Avonex, Betaseron, Copaxone, Gilenya, and Rebif • Ophthalmics medications: Ozurdex and Retisert • Pulmonary medications: Pulmozyme and Tobi • Pulmonary Arterial Hypertension medications: Adcirca, Epoprostenol, Flolan, Letairis, Remodulin, Revatio (oral and IV forms), Tracleer, Tyvaso, Veletri (RTS Epoprostenol sodium brand), and Ventavis • Respiratory Syncytial Virus medication: Synagis • Rheumatoid Arthritis and other autoimmune conditions medications: Cimzia, Enbrel (all forms), Humira (all forms), Kineret, Simponi, and Stelara • Other specialty agents: Apokyn, Arcalyst, Exiade, Sensipar, Somatuline Depot, and Somavert	**Medications purchased through a physician's office, home health agency, outpatient hospital, or other outpatient facility:** • PPO: 30% of the Plan allowance • Non-PPO: 50% of the Plan allowance and any difference between our allowance and the billed amount **Note: To receive the Plan's maximum benefit, these medications should be purchased directly from Accredo, the Express Scripts Specialty Pharmacy. When your prescription is sent to Accredo, they will contact you to discuss how quickly you need the medication. They will also ask if your preference is to have the medication shipped to your home or to your doctor. See *Section 5(f). Prescription Drug Benefits*, page 75.**	**Medications purchased through a physician's office, home health agency, outpatient hospital, or other outpatient facility:** • PPO: 30% of the Plan allowance • Non-PPO: 50% of the Plan allowance and any difference between our allowance and the billed amount **Note: To receive the Plan's maximum benefit, these medications should be purchased directly from Accredo, the Express Scripts Specialty Pharmacy. When your prescription is sent to Accredo, they will contact you to discuss how quickly you need the medication. They will also ask if your preference is to have the medication shipped to your home or to your doctor. See *Section 5(f). Prescription Drug Benefits*, page 75.**

Benefit Description	You Pay After the calendar year deductible...	
Physical and occupational therapies	**High Option**	**Standard Option**
Services of a qualified physical therapist, occupational therapist, doctor of osteopathy (D.O.), or physician for the following • Physical therapy • Occupational therapy Benefits are limited to 80 visits per person, per calendar year under **High Option** and 60 visits per person, per calendar year under **Standard Option**. Note: Visits that you pay for while meeting your calendar year deductible count toward the per person, per calendar year visit limitation.	PPO: 15% of the Plan allowance and all charges in excess of the 80 visit limitation Non-PPO: 50% of the Plan allowance and any difference between our allowance and the billed amount and all charges in excess of the 80 visit limitation	PPO: 20% of the Plan allowance and all charges in excess of the 60 visit limitation Non-PPO: 50% of the Plan allowance and any difference between our allowance and the billed amount and all charges in excess of the 60 visit limitation
Not covered: • *Any charges in excess of the 80 visit High Option or 60 visit Standard Option plan limitation for covered physical and occupational therapies* • *Exercise programs*	*All charges*	*All charges*
Speech therapy	**High Option**	**Standard Option**
Speech therapy Covered expenses are limited to charges of a licensed speech therapist for speech loss or impairment due to (a) congenital anomaly or defect, whether or not surgically corrected or (b) due to any other illness or surgery. Benefits are limited to 50 visits per person, per calendar year under **High Option** and 30 visits per person, per calendar year under **Standard Option**. Note: Visits that you pay for while meeting your calendar year deductible count toward the per person, per calendar year visit limitation.	PPO: 15% of the Plan allowance and all charges in excess of the 50 visit limitation Non-PPO: 35% of the Plan allowance and any difference between our allowance and the billed amount and all charges in excess of the 50 visit limitation	PPO: 20% of the Plan allowance and all charges in excess of the 30 visit limitation Non-PPO: 45% of the Plan allowance and any difference between our allowance and the billed amount and all charges in excess of the 30 visit limitation
Not covered: • *Voice therapy for occupation or performing arts* • *Training or therapy to improve articulation in the absence of an injury, illness, or medical condition affecting articulation* • *Any charge in excess of the 50 visit High Option or 30 visit Standard Option plan limitation for covered speech therapy*	*All charges*	*All charges*

Benefit Description	You Pay After the calendar year deductible...	
Hearing services (testing, treatment, and supplies)	**High Option**	**Standard Option**
• Hearing testing, diagnostic examination, and treatment by a licensed hearing professional for dependent children up to age 18. • External hearing aids – Benefits are limited to $1,000 per hearing aid, per ear, every three calendar years. Note: See *Orthopedic and prosthetic devices*, page 47 for coverage of implanted hearing-related devices.	PPO: 15% of the Plan allowance and all charges in excess of the benefit limitations. Non-PPO: 35% of the Plan allowance and any difference between our allowance and the billed amount and all charges in excess of the benefit limitations.	PPO: 20% of the Plan allowance and all charges in excess of the benefit limitations. Non-PPO: 45% of the Plan allowance and any difference between our allowance and the billed amount and all charges in excess of the benefit limitations.
• Hearing testing, diagnostic examination, and treatment by a licensed hearing professional for adults. • External hearing aids – Benefits are limited to $500 per hearing aid, per ear, every three calendar years. Note: See *Orthopedic and prosthetic devices*, page 47 for coverage of implanted hearing-related devices.	PPO: 15% of the Plan allowance and all charges in excess of the benefit limitations Non-PPO: 35% of the Plan allowance and any difference between our allowance and the billed amount and all charges in excess of the benefit limitations	PPO: 20% of the Plan allowance and all charges in excess of the benefit limitations Non-PPO: 45% of the Plan allowance and any difference between our allowance and the billed amount and all charges in excess of the benefit limitations
Not covered: • *Testing and examinations for prescribing or fitting of hearing aids, except as stated above* • *Hearing aid replacements within three years after the Plan has paid $1,000 per hearing aid, per ear for children up to age 18* • *Hearing aid replacements within three years after the Plan has paid $500 per hearing aid, per ear for adults.* • *Replacement batteries or adjustments for hearing aids*	*All charges*	*All charges*
Vision services (testing, treatment, and supplies)	**High Option**	**Standard Option**
• One pair of eyeglasses or contact lenses to correct an impairment directly caused by accidental ocular injury or intraocular surgery (such as for cataracts) • Vision therapy, such as eye exercises or orthoptics	PPO: 15% of the Plan allowance Non-PPO: 35% of the Plan allowance and any difference between our allowance and the billed amount	PPO: 20% of the Plan allowance Non-PPO: 45% of the Plan allowance and any difference between our allowance and the billed amount
Not covered: • *Eyeglasses or contact lenses and examinations for them, except as noted above* • *Refractions* • *Radial keratotomy, lasik and other refractive surgery*	*All charges*	*All charges*

Benefit Description	You Pay After the calendar year deductible...	
Foot care	**High Option**	**Standard Option**
• Routine foot care when you are under active treatment for a metabolic or peripheral vascular disease, such as diabetes. • Removal of nail root Note: See *Orthopedic and prosthetic devices* for information on podiatric shoe inserts.	PPO: 15% of the Plan allowance Non-PPO: 35% of the Plan allowance and any difference between our allowance and the billed amount	PPO: 20% of the Plan allowance Non-PPO: 45% of the Plan allowance and any difference between our allowance and the billed amount
• One pair of diabetic shoes per person, per calendar year	PPO: 15% of the Plan allowance Non-PPO: 35% of the Plan allowance and any difference between our allowance and the billed amount	PPO: 20% of the Plan allowance Non-PPO: 45% of the Plan allowance and any difference between our allowance and the billed amount
Not covered: • *Cutting, trimming or removal of corns, calluses, or the free edge of toenails, and similar routine treatment of conditions of the foot, except as stated above* • *Treatment of weak, strained or flat feet or bunions; and of any instability, imbalance or subluxation of the foot (except for surgical treatment)*	*All charges*	*All charges*
Orthopedic and prosthetic devices	**High Option**	**Standard Option**
• Artificial limbs and eyes • Prosthetic sleeve or sock • Orthopedic and corrective shoes when attached to a brace • Externally worn breast prostheses and surgical bras, including necessary replacements following a mastectomy • Lumbosacral supports • Crutches, surgical dressings, splints, casts, and similar supplies • Braces, corsets, trusses, elastic stockings, support hose, and other supportive devices • Implanted hearing-related devices, such as bone anchored hearing aids and cochlear implants • Internal prosthetic devices, such as artificial joints, pacemakers, and surgically implanted breast implant following mastectomy. Note: For information on the professional charges for the surgery to insert an implant, see Section 5(b), *Surgical procedures*. For information on the hospital and/or ambulatory surgery center benefits, see Section 5(c). *Services Provided by a Hospital or Other Facility, and Ambulance Services*. Note: See *Hearing services (testing, treatment, and supplies)*, page 46 for coverage of external hearing aids and testing to fit them.	PPO: 15% of the Plan allowance Non-PPO: 50% of the Plan allowance and any difference between our allowance and the billed amount	PPO: 20% of the Plan allowance Non-PPO: 50% of the Plan allowance and any difference between our allowance and the billed amount

Orthopedic and prosthetic devices - continued on next page

Benefit Description	You Pay After the calendar year deductible...	
Orthopedic and prosthetic devices (cont.)	**High Option**	**Standard Option**
Note: We will pay only for the cost of the standard item. Coverage for specialty items such as bionics is limited to the cost of the standard item. Dental prosthetic appliances are covered under High Option, see Section 5(g). Dental Benefits.	PPO: 15% of the Plan allowance Non-PPO: 50% of the Plan allowance and any difference between our allowance and the billed amount	PPO: 20% of the Plan allowance Non-PPO: 50% of the Plan allowance and any difference between our allowance and the billed amount
Not covered: • *Penile prosthetics* • *Wigs* • *Arch supports and foot orthotics* • *Heel pads and heel cups* • *Orthopedic and corrective shoes unless attached to a brace*	*All charges*	*All charges*
Durable medical equipment (DME)	**High Option**	**Standard Option**
Durable medical equipment (DME) is equipment and supplies that: 1. Are prescribed by your attending physician (i.e., the physician who is treating your illness or injury); 2. Are medically necessary; 3. Are primarily and customarily used only for a medical purpose; 4. Are generally useful only to a person with an illness or injury; 5. Are designed for prolonged use; and 6. Serve a specific therapeutic purpose in the treatment of an illness or injury. We cover rental (up to the purchase price) or purchase of prescribed durable medical equipment, at our option, including necessary repair and adjustment. Covered items include: - Oxygen equipment and oxygen - Hospital beds - Wheelchairs - Walkers Note: We will pay only for the cost of the standard item. Coverage for specialty equipment such as all-terrain wheelchairs is limited to the cost of the standard equipment.	PPO: 15% of the Plan allowance Non-PPO: 50% of the Plan allowance and any difference between our allowance and the billed amount	PPO: 20% of the Plan allowance Non-PPO: 50% of the Plan allowance and any difference between our allowance and the billed amount

Durable medical equipment (DME) - continued on next page

Benefit Description	You Pay After the calendar year deductible...	
Durable medical equipment (DME) (cont.)	**High Option**	**Standard Option**
Not covered: • *Equipment replacements provided less than 3 years after the last one we covered* • *Air conditioners, humidifiers, dehumidifiers, purifiers* • *Safety, hygiene, convenience, and exercise equipment and supplies* • *Lifts, such as seat, chair or van lifts* • *Computer devices to assist with communications* • *Computer programs of any type* • *Other items that do not meet the definition of durable medical equipment*	*All charges*	*All charges*
Home health services	**High Option**	**Standard Option**
Private duty nursing care for covered services of a registered nurse (R.N.), licensed practical nurse (L.P.N.) or licensed vocational nurse (L.V.N.) when: • prescribed by the attending physician; • the physician indicates the length of time the services are needed; and • the physician identifies the specific professional skills required by the patient and the medical necessity for the services. Benefits are limited to 50 visits per person, per calendar year under **High Option** and 25 visits per person, per calendar year under **Standard Option**. Note: Each visit taking 4 hours or less is counted as one visit. If a visit exceeds 4 hours, each 4 hours or fraction is counted as a separate visit.	PPO: 15% of the Plan allowance and all charges in excess of the 50 visit limitation Non-PPO: 50% of the Plan allowance and any difference between our allowance and the billed amount and all charges in excess of the 50 visit limitation	PPO: 20% of the Plan allowance and all charges in excess of the 25 visit limitation Non-PPO: 50% of the Plan allowance and any difference between our allowance and the billed amount and all charges in excess of the 25 visit limitation
Not covered: • *Home health aide services* • *Inpatient private duty nursing* • *Nursing care requested by, or for the convenience of, the patient or the patient's family;* • *Services primarily for hygiene, feeding, exercising, moving the patient, homemaking, companionship, or giving oral medication* • *Any charges in excess of the 50 visit High Option or 25 visit Standard Option plan limitation for covered private duty nursing care*	*All charges*	*All charges*

Benefit Description	You Pay After the calendar year deductible...	
Chiropractic	**High Option**	**Standard Option**
Chiropractic services limited to: • the initial visit/examination • 30 manipulations per person, per calendar year under **High Option** • 20 manipulations per person, per calendar year under **Standard Option** Note: X-rays are covered under *Lab, X-ray and other diagnostic tests*. Note: Services that you pay for while meeting your calendar year deductible count toward the High Option 30 manipulations limit or the Standard Option 20 manipulations limit.	PPO: 15% of the Plan allowance and all charges in excess of the benefit limitations Non-PPO: 35% of the Plan allowance and any difference between our allowance and the billed amount and all charges in excess of the benefit limitations	PPO: 20% of the Plan allowance and all charges in excess of the benefit limitations Non-PPO: 45% of the Plan allowance and any difference between our allowance and the billed amount and all charges in excess of the benefit limitations
Not covered • *Any charges in excess of the 30 manipulations per person, per calendar year limit under High Option* • *Any charges in excess of the 20 manipulations per person, per calendar year limit under Standard Option*	*All charges*	*All charges*
Alternative treatments	**High Option**	**Standard Option**
• Acupuncture by a doctor of medicine, doctor of osteopathy or licensed acupuncturist for pain relief Benefits are limited to 26 visits per person, per calendar year and are combined with acupuncture services listed in Section 5(e), page 71. Note: Visits that you pay for while meeting your calendar year deductible count toward the 26 visit limit.	PPO: 15% of the Plan allowance and all charges in excess of the 26 visit limitation Non-PPO: 35% of the Plan allowance and any difference between our allowance and the billed amount and all charges in excess of the 26 visit limitation	PPO: 20% of the Plan allowance and all charges in excess of the 26 visit limitation Non-PPO: 45% of the Plan allowance and any difference between our allowance and the billed amount and all charges in excess of the 26 visit limitation
Not covered: • *Naturopathic and homeopathic services such as naturopathic medicines* • *Massage therapist* • *Any charges in excess of the visit limitation for covered acupuncture*	*All charges*	*All charges*

Benefit Description	You Pay After the calendar year deductible...	
Educational classes and programs	**High Option**	**Standard Option**
Tobacco Cessation - Coverage is limited to: • We cover counseling sessions for tobacco cessation including proactive phone counseling, group counseling, and individual counseling. Benefits are payable for up to two attempts per person, per calendar year with up to four counseling sessions per attempt. • We cover over-the-counter (with a physician's prescription) and prescription drugs approved by the FDA to treat tobacco dependence when obtained from a Network retail pharmacy, a non-Network retail pharmacy, or Mail Order Program. The quantity of drugs reimbursed will be subject to recommended courses of treatment. See Section 5(f) for additional information on our coverage of tobacco cessation drugs (page 83). Note: See *Section 5(h). Wellness and Other Special Features* (page 90) for more information on our tobacco cessation program.	PPO: Nothing (No deductible) Non-PPO: Any difference between our allowance and the billed amount (No deductible)	PPO: Nothing (No deductible) Non-PPO: Any difference between our allowance and the billed amount (No deductible)
• Educational classes and nutritional therapy for self-management of diabetes, hyperlipidemia, and hypertension when: - Prescribed by the attending physician, and - Administered by a covered provider, such as a registered nurse or a licensed or registered dietician/ nutritionist.	PPO: 15% of the Plan allowance Non-PPO: 35% of the Plan allowance and any difference between our allowance and the billed amount	PPO: 20% of the Plan allowance Non-PPO: 45% of the Plan allowance and any difference between our allowance and the billed amount
• Weight Management Program This personalized approach to weight management will be based on the participant's personal goals, preferences and health status. To join our Weight Management Program, see *Section 5(h). Wellness and Other Special Features*, page 90.	See Section 5(h) for details	See Section 5(h) for details
• Nutritional therapy or medical nutrition therapy used to aid in the treatment of mental health and substance use disorders. Services must be rendered by a covered provider and prescribed by the attending physician.	PPO: 15% of the Plan allowance Non-PPO: 35% of the Plan allowance and any difference between our allowance and the billed amount	PPO: 20% of the Plan allowance Non-PPO: 45% of the Plan allowance and any difference between our allowance and the billed amount

Section 5(b). Surgical and Anesthesia Services Provided by Physicians and Other Healthcare Professionals

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- The calendar year deductible applies to almost all benefits in this Section. We added "(No deductible)" to show when the calendar year deductible does not apply.
  - The High Option calendar year deductibles are $300 per person (limited to $600 per Self Plus One or a Self and Family enrollment) for services of PPO providers and $300 per person (limited to $600 per Self Plus One or a Self and Family enrollment) for services of Non-PPO providers.
  - The Standard Option calendar year deductibles are $350 per person (limited to $700 per Self Plus One enrollment or $900 per Self and Family enrollment) for services of PPO providers and $350 per person (limited to $700 per Self Plus One enrollment or $900 per Self and Family enrollment) for services of Non-PPO providers.
- The Non-PPO benefits are the regular benefits of this Plan. PPO benefits apply only when you use a PPO provider. When no PPO provider is available, Non-PPO benefits apply.
- When you use a PPO hospital or ambulatory surgical center facility, some of the professionals that provide related services may not be PPO network providers. We determine how to pay these providers based on their specialty. For the following specialties we pay PPO benefits: Anesthesiologist and Assistant Surgeons. PPO benefits for these providers include PPO deductible, copay, coinsurance, and out-of-pocket maximum amounts. For all other provider specialties, we will pay Non-PPO benefits. For all Non-PPO providers, you will be responsible for any difference between the Plan allowance and billed amount for these out of network providers.
- Be sure to read Section 4, *Your Costs for Covered Services*, for valuable information about how cost-sharing works. Also, read Section 9 for information about how we pay if you have other coverage, or if you are age 65 or over.
- If you are enrolled in the SAMBA Health Benefit Plan and have Medicare Part A and Part B and it is primary, we offer the UnitedHealthcare Medicare Advantage (PPO) for the SAMBA Health Benefit Plan to our members. This plan enhances your SAMBA coverage by reducing or eliminating cost-sharing for services and adding benefits at no additional cost. **It includes a Medicare Part B subsidy of $100 per month for High Option and $75 per month for Standard Option.** The UnitedHealthcare Medicare Advantage (PPO) for the SAMBA Health Benefit Plan is subject to Medicare rules. (See Section 9 for additional details.)
- The services listed below are for the charges billed by a physician or other healthcare professional for your surgical care. See Section 5(c) for charges associated with a facility (i.e. hospital, surgical center, etc.).
- **YOU MUST GET PRIOR AUTHORIZATION FOR SOME SURGICAL PROCEDURES.** Please refer to *Other services* in Section 3 to be sure which services require prior authorization.

Benefit Description	You Pay After the calendar year deductible...	
Note: The calendar year deductible applies to almost all benefits in this Section. We say "(No deductible)" when it does not apply.		
Surgical procedures	**High Option**	**Standard Option**
A comprehensive range of services, such as: • Operative procedures • Treatment of fractures, including casting • Routine pre- and post-operative care by the surgeon • Correction of amblyopia and strabismus • Endoscopy procedures • Biopsy procedures	PPO: 15% of the Plan allowance Non-PPO: 35% of the Plan allowance and any difference between our allowance and the billed amount	PPO: 20% of the Plan allowance Non-PPO: 45% of the Plan allowance and any difference between our allowance and the billed amount

Surgical procedures - continued on next page

Benefit Description	You Pay After the calendar year deductible...	
Surgical procedures (cont.)	**High Option**	**Standard Option**
A comprehensive range of services, such as: • Removal of tumors and cysts • Correction of congenital anomalies (see *Reconstructive surgery*) • Treatment of burns • Insertion of internal prosthetic devices. See Section 5(a) – *Orthopedic and prosthetic devices* for device coverage information • Assistant surgeons – we cover up to 20% of our allowance for the surgeon's charge • Surgical treatment of severe obesity (bariatric surgery) may be eligible for benefits when the following Plan criteria are met: - Eligible patients must be adults (over age 18) or adolescents (between the ages of 11 and 17) - The patient has a documented body mass index (BMI) of 40 or greater or 35-39.9 with at least one clinically significant obesity-related comorbidity - A statement from a physician, physician's assistant, nurse practitioner, licensed mental health provider, or registered dietician that the individual has failed previous attempts to achieve and maintain weight loss by medical management. - A thorough multidisciplinary evaluation has been completed within the previous six months which includes ALL of the following: • a description of the proposed procedure • a separate medical evaluation from a physician other than the requesting surgeon that includes both a recommendation for bariatric surgery as well as a medical clearance for surgery • unequivocal clearance for bariatric surgery by a mental health provider • a nutritional evaluation by a physician or registered dietician Note: A reoperation or revisional bariatric surgical procedure is covered only when medically necessary or a complication has occurred. Note: Prior authorization for this procedure is required. Contact Cigna Healthcare and Evernorth Health Services at 800-887-9735. See *Other services* on page 19 for additional information. Note: For female surgical family planning procedures, see *Family planning*, Section 5(a). Note: For male surgical family planning procedures, see *Family planning*, Section 5(a).	PPO: 15% of the Plan allowance Non-PPO: 35% of the Plan allowance and any difference between our allowance and the billed amount	PPO: 20% of the Plan allowance Non-PPO: 45% of the Plan allowance and any difference between our allowance and the billed amount

Surgical procedures - continued on next page

Benefit Description	You Pay After the calendar year deductible...	
Surgical procedures (cont.)	**High Option**	**Standard Option**
Note: Prior authorization is required for outpatient spinal surgeries. Contact Cigna Healthcare and Evernorth Health Services at 800-887-9735. See Other services on page 19 for additional information.	PPO: 15% of the Plan allowance Non-PPO: 35% of the Plan allowance and any difference between our allowance and the billed amount	PPO: 20% of the Plan allowance Non-PPO: 45% of the Plan allowance and any difference between our allowance and the billed amount
When multiple surgical procedures performed during the same operative session add time or complexity to patient care, our benefits are: • For the primary procedure: - Full Plan allowance • For the secondary procedure(s): - One-half of the Plan allowance Note: Multiple surgical procedures performed through the same incision are "incidental" to the primary surgery. That is, the procedure would not add time or complexity to patient care. We do not pay extra for incidental procedures.	PPO: 15% of the Plan allowance for the primary procedure and 15% of one-half of the Plan allowance for the secondary procedure(s) Non-PPO: 35% of the Plan allowance for the primary procedure and 35% of one-half of the Plan allowance for the secondary procedure(s); and any difference between our allowance and the billed amount	PPO: 20% of the Plan allowance for the primary procedure and 20% of one-half of the Plan allowance for the secondary procedure(s) Non-PPO: 45% of the Plan allowance for the primary procedure and 45% of one-half of the Plan allowance for the secondary procedure(s); and any difference between our allowance and the billed amount
Not covered: • *Reversal of voluntary sterilization* • *Services of a standby surgeon, except during angioplasty or other high risk procedures when we determine standbys are medically necessary* • *Routine treatment of conditions of the foot (see Section 5 (a) Foot care)* • *Eye surgery, such as radial keratotomy, lasik and laser surgery when the primary purpose is to correct myopia (nearsightedness), hyperopia (farsightedness) or astigmatism (blurring)*	*All charges*	*All charges*
Reconstructive surgery	**High Option**	**Standard Option**
• Surgery to correct a functional defect • Surgery to correct a condition caused by injury or illness if: - the condition produced a major effect on the member's appearance and - the condition can reasonably be expected to be corrected by such surgery • Surgery to correct a condition that existed at or from birth and is a significant deviation from the common form or norm. Examples of congenital anomalies are: protruding ear deformities; cleft lip; cleft palate; birth marks; and webbed fingers and toes.	PPO: 15% of the Plan allowance Non-PPO: 35% of the Plan allowance and any difference between our allowance and the billed amount	PPO: 20% of the Plan allowance Non-PPO: 45% of the Plan allowance and any difference between our allowance and the billed amount

Reconstructive surgery - continued on next page

Benefit Description	You Pay After the calendar year deductible...	
Reconstructive surgery (cont.)	**High Option**	**Standard Option**
• All stages of breast reconstruction surgery following a mastectomy, such as: - surgery to produce a symmetrical appearance of breasts; - treatment of any physical complications, such as lymphedemas; - breast prostheses; and surgical bras and replacements (see Section 5(a) *Orthopedic and prosthetic devices* for coverage) Note: We pay for internal breast prostheses as orthopedic and prosthetic devices, see Section 5(a). Note: If you need a mastectomy, you may choose to have the procedure performed on an inpatient basis and remain in the hospital up to 48 hours after the admission	PPO: 15% of the Plan allowance Non-PPO: 35% of the Plan allowance and any difference between our allowance and the billed amount	PPO: 20% of the Plan allowance Non-PPO: 45% of the Plan allowance and any difference between our allowance and the billed amount
Not covered: • *Cosmetic surgery – any surgical procedure (or any portion of a procedure) performed primarily to improve physical appearance through change in bodily form, except repair of accidental injury (See Section 5(d) Accidental injury)* • *Reversal of gender reassignment surgery* • *Surgery for Sex-Trait Modification to treat gender dysphoria*	*All charges*	*All charges*
Oral and maxillofacial surgery	**High Option**	**Standard Option**
Oral surgical procedures, limited to: • Reduction of fractures of the jaws or facial bones • Surgical correction of cleft lip, cleft palate or severe functional malocclusion • Removal of stones from salivary ducts • Excision of impacted teeth, bony cysts of the jaw, torus palatinus, leukoplakia, or malignancies • Excision of cysts and incision of abscesses not involving the teeth • Other surgical procedures that do not involve the teeth or their supporting structures • Freeing of muscle attachments	PPO: 15% of the Plan allowance Non-PPO: 35% of the Plan allowance and any difference between our allowance and the billed amount	PPO: 20% of the Plan allowance Non-PPO: 45% of the Plan allowance and any difference between our allowance and the billed amount
Not covered: • *Oral implants and transplants* • *Procedures that involve the teeth or their supporting structures (such as the periodontal membrane, gingiva, and alveolar bone)*	*All charges*	*All charges*

Benefit Description	You Pay After the calendar year deductible...	
Organ/tissue transplants	**High Option**	**Standard Option**
These **solid organ and tissue transplants** are subject to medical necessity and experimental/investigational review by the Plan. See *Other services* under *You need prior Plan approval for certain services* on page 19. Solid organ and tissue transplants are limited to: • Autologous pancreas islet cell transplant (as an adjunct to total or near total pancreatectomy) only for patients with chronic pancreatitis • Cornea • Heart • Heart/lung • Intestinal transplants - Isolated small intestine - Small intestine with the liver - Small intestine with multiple organs, such as the liver, stomach, and pancreas • Kidney • Kidney/pancreas • Liver • Lung: single/bilateral/lobar • Pancreas	PPO: 15% of the Plan allowance Non-PPO: 35% of the Plan allowance and any difference between our allowance and the billed amount and all charges after the Plan pays $100,000 per transplant	PPO: 20% of the Plan allowance Non-PPO: 45% of the Plan allowance and any difference between our allowance and the billed amount and all charges after the Plan pays $100,000 per transplant
These **tandem blood or marrow stem cell transplants for covered transplants** are subject to medical necessity review by the Plan. Refer to *Other services* in Section 3 for prior authorization procedures. • Autologous tandem transplants for: - AL Amyloidosis - Multiple myeloma (de novo and treated) - Recurrent germ cell tumors (including testicular cancer)	PPO: 15% of the Plan allowance Non-PPO: 35% of the Plan allowance and any difference between our allowance and the billed amount and all charges after the Plan pays $100,000 per transplant	PPO: 20% of the Plan allowance Non-PPO: 45% of the Plan allowance and any difference between our allowance and the billed amount and all charges after the Plan pays $100,000 per transplant

Organ/tissue transplants - continued on next page

Benefit Description	You Pay After the calendar year deductible...	
Organ/tissue transplants (cont.)	**High Option**	**Standard Option**
Blood or marrow stem cell transplants The Plan extends coverage for the diagnoses as indicated below. Refer to *Other services* in Section 3 for prior authorization procedures. • Allogeneic transplants for: - Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia - Acute myeloid leukemia - Advanced Hodgkin's lymphoma with recurrence (relapsed) - Advanced Myeloproliferative Disorders (MPD's) - Advanced neuroblastoma - Advanced non-Hodgkin's lymphoma with recurrence (relapsed) - Chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL) - Hemoglobinopathy - Infantile malignant osteopetrosis - Kostmann's Syndrome - Leukocyte adhesion deficiencies - Marrow failure and related disorders (i.e., Fanconi's, Paroxysmal Nocturnal Hemoglobinuria, Pure Red Cell Aplasia) - Mucolipidosis (e.g., Gaucher's disease, metachromatic leukodystrophy, adrenoleukodystrophy) - Mucopolysaccharidosis (e.g., Hunter's syndrome, Hurler's syndrome, Sanfilippo's syndrome, Maroteaux-Lamy syndrome variants) - Myelodysplasia/Myelodysplastic syndromes - Paroxysmal Nocturnal Hemoglobinuria - Phagocytic/Hemophagocytic deficiency diseases (e.g., Wiskott-Aldrich syndrome) - Severe combined immunodeficiency - Severe or very severe aplastic anemia - Sickle cell anemia - X-linked lymphoproliferative syndrome • Autologous transplants for: - Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia - Advanced Hodgkin's lymphoma with recurrence (relapsed) - Advanced non-Hodgkin's lymphoma with recurrence (relapsed) - Amyloidosis	PPO: 15% of the Plan allowance Non-PPO: 35% of the Plan allowance and any difference between our allowance and the billed amount and all charges after the Plan pays $100,000 per transplant	PPO: 20% of the Plan allowance Non-PPO: 45% of the Plan allowance and any difference between our allowance and the billed amount and all charges after the Plan pays $100,000 per transplant

Organ/tissue transplants - continued on next page

Benefit Description	You Pay After the calendar year deductible...	
Organ/tissue transplants (cont.)	**High Option**	**Standard Option**
Blood or marrow stem cell transplants The Plan extends coverage for the diagnoses as indicated below. Refer to *Other services* in Section 3 for prior authorization procedures. • Autologous transplants for: - Breast cancer - Ependymoblastoma - Ewing's sarcoma - Medulloblastoma - Multiple myeloma - Neuroblastoma - Pineoblastoma - Testicular, mediastinal, retroperitoneal, and ovarian germ cell tumors	PPO: 15% of the Plan allowance Non-PPO: 35% of the Plan allowance and any difference between our allowance and the billed amount and all charges after the Plan pays $100,000 per transplant	PPO: 20% of the Plan allowance Non-PPO: 45% of the Plan allowance and any difference between our allowance and the billed amount and all charges after the Plan pays $100,000 per transplant
Non-myeloablative, reduced intensity conditioning or RIC transplants performed in a clinical trial setting for members with a diagnosis listed below are subject to medical necessity review by the Plan. Refer to *Other services* in Section 3 for prior authorization procedures: • Allogeneic transplants for: - Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia - Acute myeloid leukemia - Advanced Hodgkin's lymphoma with recurrence (relapsed) - Advanced Myeloproliferative Disorders (MPDs) - Advanced non-Hodgkin's lymphoma with recurrence (relapsed) - Chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL) - Hemoglobinopathy - Marrow failure and related disorders (i.e., Fanconi's, PNH, Pure Red Cell Aplasia) - Myelodysplasia/Myelodysplastic syndromes - Paroxysmal Nocturnal Hemoglobinuria - Severe combined immunodeficiency - Severe or very severe aplastic anemia	PPO: 15% of the Plan allowance Non-PPO: 35% of the Plan allowance and any difference between our allowance and the billed amount and all charges after the Plan pays $100,000 per transplant	PPO: 20% of the Plan allowance Non-PPO: 45% of the Plan allowance and any difference between our allowance and the billed amount and all charges after the Plan pays $100,000 per transplant

Organ/tissue transplants - continued on next page

Benefit Description	You Pay After the calendar year deductible...	
Organ/tissue transplants (cont.)	**High Option**	**Standard Option**
Non-myeloablative, reduced intensity conditioning or RIC transplants performed in a clinical trial setting for members with a diagnosis listed below are subject to medical necessity review by the Plan. Refer to *Other services* in Section 3 for prior authorization procedures: • Autologous transplants for: - Acute lymphocytic or nonlymphocytic (i.e., myelogenous) leukemia - Advanced Hodgkin's lymphoma with recurrence (relapsed) - Advanced non-Hodgkin's lymphoma with recurrence (relapsed) - Amyloidosis - Neuroblastoma	PPO: 15% of the Plan allowance Non-PPO: 35% of the Plan allowance and any difference between our allowance and the billed amount and all charges after the Plan pays $100,000 per transplant	PPO: 20% of the Plan allowance Non-PPO: 45% of the Plan allowance and any difference between our allowance and the billed amount and all charges after the Plan pays $100,000 per transplant
These blood or marrow stem cell transplants are covered only in a National Cancer Institute or National Institutes of Health **approved clinical trial** or a Plan-designated Cigna Lifesource transplant facility and if approved by the Plan's medical director in accordance with the Plan's protocols. Refer to *Other services* in Section 3 for prior authorization procedures. If you are a participant in a clinical trial, the Plan will provide benefits for related routine care that is medically necessary (such as doctor visits, lab tests, X-rays and scans, and hospitalization related to treating the patient's condition) if it is not provided by the clinical trial. Section 9 has additional information on costs related to clinical trials. We encourage you to contact the Plan to discuss specific services if you participate in a clinical trial. • Allogeneic transplants for: - Beta Thalassemia Major - Multiple myeloma - Sickle cell anemia • Non-myeloablative allogeneic, reduced intensity conditioning or RIC transplants for: - Acute lymphocytic or non-lymphocytic (i.e. myelogenous) leukemia - Advanced Hodgkin's lymphoma - Advanced non-Hodgkin's lymphoma - Chronic lymphocytic leukemia - Chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL) - Chronic myelogenous leukemia - Multiple myeloma - Myelodysplasia/Myelodysplastic Syndrome - Myeloproliferative disorders (MPDs)	PPO: 15% of the Plan allowance Non-PPO: 35% of the Plan allowance and any difference between our allowance and the billed amount and all charges after the Plan pays $100,000 per transplant	PPO: 20% of the Plan allowance Non-PPO: 45% of the Plan allowance and any difference between our allowance and the billed amount and all charges after the Plan pays $100,000 per transplant

Organ/tissue transplants - continued on next page

Benefit Description	You Pay After the calendar year deductible...	
Organ/tissue transplants (cont.)	**High Option**	**Standard Option**
These blood or marrow stem cell transplants are covered only in a National Cancer Institute or National Institutes of Health **approved clinical trial** or a Plan-designated Cigna Lifesource transplant facility and if approved by the Plan's medical director in accordance with the Plan's protocols. Refer to *Other services* in Section 3 for prior authorization procedures. If you are a participant in a clinical trial, the Plan will provide benefits for related routine care that is medically necessary (such as doctor visits, lab tests, X-rays and scans, and hospitalization related to treating the patient's condition) if it is not provided by the clinical trial. Section 9 has additional information on costs related to clinical trials. We encourage you to contact the Plan to discuss specific services if you participate in a clinical trial. • Autologous transplants for: - Advanced childhood kidney cancers - Advanced Ewing sarcoma - Aggressive non-Hodgkin's lymphomas - Childhood rhabdomyosarcoma - Chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL) - Epithelial ovarian cancer - Mantle cell (non-Hodgkin's lymphoma) - Multiple sclerosis - Scleroderma - Scleroderma-SSc (severe, progressive) - Systemic sclerosis	PPO: 15% of the Plan allowance Non-PPO: 35% of the Plan allowance and any difference between our allowance and the billed amount and all charges after the Plan pays $100,000 per transplant	PPO: 20% of the Plan allowance Non-PPO: 45% of the Plan allowance and any difference between our allowance and the billed amount and all charges after the Plan pays $100,000 per transplant
Covered expenses for the purpose of this benefit are: • The pretransplant evaluation; • Organ procurement; • The transplant procedure itself (hospital and doctor fees); • Transplant-related follow-up care for up to one year from the date the transplant procedure is performed; and • Pharmacy costs for immunosuppressant and other transplant-related medication.	PPO: 15% of the Plan allowance Non-PPO: 35% of the Plan allowance and any difference between our allowance and the billed amount and all charges after the Plan pays $100,000 per transplant	PPO: 20% of the Plan allowance Non-PPO: 45% of the Plan allowance and any difference between our allowance and the billed amount and all charges after the Plan pays $100,000 per transplant

Organ/tissue transplants - continued on next page

Benefit Description	You Pay After the calendar year deductible...	
Organ/tissue transplants (cont.)	**High Option**	**Standard Option**
The Plan uses specific Plan-designated organ/tissue transplant facilities. Before your initial evaluation as a potential candidate for a transplant procedure, you, your representative, or your doctor must contact the Cigna Lifesource Transplant Unit at 800-668-9682 to initiate the pretransplant evaluation. The clinical results of the evaluation will be reviewed to determine if the proposed procedure meets the Plan's definition of medically necessary. A case manager will assist the patient in accessing the appropriate transplant facility. If you choose a Plan-designated transplant facility, the Plan will provide an allowance for preapproved reasonable travel and lodging costs (see *Travel/Lodging Benefit* below). Note: We cover related medical and hospital expenses of the actual donor for the initial transplant confinement when we cover the recipient, if these expenses are approved through Cigna Lifesource Transplant Unit and not covered by any other health plan.	PPO: 15% of the Plan allowance Non-PPO: 35% of the Plan allowance and any difference between our allowance and the billed amount and all charges after the Plan pays $100,000 per transplant	PPO: 20% of the Plan allowance Non-PPO: 45% of the Plan allowance and any difference between our allowance and the billed amount and all charges after the Plan pays $100,000 per transplant
Travel/Lodging Benefit – If the recipient lives more than 60 miles from a Plan-designated transplant facility, the Plan will provide an allowance for preapproved travel and lodging expenses up to $10,000 per transplant under the **High Option** and up to $5,000 per transplant under the **Standard Option**. The allowance will provide coverage of reasonable travel and temporary lodging expenses for the recipient and one companion (two companions if the recipient is a minor) and the actual organ donor, if applicable. **Limited Benefits** – If you do not use a Plan-designated transplant facility, total benefit payments, including donor expenses, the transplant procedure itself (hospital and doctor fees), transplant-related follow-up care for one year from the date the transplant procedure is performed, and pharmacy costs for 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.	PPO: 15% of the Plan allowance Non-PPO: 35% of the Plan allowance and any difference between our allowance and the billed amount and all charges after the Plan pays $100,000 per transplant	PPO: 20% of the Plan allowance Non-PPO: 45% of the Plan allowance and any difference between our allowance and the billed amount and all charges after the Plan pays $100,000 per transplant
Not covered: • *Donor screening tests and donor search expenses, except those approved through the Cigna Lifesource Transplant Unit* • *Implants of artificial organs* • *Transplants and related services that we have not approved*	*All charges*	*All charges*

Benefit Description	You Pay After the calendar year deductible...	
Anesthesia	**High Option**	**Standard Option**
Professional services provided in – • Hospital (inpatient) • Hospital outpatient department • Skilled nursing facility • Ambulatory surgical center • Office Note: When anesthesia services are performed and billed by two providers (e.g., a CRNA under the direction of an M.D.) for the same procedure or operative session, the total Plan allowance for both providers may not exceed the amount that the Plan would allow had the services been rendered solely by one provider, unless the PPO contract provides for a different amount.	PPO: 15% of the Plan allowance Non-PPO: 35% of the Plan allowance and any difference between our allowance and the billed amount	PPO: 20% of the Plan allowance Non-PPO: 45% of the Plan allowance and any difference between our allowance and the billed amount
Not covered: • *Anesthesia in conjunction with a non-covered surgical procedure*	*All charges*	*All charges*

Section 5(c). Services Provided by a Hospital or other Facility, and Ambulance Services

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- In this Section, unlike Sections 5(a) and 5(b), the calendar year deductible applies to only a few benefits. We added "(calendar year deductible applies)."
  - The High Option calendar year deductibles are $300 per person (limited to $600 per Self Plus One or a Self and Family enrollment) for services of PPO providers and $300 per person (limited to $600 per Self Plus One or a Self and Family enrollment) for services of Non-PPO providers.
  - The Standard Option calendar year deductibles are $350 per person (limited to $700 per Self Plus One enrollment or $900 per Self and Family enrollment) for services of PPO providers and $350 per person (limited to $700 per Self Plus One enrollment or $900 per Self and Family enrollment) for services of Non-PPO providers.
- The Non-PPO benefits are the regular benefits of this Plan. PPO benefits apply only when you use a PPO provider. When no PPO provider is available, Non-PPO benefits apply.
- When you use a PPO facility, some of the professionals that provide related services may not be PPO network providers. We determine how to pay these providers based on their specialty. For the following specialties, we pay PPO benefits: Anesthesiologist, Assistant Surgeons, Emergency Room Physicians, Pathologists, and Radiologists. PPO benefits for these providers include PPO deductible, copay, coinsurance, and out-of-pocket maximum amounts. For all other provider specialties, we will pay Non-PPO benefits. For all Non-PPO providers, you will be responsible for any difference between the Plan allowance and billed amount for these out of network providers.
- Be sure to read Section 4, *Your Costs for Covered Services* for valuable information about how cost-sharing works. Also, read Section 9 for information about how we pay if you have other coverage, or if you are age 65 or over.
- If you are enrolled in the SAMBA Health Benefit Plan and have Medicare Part A and Part B and it is primary, we offer the UnitedHealthcare Medicare Advantage (PPO) for the SAMBA Health Benefit Plan to our members. This plan enhances your SAMBA coverage by reducing or eliminating cost-sharing for services and adding benefits at no additional cost. **It includes a Medicare Part B subsidy of $100 per month for High Option and $75 per month for Standard Option.** The UnitedHealthcare Medicare Advantage (PPO) for the SAMBA Health Benefit Plan is subject to Medicare rules. (See Section 9 for additional details.)
- The amounts listed below are for the charges billed by the facility (i.e., hospital or surgical center) or ambulance service for your surgery or care. Any costs associated with the professional charge (i.e., physicians, etc.) are in Sections 5(a) or 5(b).
- When you receive hospital observation services as an outpatient, we cover those services at the same benefit level we cover inpatient room and board services. These benefits are listed under the *Outpatient hospital or ambulatory surgical center* benefits listed on page 65. Inpatient benefits will apply only when your physician formally admits you to the hospital as an inpatient. See Section 10, page 115 for the definition of observation services. It is your responsibility to ensure that we are contacted for precertification if you are admitted as an inpatient. Please refer to the precertification information shown in Section 3.
- **YOU MUST GET PRECERTIFICATION FOR HOSPITAL STAYS; FAILURE TO DO SO WILL RESULT IN A MINIMUM $500 PENALTY.** Please refer to the precertification information shown in Section 3 to be sure which services require precertification.

Benefit Description	You Pay	
Note: The calendar year deductible applies ONLY when we say below: "(calendar year deductible applies)".		
Inpatient hospital	**High Option**	**Standard Option**
Room and board, such as • Ward, semiprivate, or intensive care accommodations • General nursing care • Meals and special diets Note: We only cover a private room when you must be isolated to prevent contagion. Otherwise, we will pay the hospital's average charge for semiprivate accommodations. If the hospital only has private rooms, we base our payment on the lowest rate for a private room. Note: When the hospital bills a flat rate, we prorate the charges to determine how to pay them, as follows: 30% room and board and 70% other charges. Note: A confinement is defined in Section 10, page 112.	PPO: Nothing after a $250 copayment per confinement Note: For facility care related to maternity, including care at birthing facilities, we waive the per confinement copayment when you use a PPO facility. Non-PPO: $350 copayment per confinement and 35% of the Plan allowance and any difference between our allowance and the billed amount	PPO: Nothing after a $250 copayment per confinement Note: For facility care related to maternity, including care at birthing facilities, we waive the per confinement copayment when you use a PPO facility. Non-PPO: $450 copayment per confinement and 45% of the Plan allowance and any difference between our allowance and the billed amount
Other hospital services and supplies, such as: • Operating, recovery, maternity, and other treatment rooms • Observation care services • Prescribed drugs and medications • Diagnostic laboratory tests and X-rays • Blood or blood plasma, if not donated or replaced • Dressings, splints, casts, and sterile tray services • Medical supplies and equipment, including oxygen • Anesthetics Note: We base payment on whether the facility or a healthcare professional bills for the services or supplies. For example, when the hospital bills for anesthetic services, we pay Hospital benefits and when the anesthesiologist bills, we pay Anesthesia benefits.	PPO: 15% of the Plan allowance Note: For facility care related to maternity, including care at birthing facilities, we waive the coinsurance and pay covered services in full when you use a PPO facility. Non-PPO: 35% of the Plan allowance and any difference between our allowance and the billed amount	PPO: 20% of the Plan allowance Note: For facility care related to maternity, including care at birthing facilities, we waive the coinsurance and pay covered services in full when you use a PPO facility. Non-PPO: 45% of the Plan allowance and any difference between our allowance and the billed amount
Not covered: • *Any part of a hospital admission that is not medically necessary (see definition), such as when you do not need acute hospital inpatient (overnight) care, but could receive care in some other setting without adversely affecting your condition or the quality of your medical care. Note: In this event, we pay benefits for services and supplies other than room and board and in-hospital physician care at the level they would have been covered if provided in an alternative setting* • *Custodial care; see definition on page 112* • *Non-covered facilities or any facility used principally for convalescence, for rest, for a nursing home, for the aged, for domiciliary or custodial care, or as a school* • *Personal comfort items, such as telephone, television, barber services, guest meals and beds* • *Hospitalization for non-covered surgical procedures*	*All charges*	*All charges*

Benefit Description	You Pay	
Outpatient hospital or ambulatory surgical center	**High Option**	**Standard Option**
Other services and supplies such as: • Operating, recovery and other treatment rooms • Prescribed drugs and medications • Diagnostic laboratory tests, X-rays, and pathology services • Administration of blood, blood plasma, and other biologicals • Blood and blood plasma, if not donated or replaced • Pre-surgical testing • Dressings, casts, and sterile tray services • Medical supplies, including oxygen • Anesthetics and anesthesia service Note: We cover hospital services and supplies related to dental procedures when necessitated by a non-dental physical impairment. Note: For outpatient facility care related to maternity, including care at birthing facilities, we waive the deductible and coinsurance and pay covered services in full when you use a PPO facility.	PPO: 15% of the Plan allowance Non-PPO: 35% of the Plan allowance and any difference between our allowance and the billed amount (calendar year deductible applies)	PPO: 20% of the Plan allowance (calendar year deductible applies) Non-PPO: 45% of the Plan allowance and any difference between our allowance and the billed amount (calendar year deductible applies)
Outpatient observation services billed by a hospital Note: Refer to Section 5(a) for services billed by professional providers during an observation stay. Note: For hospital outpatient observation care that subsequently results in an inpatient admission, the observation care rendered is considered part of the admission and paid as other hospital services under *Inpatient hospital benefits* as described on page 64.	PPO: $250 copayment for outpatient observation service charges for the duration of services plus 15% of the Plan allowance for other related hospital charges Non-PPO: $350 copayment for observation service charges for the duration of services plus 35% of the Plan allowance for observation services including other related hospital charges and any difference between our allowance and the billed amount	PPO: $250 copayment for outpatient observation service charges for the duration of services plus 20% of the Plan allowance for other related hospital charges Non-PPO: $450 copayment for observation service charges for the duration of services plus 45% of the Plan allowance for observation services including other related hospital charges and any difference between our allowance and the billed amount
Not covered: • *Outpatient facility charges related to non-covered surgical procedures*	*All charges*	*All charges*

Benefit Description	You Pay	
Extended care benefits/Skilled nursing care facility benefits	**High Option**	**Standard Option**
Inpatient confinement at a skilled nursing facility following transfer from a covered acute inpatient confinement when skilled care is still required. Benefits are limited to the first 45 days per person, per calendar year under the **High Option** and the first 30 days per person, per calendar year under the **Standard Option**. Note: When Medicare A is primary, the initial days paid in full by Medicare are considered part of the 45 days per calendar year benefit under High Option and the 30 days per calendar year benefit under Standard Option.	PPO: 15% of the Plan allowance and all charges after the first 45 days Non-PPO: 35% of the Plan allowance and any difference between our allowance and the billed amount and all charges after the first 45 days	PPO: 20% of the Plan allowance and all charges after the first 30 days Non-PPO: 45% of the Plan allowance and any difference between our allowance and the billed amount and all charges after the first 30 days
Not covered: • *Custodial care* • *Personal comfort services such as beauty and barber services* • *Any charges in excess of the first 45 days (High Option) or the first 30 days (Standard Option) Plan limitation for covered skilled nursing facility care*	*All charges*	*All charges*
Hospice care	**High Option**	**Standard Option**
Hospice is a coordinated program of maintenance and supportive care for the terminally ill provided by a medically supervised team under the direction of a Plan-approved independent hospice administration. Note: A terminally ill person is a covered individual whose life expectancy is six months or less, as certified by the primary doctor. These benefits will be paid if the hospice care program begins after a person's primary doctor certifies terminal illness and life expectancy of six months or less and any services or inpatient hospice stay that is part of the program is: • Provided while the person is covered by the Plan • Ordered by the supervising doctor • Charged by the hospice care program	See below	See below
Inpatient services • Limited to 14 days per person, per calendar year	PPO: 15% of the Plan allowance and all charges in excess of the 14 day limitation for inpatient care Non-PPO: 35% of the Plan allowance and any difference between our allowance and the billed amount and all charges in excess of the 14 day limitation for inpatient care	PPO: 20% of the Plan allowance and all charges in excess of the 14 day limitation for inpatient care Non-PPO: 45% of the Plan allowance and any difference between our allowance and the billed amount and all charges in excess of the 14 day limitation for inpatient care

Hospice care - continued on next page

Benefit Description	You Pay	
Hospice care (cont.)	**High Option**	**Standard Option**
Outpatient services • Limited to $15,000 per person for covered services provided within six months from the date the person entered or re-entered (after a period of remission) a hospice care program	PPO: 15% of the Plan allowance and all charges in excess of the $15,000 benefit limit for outpatient care Non-PPO: 35% of the Plan allowance and any difference between our allowance and the billed amount and all charges in excess of the $15,000 benefit limit for outpatient care	PPO: 20% of the Plan allowance and all charges in excess of the $15,000 benefit limit for outpatient care Non-PPO: 45% of the Plan allowance and any difference between our allowance and the billed amount and all charges in excess of the $15,000 benefit limit for outpatient care
Not covered: • *Any charges in excess of the 14 day per person, per calendar year Plan limitation for covered inpatient hospice care* • *Any charges in excess of the $15,000 Plan limitation for covered outpatient care* • *Charges incurred during a period of remission* *Note: A remission is a halt or actual reduction in the progression of illness resulting in discharge from a hospice care program with no further expenses incurred. A re-admission within 3 months of a prior discharge is considered the same period of care. A new period begins 3 months after a prior discharge, with maximum benefits available.*	*All Charges*	*All Charges*
Ambulance	**High Option**	**Standard Option**
• Local professional ambulance service (within 100 miles) to the first hospital equipped to treat your condition • All other local ambulance service when medically appropriate • Air ambulance to nearest facility where necessary treatment is available if no emergency ground transportation is available or suitable and the patient's condition warrants immediate evacuation	PPO: 15% of the Plan allowance (calendar year deductible applies) Non-PPO: 35% of the Plan allowance and any difference between our allowance and the billed amount (calendar year deductible applies)	PPO: 20% of the Plan allowance (calendar year deductible applies) Non-PPO: 45% of the Plan allowance and any difference between our allowance and the billed amount (calendar year deductible applies)
Not covered: • *Ambulance transport for you or your family's convenience* • *Air ambulance if transport is beyond the nearest available suitable facility, but is requested by the patient or physician for continuity of care or other reasons*	*All Charges*	*All Charges*

Section 5(d). Emergency Services/Accidents

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- The calendar year deductible applies to almost all benefits in this Section. We added "(No deductible)" to show when the calendar year deductible does not apply.
  - The High Option calendar year deductibles are $300 per person (limited to $600 per Self Plus One or a Self and Family enrollment) for services of PPO providers and $300 per person (limited to $600 per Self Plus One or a Self and Family enrollment) for services of Non-PPO providers.
  - The Standard Option calendar year deductibles are $350 per person (limited to $700 per Self Plus One enrollment or $900 per Self and Family enrollment) for services of PPO providers and $350 per person (limited to $700 per Self Plus One enrollment or $900 per Self and Family enrollment) for services of Non-PPO providers
- The Non-PPO benefits are the regular benefits of this Plan. PPO benefits apply only when you use a PPO provider. When no PPO provider is available, Non-PPO benefits apply.
- Be sure to read Section 4, *Your Costs for Covered Services,* for valuable information about how cost-sharing works. Also, read Section 9 for information about how we pay if you have other coverage, or if you are age 65 or over.
- If you are enrolled in the SAMBA Health Benefit Plan and have Medicare Part A and Part B and it is primary, we offer the UnitedHealthcare Medicare Advantage (PPO) for the SAMBA Health Benefit Plan to our members. This plan enhances your SAMBA coverage by reducing or eliminating cost-sharing for services and adding benefits at no additional cost. **It includes a Medicare Part B subsidy of $100 per month for High Option and $75 per month for Standard Option.** The UnitedHealthcare Medicare Advantage (PPO) for the SAMBA Health Benefit Plan is subject to Medicare rules. (See Section 9 for additional details.)

What is an accidental injury?

An accidental injury is a bodily injury sustained solely through violent, external, and accidental means, such as broken bones, animal bites, and poisonings. See Section 5(g) for dental care for accidental injury.

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

Benefit Description	You pay After the calendar year deductible…	
Note: The calendar year deductible applies to almost all benefits in this Section. We say "(No deductible)" when it does not apply.		
Accidental injury	**High Option**	**Standard Option**
If you receive care for your accidental injury within 24 hours, we cover: • All medically necessary physician services and supplies • Related hospital services Note: Services received after 24 hours are considered the same as any other illness and regular Plan benefits will apply.	PPO: Nothing (No deductible) Non-PPO: Only the difference between our allowance and the billed amount (No deductible)	PPO: Nothing (No deductible) Non-PPO: Only the difference between our allowance and the billed amount (No deductible)

Benefit Description	You pay After the calendar year deductible…	
Medical emergency	**High Option**	**Standard Option**
If you receive outpatient care for your medical emergency in a hospital emergency room, we cover: • Non-surgical physician services and supplies • Related outpatient hospital services • Observation room • Surgery and related services Note: We pay inpatient hospital benefits if you are admitted. See Section 5(c).	PPO: 15% of the Plan allowance Non-PPO: 15% of the Plan allowance and any difference between our allowance and the billed amount	PPO: 20% of the Plan allowance Non-PPO: 20% of the Plan allowance and any difference between our allowance and the billed amount
If you receive care for your medical emergency in other than an outpatient hospital emergency room, we cover: • Non-surgical physician services and supplies • Surgery and related services • Other related outpatient services	PPO: 15% of the Plan allowance Non-PPO: 35% of the Plan allowance and any difference between our allowance and the billed amount	PPO: 20% of the Plan allowance Non-PPO: 45% of the Plan allowance and any difference between our allowance and the billed amount
Ambulance – accidental injury	**High Option**	**Standard Option**
We pay 100% of covered ambulance services when services are rendered within 24 hours of your accidental injury for the following: • Local professional ambulance service (within 100 miles) to the first hospital equipped to treat your condition • All other local ambulance service when medically appropriate • Air ambulance to nearest facility where necessary treatment is available if no emergency ground transportation is available or suitable and the patient's condition warrants immediate evacuation	PPO: Nothing (No deductible) Non-PPO: Only the difference between our allowance and the billed amount (No deductible)	PPO: Nothing (No deductible) Non-PPO: Only the difference between our allowance and the billed amount (No deductible)
Ambulance – non-accidental injury	**High Option**	**Standard Option**
• Local professional ambulance service (within 100 miles) to the first hospital equipped to treat your condition • All other local ambulance service when medically appropriate • Air ambulance to nearest facility where necessary treatment is available if no emergency ground transportation is available or suitable and the patient's condition warrants immediate evacuation	PPO: 15% of the Plan allowance (calendar year deductible applies) Non-PPO: 35% of the Plan allowance and any difference between our allowance and the billed amount (calendar year deductible applies)	PPO: 20% of the Plan allowance (calendar year deductible applies) Non-PPO: 45% of the Plan allowance and any difference between our allowance and the billed amount (calendar year deductible applies)

Section 5(e). Mental Health and Substance Use Disorder Benefits

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- The calendar year deductible applies to almost all benefits in this Section. We added "(No deductible)" to show when the calendar year deductible does not apply.
  - The High Option calendar year deductibles are $300 per person (limited to $600 per Self Plus One or a Self and Family enrollment) for services of PPO providers and $300 per person (limited to $600 per Self Plus One or a Self and Family enrollment) for services of Non-PPO providers.
  - The Standard Option calendar year deductibles are $350 per person (limited to $700 per Self Plus One enrollment or $900 per Self and Family enrollment) for services of PPO providers and $350 per person (limited to $700 per Self Plus One enrollment or $900 per Self and Family enrollment) for services of Non-PPO providers.
- Be sure to read Section 4, *Your Costs for Covered Services*, for valuable information about how cost-sharing works. Also, read Section 9 for information about how we pay if you have other coverage, of if you are age 65 or over.
- If you are enrolled in the SAMBA Health Benefit Plan and have Medicare Part A and Part B and it is primary, we offer the UnitedHealthcare Medicare Advantage (PPO) for the SAMBA Health Benefit Plan to our members. This plan enhances your SAMBA coverage by reducing or eliminating cost-sharing for services and adding benefits at no additional cost. **It includes a Medicare Part B subsidy of $100 per month for High Option and $75 per month for Standard Option.** The UnitedHealthcare Medicare Advantage (PPO) for the SAMBA Health Benefit Plan is subject to Medicare rules. (See Section 9 for additional details.)
- **YOU MUST GET PRIOR AUTHORIZATION FOR CERTAIN SERVICES.** To be eligible to receive full benefits, you must follow the prior authorization process.
  - The medical necessity of your admission to a hospital or other covered facility (such as a residential treatment center) must be authorized prior to admission. Emergency admissions must be reported within two business days following the day of admission even if you have been discharged. Otherwise, benefits will be reduced by $500. See Section 3 for details.
  - To obtain prior authorization call Cigna Healthcare and Evernorth Health Services at 800-887-9735.

Benefit Description	You Pay After the calendar year deductible…	
Note: The calendar year deductible applies to almost all benefits in this Section. We say "(No deductible)" when it does not apply.		
Professional services	**High Option**	**Standard Option**
We cover professional services by licensed professional mental health and substance use disorder treatment practitioners when acting within the scope of their license, such as psychiatrists, psychologists, clinical social workers, licensed professional counselors, or marriage and family therapists.	Your cost-sharing responsibilities are no greater than for other illnesses or conditions.	Your cost-sharing responsibilities are no greater than for other illnesses or conditions.

Professional services - continued on next page

Benefit Description	You Pay After the calendar year deductible…	
Professional services (cont.)	**High Option**	**Standard Option**
Diagnosis and treatment of psychiatric conditions, mental illness, or mental disorders. Services include: • Diagnostic evaluation • Crisis intervention and stabilization for acute episodes • Medication evaluation and management (pharmacotherapy) • Treatment and counseling, including psychotherapy and cognitive behavioral therapy (including individual or group therapy visits) • Diagnosis and treatment related to gender dysphoria • Diagnosis and treatment of substance use disorders, including detoxification, treatment and counseling • Professional charges for intensive outpatient treatment in a provider's office or other professional setting • Behavioral health integration services (see definition in Section 10, page 111) • Collaborative care management (CoCM) services (see definition in Section 10, page 112)	PPO: $15 copayment per outpatient office visit to primary care providers; $25 copayment per outpatient office visit to specialists (No deductible) Non-PPO: 35% of the Plan allowance and any difference between our allowance and the billed amount	PPO: $20 copayment per outpatient office visit to primary care providers; $30 copayment per outpatient office visit to specialists (No deductible) Non-PPO: 45% of the Plan allowance and any difference between our allowance and the billed amount
• Phone consultations and online medical evaluation and management services (telehealth) by a healthcare provider other than Teladoc Health Note: For additional telehealth benefits see Telehealth with Teladoc Health below.	PPO: $10 copayment per outpatient office visit to primary care providers; $20 copayment per outpatient office visit to specialists (No deductible) Non-PPO: 35% of the Plan allowance and any difference between our allowance and the billed amount	PPO: $15 copayment per outpatient office visit to primary care providers; $25 copayment per outpatient office visit to specialists (No deductible) Non-PPO: 45% of the Plan allowance and any difference between our allowance and the billed amount
• Inpatient professional services • Electroconvulsive therapy performed in an inpatient or outpatient setting	PPO: 15% of the Plan allowance Non-PPO: 35% of the Plan Allowance and any difference between our allowance and the billed amount	PPO: 20% of the Plan Allowance Non-PPO: 45% of the Plan allowance and any difference between our allowance and the billed amount
• Acupuncture by a doctor of medicine, doctor of osteopathy or licensed acupuncturist as an alternative therapy for depression Note: Benefits are limited to 26 visits per person, per calendar year and are combined with acupuncture services listed in Section 5(a), see page 50. Note: Visits that you pay for while meeting your calendar year deductible count toward the 26 visit limit.	PPO: 15% of the Plan allowance and all charges in excess of the 26 visit limitation Non-PPO: 35% of the Plan Allowance and any difference between our allowance and the billed amount and all charges in excess of the 26 visit limitation	PPO: 20% of the Plan allowance and all charges in excess of the 26 visit limitation Non-PPO: 45% of the Plan Allowance and any difference between our allowance and the billed amount and all charges in excess of the 26 visit limitation

Benefit Description	You Pay After the calendar year deductible…	
Telehealth services	**High Option**	**Standard Option**
Telehealth with Teladoc Health You can receive treatment and support from board-certified psychologists, psychiatrists, social workers, and therapists for conditions such as anxiety, depression, eating disorders, and more. Covered services include visits through the web or your mobile device to obtain a consultation, counseling and prescriptions (when appropriate). This includes services for covered adolescent patients ages 13 to 17. Visit www. TeladocHealth.com or call 800-Teladoc (835-2362) to schedule a telehealth visit. Note: Benefits are combined with telehealth services listed in Section 5(a), see page 32. Refer to *Section 5(h). Wellness and Other Special Features* for additional information.	Teladoc Health Providers: Nothing (No deductible) for the first 5 visits per calendar year for any covered telehealth service; $10 copayment per telehealth service beginning with the 6th visit (No deductible)	Teladoc Health Providers: Nothing (No deductible) for the first 5 visits per calendar year for any covered telehealth service; $15 copayment per telehealth service beginning with the 6th visit (No deductible)
Diagnostics	**High Option**	**Standard Option**
• Psychological and neuropsychological testing necessary to determine the appropriate psychiatric treatment • Outpatient diagnostic tests provided and billed by a licensed mental health and substance use disorder treatment practitioner • Outpatient diagnostic tests provided and billed by a laboratory, hospital or other covered facility • Inpatient diagnostic tests provided and billed by a hospital or other covered facility	PPO: 15% of the Plan allowance Non-PPO: 35% of the Plan allowance and any difference between our allowance and the billed amount	PPO: 20% of the Plan allowance Non-PPO: 45% of the Plan allowance and any difference between our allowance and the billed amount
Inpatient hospital or other covered facility	**High Option**	**Standard Option**
Inpatient services provided and billed by a hospital or other covered facility • Room and board, such as semiprivate or intensive accommodations, general nursing care, meals and special diets, and other hospital services Note: There are no benefits available for Residential Treatment Center (RTC) facilities licensed as a skilled nursing facility, group home, halfway house, or similar type facility.	PPO: $250 copayment per confinement, nothing for room and board and 15% of the Plan allowance for other hospital services (No deductible) Non-PPO: $350 copayment per confinement plus 35% of the Plan allowance and any difference between our allowance and the billed amount (No deductible)	PPO: $250 copayment per confinement, nothing for room and board and 20% of the Plan allowance for other hospital services (No deductible) Non-PPO: $450 copayment per confinement plus 45% of the Plan allowance and any difference between our allowance and the billed amount (No deductible)
Outpatient hospital or other covered facility	**High Option**	**Standard Option**
Outpatient services provided and billed by a hospital or other covered facility • Services such as partial hospitalization (day or after care), half-way house, residential treatment, full-day hospitalization, or facility-based intensive outpatient treatment	PPO: 15% of the Plan allowance Non-PPO: 35% of the Plan allowance and any difference between our allowance and the billed amount	PPO: 20% of the Plan allowance Non-PPO: 45% of the Plan allowance and any difference between our allowance and the billed amount

Benefit Description	You Pay After the calendar year deductible…	
Not covered	**High Option**	**Standard Option**
Not covered: • *Marital counseling* • *Treatment for learning disabilities and mental retardation* • *Travel time to the patient's home to conduct therapy* • *Services rendered or billed by schools or members of their staff* • *Psychoanalysis or psychotherapy credited toward earning a degree or to further education or training regardless of diagnosis or symptoms that may be present* • *Outdoor residential programs* • *Recreational therapy* • *Residential therapeutic camps (i.e., Outward Bound, wilderness camps, etc.)* • *Equine therapy* • *Domiciliary care provided because care in the home is not available or is unsuitable*	*All charges*	*All charges*

Section 5(f). Prescription Drug Benefits

Important things you should keep in mind about these benefits:

- We cover prescribed drugs and medications as described in the chart beginning on page 81.
- Please remember that all benefits are subject to the definitions, limitations and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Certain prescription drugs and supplies require prior authorization by Express Scripts, such as specialty drugs that are used to treat chronic complex conditions including, but not limited to, hemophilia, immune deficiency, growth hormone deficiencies, rheumatoid arthritis, and multiple sclerosis. Call Express Scripts at 855-315-8527 for more information.
- Your prescribers must obtain prior approval/authorizations for certain prescription drugs and supplies before attempting to fill the prescription. Prior approval/authorizations must be renewed periodically.
- Federal or state laws may prevent the pharmacy from accepting unused drugs.
- **The calendar year deductible does not apply to prescription drugs from retail or mail order pharmacies.**
- Each new enrollee will receive a description of our prescription drug program, a prescription drug identification card, a mail order form/patient profile, and a preaddressed reply envelope.
- The Non-PPO benefits are the regular benefits of this Plan. PPO benefits apply only when you use a PPO provider. When no PPO provider is available, Non-PPO benefits apply.
- We do not honor or coordinate benefits with drug coupon/copay cards. You are responsible for your copay or coinsurance as indicated in this brochure.
- Be sure to read Section 4, *Your Costs for Covered Services*, for valuable information about how cost-sharing works. Also, read Section 9 for information about how we pay if you have other coverage, or if you are age 65 or over.
- If you are enrolled in the SAMBA Health Benefit Plan and have Medicare Part A and Part B and it is primary, we offer the UnitedHealthcare Medicare Advantage (PPO) for the SAMBA Health Benefit Plan to our members. This plan enhances your SAMBA coverage by reducing or eliminating cost-sharing for services and adding benefits at no additional cost. **It includes a Medicare Part B subsidy of $100 per month for High Option and $75 per month for Standard Option.** The UnitedHealthcare Medicare Advantage (PPO) for the SAMBA Health Benefit Plan is subject to Medicare rules. (See Section 9 for additional details.)
- A PDP EGWP provides prescription drug coverage only, while an MAPD EGWP combines prescription drug, physician, and hospital coverage. Enrollees are encouraged to review their options under the plan to choose what best serves their needs as the PDP EGWP or MAPD EGWP may not offer the same coverage or pricing.
- If you are enrolled in the SAMBA Health Benefit Plan and have Medicare Part A and/or Medicare Part B and are not enrolled in our Medicare Advantage Plan (Part C) (UnitedHealthcare Medicare Advantage (PPO) for the SAMBA Health Benefit Plan), you will be automatically enrolled in the Medicare Prescription Drug Plan (PDP) Employer Group Waiver Plan (EGWP), Express Scripts Medicare® (PDP) for the SAMBA Health Benefit Plan. **This Plan enhances your SAMBA coverage by reducing the overall cost-sharing for your prescription drug purchases.** Members will have the opportunity to opt-out should they choose to do so and will continue to receive the Plan's regular prescription drug coverage. If you choose to disenroll and then want to re-enroll in this program, the ability to do so is limited to one time per calendar year. See Section 9 for additional details.
- **The exclusion for hormone treatments for Sex-Trait Modification for gender dysphoria** only pertains to chemical and surgical modification of an individual's sex traits (including as part of "gender transition" services). **We do not exclude coverage for entire classes of pharmaceuticals**, e.g., GnRH agonists may be prescribed during IVF, for reduction of endometriosis or fibroids, and for cancer treatment or prostate cancer/ tumor growth prevention.

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

- **Who can write your prescription.** A U. S. licensed physician or dentist, and in states allowing it, licensed/certified providers with prescriptive authority prescribing within their scope of practice must prescribe your medication.
- **Where you can obtain them.** You may fill the prescription at a participating Express Scripts network pharmacy, a non-network pharmacy, the Express Scripts Mail Service, or the Express Scripts Specialty Pharmacy. To receive the Plan's maximum benefit, you must fill the prescription at a participating Express Scripts network pharmacy, through the Express Scripts Mail Service for maintenance medications, or through an Express Scripts Specialty Pharmacy for specialty drugs.
- **We use a formulary.** Our formulary is the National Preferred Formulary through Express Scripts. The formulary identifies cost-effective medications that have been selected for their clinical effectiveness. If your physician believes a brand name product is necessary or there is no generic available, your physician may prescribe a brand name drug from a formulary list. By asking your doctor to prescribe formulary medications, you can help reduce your costs while maintaining high quality care. There are safe, proven medication alternatives in each therapy class that are covered on the formulary. Please see our online formulary and drug pricing search tools at the following:www. SambaPlans.com/health-benefit-plan/. Some drugs are excluded from the formulary and coverage. Visit www. SambaPlans.com/health-benefit-plan/ for a list of excluded medications. This list is not all inclusive and there may be changes to the list during the year. A formulary exception process is available to physicians if they feel the formulary alternatives are not appropriate. Your doctor may request a clinical exception by calling 855-315-8527.

  Your copayment or coinsurance amounts are less for drugs listed on the formulary than those that are not.

  Our payment levels are categorized as:

  Tier 1: generic drugs
  Tier 2: formulary or preferred brand name drugs
  Tier 3: non-formulary or non-preferred brand name drugs
  Tier 4: generic/preferred specialty drugs
  Tier 5: non-preferred specialty drugs

- **Generic drugs** or generic equivalents are medications that have the same active ingredients, and provide the same clinical benefits as their brand-name counterparts. Generic equivalents become available when a brand name drug patent expires. They may look different than their corresponding brand name drugs in size, shape or color, but they meet the same U.S. Food and Drug Administration standards for safety, purity and potency.
- **Single source brand drugs** are brand name drugs that do not have a generic equivalent which are marketed under a registered trade name or trademark and are available from only one manufacturer. These products are generally patent-protected for a period of time.
- **Multisource brand drugs** are brand name drugs which have a generic equivalent available.
- **Specialty drugs,** including biotech drugs, require special handling and close monitoring and are used to treat chronic complex conditions including, but not limited to: hemophilia, immune deficiency, growth hormone deficiencies, multiple sclerosis, Crohn's disease, hepatitis C, HIV, hormonal disorders, infertility, rheumatoid arthritis, and pulmonary disorders. ***These drugs may require prior authorization.***

  You are required to obtain all specialty drugs used for long term therapy (chronic specialty drugs) from Accredo (home delivery), your exclusive Specialty Pharmacy. The Plan will allow two fills at retail for specialty drugs used for short term therapy for the treatment of an acute condition. You will be responsible for the full cost of any short term therapy (acute) specialty drugs after two retail fills and any long term therapy (chronic) specialty drugs purchased at a pharmacy other than Accredo. Note: This does not apply to specialty medications you purchase from a retail pharmacy outside the 50 United States. You file a claim for them as you would for other medications purchased in this manner.

  Express Scripts can advise you if your prescription is required to be obtained from Accredo and cannot be obtained from a retail pharmacy. Your physician can fax your prescription directly to Accredo at 800-391-9707 or you can mail your prescription to: Express Scripts, P. O. Box 66577, St. Louis, MO 63166-6577.

  Call Express Scripts at 855-315-8527 for prior authorization and if you have any questions regarding quantity limits, or other issues related to their Specialty Pharmacy services.

- **Compound Medications** are made when a licensed pharmacist combines or mixes multiple ingredients to meet a doctor's request. The U.S. Food and Drug Administration (FDA) does not verify the quality, safety and/or effectiveness of compound medications. While they may be used if an FDA approved commercially available drug does not work, compound medications have ingredients that can often cost more but are not necessarily more effective than similar FDA-approved medications.

  Compounded prescriptions are not FDA approved and not covered under the Plan. Investigational drugs are not FDA approved; therefore, if the compound includes an investigational drug, the compound will not be covered. Your doctor must call Express Scripts Member Services at 855-315-8527 to determine if the compound medication is covered. If coverage is not approved, you will be responsible for the full cost of the compound medication. Ask your doctor to prescribe FDA approved manufactured products for your condition.

- **These are the Dispensing Limitations**
  - **High Option and Standard Option Retail:** You may only obtain a 30-day supply and one refill through the Express Scripts system available at most pharmacies. ***Note: If you remain on a medication longer than 60 days (i.e., initial fill plus one refill), you must obtain subsequent refills through the Express Scripts Mail Service or through the Smart90® Program as described below.*** If you continue to use the retail pharmacy after the second fill, you will pay the entire cost of the medication. This limit does not apply to medications not available through the Express Scripts Mail Service. Call 855-315-8527 to locate a participating Express Scripts network pharmacy in your area.
  - **High Option and Standard Option Mail Order:** You may purchase up to a 90-day supply of covered drugs or supplies through the Express Scripts Mail Service. You order your prescription or refill by mail from the Express Scripts Mail Service. The Express Scripts Mail Service will fill your prescription.

    Note: Not all drugs may be available through the Express Scripts Mail Service. Any drugs which cannot be dispensed in accordance with the Express Scripts Mail Service dispensing protocols or which requires special record-keeping procedures may be excluded. However, these excluded drugs are covered under the retail prescription drug program.
  - **High Option and Standard Option Specialty Drugs:** You are required to obtain all specialty drugs used for long term therapy (chronic specialty drugs) from Accredo (home delivery), your exclusive Specialty Pharmacy. The Plan will allow two fills for short term therapy (acute specialty drugs) at a retail pharmacy. You will be responsible for the full cost of any short term therapy (acute) specialty drugs after two fills and any long term therapy (chronic) specialty drugs purchased at a pharmacy other than Accredo.
  - **Smart90®Program:** Maintenance and long-term medications are taken regularly for chronic or long term therapy. Examples include medications for managing high blood pressure, diabetes, or high cholesterol. Through Express Scripts Smart90® Program, you may purchase up to a 90-day supply of these covered long-term maintenance prescription drugs and supplies at select participating retail pharmacies. Visit www. express-scripts.com or call 855-315-8527 to locate a Smart90® participating pharmacy in your area. You will pay the applicable mail order copayment for each prescription purchased.

  If your physician prescribes a new medication that will be taken over an extended period of time and you prefer to receive your maintenance medication through the mail, you should request two prescriptions – one to be used for the participating Express Scripts network pharmacy and the other for Express Scripts Mail Service. You may obtain up to a 30-day supply right away through the prescription card program and up to a 90-day supply from the Express Scripts Mail Service. In addition, you may utilize the Smart90® Program (see above) for your maintenance medications and receive a 90-day supply from select participating pharmacies. In most cases, refills cannot be obtained until 75% of the prescription has been used. Call us or visit our website if you have any questions about dispensing limits.

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

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

  All matters pertaining to the dispensing of covered drugs or the practice of pharmacy in general are subject to the professional judgment of the dispensing pharmacist subject to applicable pharmacy laws.

  A generic equivalent will be dispensed if it is available, unless your physician specifically requires a brand name. If you receive a brand name drug when an FDA-approved generic drug is available, you have to pay the difference in cost between the brand name drug and the generic plus the generic copay.

- **Why use generic drugs?** Generic drugs are lower-priced drugs that are the therapeutic equivalent to more expensive brand name drugs. They must contain the same active ingredients and must be equivalent in strength and dosage to the original brand name product. Generics cost less than the equivalent brand name product. The U.S. Food and Drug Administration sets quality standards for generic drugs to ensure that these drugs meet the same standards of quality and strength as brand name drugs.

  You and your doctor have the option to request a brand name drug even if a generic equivalent is available. However, you will be resonsible for the difference in cost between the brand name drug and the generic even when the physician indicates "dispense as written" (DAW). Using the most cost-effective medication saves money

- **Patient Safety, Economy and Effectiveness Programs**
  SAMBA has several programs to promote patient safety, economic and efficacious pharmacy management. These programs work to ensure that safe and appropriate quantities of medication are being dispensed. The result is improved care and safety for our members. These programs include:
  - **Quantity allowances.** Specific allowances are in place for certain medications, based on FDA-approved prescribing and safety information and clinical guidelines. These include but are not limited to quantity limits and refills.
  - **Drug Utilization Review (DUR).** When you fill your prescription at a network pharmacy or through the mail order drug program, we and/or the pharmacist may electronically access information about prior prescriptions, checking for harmful drug interactions, drug duplication, excessive use, and the frequency of refills. DUR helps protect against potentially dangerous drug interactions or inappropriate use. When appropriate, your pharmacist(s) and/or Express Scripts may contact your physician(s) to discuss an alternative drug or treatment option, prescription drug compliance, and the best and most cost-effective use of services. In addition, we may perform a periodic review of prescriptions to help ensure your safety and to provide health education and support. Upon review, we may contact you or your provider(s) to discuss your current medical situation and may offer assistance in coordinating care and treatment.
  - **High-Cost Generic Management:** This program targets high-cost generics, triggering a reject at point-of-sale, which allows you and/or your prescriber to switch to lower cost generic alternatives when appropriate.

    How High-Cost Generic Management works:

    For the patient
    Members are notified that a targeted drug is not covered without a coverage review
    Members may speak with their prescriber about lower cost generic alternatives or coverage review

    At the pharmacy
    Targeted high-cost generics trigger a reject (prior authorization required) at point-of-sale
    Pharmacists are prompted to speak with prescribers about lower cost generic alternatives
    Coverage reviews ensure that patients that meet clinical criteria have a pathway to continued care

    For the prescriber
    Prior authorization criteria require a trial of specific generic alternatives
    May have other requirements based on age, indication or other clinical guidelines
    Criteria are more stringent than standard utilization management and typically require documentation
  - **Opioid Management Program:** This program is focused on significantly reducing unnecessary prescribing, dispensing and use of opioids. The program is designed to lower risk at each touchpoint of the care continuum – including prescribers, pharmacies and patients. The Opioid Management Program is intended to accomplish the following:
    - Prevent excess opioid medications from being dispensed by limiting first fill of short-acting opioids to a 7-day supply.
    - Encourage safe starts of long-acting opioids through enhanced prior authorization whenever a long-acting opioid is not in the member's claim history.
    - Ensure doses across all opioids are safe and medically necessary.

    Specially trained pharmacists will contact patients when they fill: (a) two or more different short-acting opioids within a 30-day period, (b) two or more long-acting opioids within a 21-day period from two or more prescribers, or (c) a combination of three or more different opioids.
  - **RationalMed Program:** This program improves clinical quality through early risk detection and intervention. By review and analysis of integrated pharmacy and medical data, the program helps identify and resolve potential safety issues that increase risk of hospitalizations and adverse events. Once identified, concerns are brought to the attention of the physician.

- **Prior authorization:** Prior authorization must be obtained for certain prescription drugs and supplies to assess appropriate therapy and drug dosage before providing benefits. In addition to those drugs listed on pages 74 and 75, other medications that require prior authorization include, but are not limited to, anabolic steroids, narcolepsy drugs, topical acne medications, testosterone products, gene therapies, and select pain medications. Also included are the following therapy categories: metabolic/immune diseases, rare diseases, anti-infectives, antifungals, blood disorders, neurological, gastrointestinal, cardiovascular, and ophthalmic.

  Our prior authorization review uses Plan rules based on FDA-approved prescribing and safety information, clinical guidelines and uses that are considered reasonable, safe, and effective. Prescribers can initiate a coverage review through Express Scripts at 800-753-2851.

  Other medications might be limited to a certain amount (such as quantity or dosage) within a specific time period, or require authorization to confirm clinical use based on FDA labeling. To find out if your medication requires prior authorization, contact Express Scripts at 855-315-8527.
- **SafeGuard Rx Program:** This suite of solutions target specific chronic therapeutic conditions. The specific programs achieve better outcomes by focusing on adherence and improving care with an emphasis on ensuring members receive appropriate therapy and specialized care for their condition. Medications used to treat high cholesterol, diabetes, asthma/COPD and multiple sclerosis are examples of targeted therapies.
- **Step Therapy:** Ensures that a generic alternative or brand alternative within a therapeutic category is used as a first-line treatment, before the use of a similar but more expensive drug. Specific therapeutic categories are identified as appropriate for preferred drug step therapy.

  The Plan requires the Step Therapy program for Colchicine, Cox-2 inhibitors, Hypnotics, Nasal Steroids, Nonsteroidal Anti-inflammatory drugs, Ophthalmic antiallergy, Proton Pump Inhibitors, Tetracyclines, Topical Acne/Rosacea, Topical Antifungal, Topical Corticosteroids and Topical Immunomodulators. Also included are the following therapeutic categories: allergies, analgesics, antifungals, anti-infectives, asthma/COPD, attention disorders, blood disorders, bone conditions, benign prostate hypertrophy, constipation, contraceptives, cough and cold, depression, diabetes, endocrine, gout, headaches, hepatitis C, cholesterol, hypertension, inflammatory conditions, migraine, musculoskeletal conditions, nausea and vomiting, mental health, ophthalmic, overactive bladder, pain, Parkinson's, pulmonary arterial hypertension, respiratory conditions, skin, topical inflammatory, transplant, urinary disorders, and ulcer.

  The Plan also participates in Step Therapy rules on specialty drugs. Therapies include, but are not limited to: Growth Hormones, Inflammatory Conditions, and Multiple Sclerosis.

  In situations where the targeted drug is prescribed, doctors are notified of lower-cost generics and preferred brands. If the doctor approves, the cost-effective medication is dispensed. If the doctor disapproves, a coverage review is initiated. If the coverage review is approved, the member is responsible for the Plan's normal coinsurance (see *Covered medications and supplies* on page 81). If the coverage review is denied, the member is responsible for the full cost of the drug. If the member does not first obtain the Plan's approval, they will pay the full cost of the drug. If approval is obtained after filling the prescription, the member may be reimbursed for any amount they paid minus their normal coinsurance. Coverage reviews can be initiated by the member, pharmacist, or doctor by calling Express Scripts at 800-753-2851.
- **EncircleRx℠:**
  - **Weight Management Program Solution:** Enrollment and ongoing engagement in the Omada lifestyle modification program, coupled with appropriate GLP-1s, will provide patients the best outcomes in their weight loss journey.

    Documentation will be required from the provider, along with a BMI of 32 or greater (27 with comorbidities), to ensure that GLP-1s are prescribed to patients who need them most to achieve a healthier weight.

    The lifestyle modification program plays an important role in the weight loss journey of the EncircleRx patient. Omada is a virtual vendor that educates, motivates, and holds the patient accountable to their weight loss goals and continually supports them on their weight loss journey. This program incorporates the Omada Health app and digital weight scale at no additional charge to the member. Users of GLP-1s for weight loss are required to be engaged in the lifestyle program. Four weigh-ins and four app engagements per month are required for the member to continue weight loss GLP-1 medication.

    See Section 5(h), page 91, for more information.

- **Diabetes Program Solution:** This program will help avoid misuse of GLP-1s labeled for diabetes and ensure that the patient utilizing FDA labeled diabetes GLP-1s are not using the medications for weight loss.

  Prior Authorization is required for certain GLP-1 diabetes medications. Clinical documentation for patients with Type 2 diabetes may be requested from your provider.

- **EnReachRx℠:** Provides a high-touch patient support clinical model for members filling their GLP-1 prescriptions. Enhanced clinical services for the patient include pharmacist and clinician coaching, dose optimization support to help patients reach therapeutic levels and manage side effects, and digital tools for GLP-1 patient education.

  Dispensing pharmacies providing care in this program include retail pharmacies anchored by Walgreens (allowing two 30-day prescriptions) and Costco (30- or 90-day prescriptions).

  Note: There will be no change to GLP-1 prescriptions filled at any other participating retail pharmacy. Those members will be able to fill one 30-day supply and one refill of GLP-1s at these participating pharmacies. Members who transition to a 90-day supply of GLP-1s will move to the EnGuide℠ Pharmacy (home delivery), Costco, or a current Smart90 pharmacy.

- **EnGuide℠:** A focused GLP-1 home delivery pharmacy providing comprehensive support for both patient and prescriber throughout the care journey. All mail order/home delivery of GLP-1 prescriptions will be filled through EnGuide℠.

  Services include specially-trained pharmacists knowledgeable in GLP-1 therapy, enhanced clinical care and patient support, and fulfillment using proprietary technologies in ice packaging and delivery protection.

Contact Express Scripts at 855-315-8527 for additional information regarding patient safety, economic or effective management programs listed above.

- **To claim benefits.**
  - **From a pharmacy** – When you purchase medication from a network pharmacy use your SAMBA/Express Scripts Identification Card. In most cases, you simply present the card, together with the prescription, to the pharmacist; the claim is automatically filed through the Express Scripts system.

    If you do not use your identification card when purchasing your medication, or you use a non-network or overseas pharmacy, you must submit a direct reimbursement claim form with supporting documentation to claim benefits. You can submit this form online by logging in to your account at www. express-scripts.com and locating the "Submit your claim online" link on the *Forms and Cards* page. You may also obtain these forms by calling Express Scripts toll-free at 855-315-8527 or by visiting the SAMBA website at www. SambaPlans.com/health-benefit-plan/. Service is available 7 days a week, 24 hours a day. Follow the instructions on the form and mail it to:

    Express Scripts
    Attention: Commercial Claims
    P. O. Box 14711
    Lexington, KY 40512-4711

    Note: Reimbursement will be limited to SAMBA's cost had you used a participating pharmacy minus the copayments described under *Covered medications and supplies* on page 81.

  - **By mail** – The Plan will send you information on Express Scripts Mail Service:

    1. Ask your doctor to give you a new prescription for up to a 90-day supply of your regular medication plus refills, if appropriate;

    2. Complete the patient profile/order form the first time you order under the program; and

    3. Complete a mail order envelope, enclose your prescriptions, and mail them along with the required copayment for each prescription or refill to:

    Express Scripts Home Delivery Service
    P. O. Box 66577
    St. Louis, MO 63166-6577

    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 from Express Scripts Mail Service. In the meantime, if you have questions about a particular drug or a prescription, and to request your first order forms, you may call 855-315-8527 toll-free. Customer service is available 7 days a week, 24 hours a day. You may also download order forms from www. express-scripts.com.

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

- **Coordinating with other drug coverage.**

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

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

Express Scripts
Attention: Commercial Claims
P. O. Box 14711
Lexington, KY 40512-4711

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

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

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

- **Medicare Part D insurance coverage**

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

Benefits Description	You Pay	
Note: The calendar year deductible applies to almost all benefits in this Section. We say "(No deductible)" when it does not apply.		
Covered medications and supplies	**High Option**	**Standard Option**
You may purchase the following medications and supplies prescribed by a physician from either a pharmacy or by mail: • Drugs and medications that by Federal law of the United States require a doctor's written prescription for purchase, except those listed as *Not covered* • Insulin • Diabetic supplies limited to: - Disposable needles and syringes for the administration of covered medications, such as insulin - Lancets - Test strips - Glucose meters - Insulin pumps • Medications prescribed to treat obesity Note: Certain medications require prior authorization and/or approval. Contact Express Scripts at 855-315-8527 for more information. Note: Retail copayments will apply to prescription drugs billed by a skilled nursing facility, nursing home or extended care facility. Note: You may purchase up to a 90-day supply of covered drugs and supplies at select participating pharmacies through Express Scripts Smart90® Program. You will pay the applicable mail order copayment for each prescription purchased. See *Smart90® Program* on page 76. Note: For generic and brand name drug purchases, if the cost of your prescription is less than your cost-sharing amount listed here, you pay only the cost of your prescription. If there is no generic equivalent available, you will have to pay the brand name copayment.	Copayments per prescription or refill are: Retail: • $10 generic • 30% of the Plan allowance ($100 maximum) preferred brand name • 45% of the Plan allowance ($300 maximum) non-preferred brand name Note: For retail purchases made at a non-Network pharmacy, you pay the same per prescription copayments/coinsurances as listed above, plus the difference in cost had you used a participating Plan network pharmacy. Network Mail Order: • $15 generic • 30% of the Plan allowance ($200 maximum) preferred brand name • 45% of the Plan allowance ($400 maximum) non-preferred brand name	Copayments per prescription or refill are: Retail: • $12 generic • 35% of the Plan allowance ($150 maximum) preferred brand name • 50% of the Plan allowance ($300 maximum) non-preferred brand name Note: For retail purchases made at a non-Network pharmacy, you pay the same per prescription copayments/coinsurances as listed above, plus the difference in cost had you used a participating Plan network pharmacy. Network Mail Order: • $20 generic • 35% of the Plan allowance ($300 maximum) preferred brand name • 50% of the Plan allowance ($400 maximum) non-preferred brand name
GLP-1 medications for weight loss Members obtaining weight loss medications are required to be enrolled in the Omada Virtual Health Program. See pages 78 and 91 for more information. Note: GLP-1 drugs require prior authorization and may be subject to quantity limits. Contact Express Scripts at 855-315-8527 for more information.	50% of the Plan allowance	50% of the Plan allowance

Covered medications and supplies - continued on next page

Benefits Description	You Pay	
Covered medications and supplies (cont.)	**High Option**	**Standard Option**
Specialty drugs: • used to treat chronic complex conditions and require special handling and close monitoring • must be obtained through Accredo, the Express Scripts Specialty Pharmacy See description of *Specialty drugs* on page 75. Note: Specialty drugs may require prior authorization, be subject to quantity limits or require step therapy. Contact Express Scripts at 855-315-8527. See *Other services* under *You need prior Plan approval for certain services* on page 19. Note: Certain specialty drugs dispensed by sources other than through the Express Scripts Network of Pharmacies are covered under *Specialty drugs*, Section 5(a), see page 44.	Copayments per prescription or refill (30-day supply) are: • 30% of the Plan allowance ($160 maximum) generic or preferred specialty • 45% of the Plan allowance ($320 maximum) non-preferred specialty	Copayments per prescription or refill (30 day supply) are: • 35% of the Plan allowance ($240 maximum) generic or preferred specialty • 50% of the Plan allowance ($480 maximum) non-preferred specialty
Fertility drugs: • Prescription drugs for the treatment of infertility Note: Benefits for IVF-related drugs are limited to three (3) cycles per person, per calendar year under both **High Option** and **Standard Option**.	Regular Plan benefits, cost sharing, and rules will apply depending on the fertility drug that is prescribed and the category in which your prescription falls (generic, preferred brand name, non-preferred brand name, or specialty)	Regular Plan benefits, cost sharing, and rules will apply depending on the fertility drug that is prescribed and the category in which your prescription falls (generic, preferred brand name, non-preferred brand name, or specialty)
Contraceptive drugs and devices as listed in the Health Resources and Services Administration site https ://www.hrsa.gov/womens-guidelines. Contraceptive coverage is available at no cost to FEHB members. The contraceptive benefit includes at least one option in each of the HRSA-supported categories of contraception (as well as the screening, education, counseling, and follow-up care). Any contraceptive that is not already available without cost sharing on the formulary can be accessed through the contraceptive exceptions process described below. Exceptions are available through the Prior Authorization (PA) process. PA reviews can be initiated by the member, pharmacist or provider. Members can contact Express Scripts at 855-315-8527. Providers can initiate an electronic PA. Once we have been contacted with exception request information sufficient for us to make a determination, you will receive a response within 24 hours or the next business day. Contraceptive exception requests are not subject to Section 8. The Disputed Claims Process. If you have difficulty accessing contraceptive coverage or other reproductive healthcare, you can contact contraception@opm.gov.	Network Retail: Nothing Note: For retail purchases made at a non-Network pharmacy, you pay the same per prescription copayment/coinsurance as listed on page 81, plus the difference in cost had you used a participating Express Scripts network pharmacy. Network Mail Order: Nothing	Network Retail: Nothing Note: For retail purchases made at a non-Network pharmacy, you pay the same per prescription copayment/coinsurance as listed on page 81, plus the difference in cost had you used a participating Express Scripts network pharmacy. Network Mail Order: Nothing

Covered medications and supplies - continued on next page

Benefits Description	You Pay	
Covered medications and supplies (cont.)	**High Option**	**Standard Option**
Over-the-counter emergency contraceptive drugs (the "morning after pill") and over-the-counter FDA-approved contraception methods are covered if prescribed by a doctor and purchased at a network pharmacy. Reimbursement for covered over-the-counter contraceptives can be submitted by the member following the steps outlined on page 79 under *To claim benefits*. Note: You may purchase up to a 90-day supply of covered drugs and supplies at select participating pharmacies through Express Scripts' Smart90® Program. See *Smart90® Program* on page 76. Note: For additional Family Planning benefits see Section 5 (a).	Network Retail: Nothing Note: For retail purchases made at a non-Network pharmacy, you pay the same per prescription copayment/coinsurance as listed on page 81, plus the difference in cost had you used a participating Express Scripts network pharmacy. Network Mail Order: Nothing	Network Retail: Nothing Note: For retail purchases made at a non-Network pharmacy, you pay the same per prescription copayment/coinsurance as listed on page 81, plus the difference in cost had you used a participating Express Scripts network pharmacy. Network Mail Order: Nothing
Opioid rescue agents are covered under this Plan with no cost sharing when obtained with a prescription from a network pharmacy in any prescription form available such as nasal sprays and intramuscular injections. For more information consult the FDA guidelines at: https ://www. fda.gov/consumers/consumer-updates/access-naloxone-can-save-life-during-opioid-overdose. Or call SAMHSA's National Helpline 1-800-662-HELP (4357) or go to https ://www. findtreatment.samhsa.gov/.	PPO: Nothing for the first two fills per patient, per calendar year Non-PPO: Nothing for the first two fills per patient, per calendar year, plus any difference between our allowance and the billed amount Note: For refills, after the first two fills, you pay the same per prescription copayment/ coinsurance as listed on page 81.	PPO: Nothing for the first two fills per patient, per calendar year Non-PPO: Nothing for the first two fills per patient, per calendar year, plus any difference between our allowance and the billed amount Note: For refills after the first two fills, you pay the same per prescription copayment/ coinsurance as lists on page 81.
Tobacco cessation medications: Over-the-counter (with a physician's prescription) and prescription drugs approved by the FDA to treat tobacco dependence when obtained from a participating Express Scripts network retail pharmacy, a non-Network retail pharmacy, or the Express Scripts Mail Service. Note: To receive benefits for over-the-counter tobacco cessation medications and products, you must have a physician's prescription. Note: You and your doctor have the option to request a brand name drug even if a generic equivalent is available. However, you will be responsible for the difference in cost between the brand name drug and the generic even when the physician indicates "dispense as written" (DAW). Note: The quantity of drugs reimbursed will be subject to recommended courses of treatment.	PPO: Nothing (no deductible) Non-PPO: Any difference between our allowance and the billed amount (No deductible)	PPO: Nothing (No deductible) Non-PPO: Any difference between our allowance and the billed amount (No deductible)

Covered medications and supplies - continued on next page

Benefits Description	You Pay	
Covered medications and supplies (cont.)	**High Option**	**Standard Option**
Not covered: • *Drugs and supplies for cosmetic purposes, e.g., Retin A, Minoxidil, Rogaine* • *Vitamins, nutrients and food supplements not listed as a covered benefit even if a physician prescribes or administers them* • *Over-the-counter nutritional supplements and medical foods* • *Topical fluoride* • *The difference in cost between the brand name drug and the generic substitute when a generic equivalent is available* • *Drugs for sexual dysfunction, e.g., Viagra, Muse, Caverject, etc.* • *Charges in excess of the Plan benefit limitation for covered fertility drugs* • *Nonprescription medications (over-the-counter medications) not shown as covered* • *Compound drugs that are not FDA approved manufactured products* • *Drugs prescribed in connection with Sex-Trait Modification for treatment of gender dysphoria*	*All Charges*	*All charges*
Preventive care medications	**High Option**	**Standard Option**
Preventive medications and supplies with USPSTF A and B recommendations. These drugs and supplements are covered without cost-share and may include over-the-counter vitamins and low dose aspirin for certain patients when prescribed by a healthcare professional and filled at a network pharmacy. These benefits are subject to change as USPSTF recommendations change. For current recommendations go to www.uspreventiveservicestaskforce.org/BrowseRec/Index/browse-recommendations. Note: Benefits for the medicines referenced above are subject to the dispensing limitations described on page 76 and are limited to recommended prescribed limits. To receive benefits, you must have a written prescription from your physician.	Network Retail: Nothing Network Mail Order: Nothing	Network Retail: Nothing Network Mail Order: Nothing

Section 5(g). Dental Benefits

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- If you are enrolled in a Federal Employees Dental/Vision Insurance Program (FEDVIP) Dental Plan, your FEHB Plan will be First/Primary payor of any benefit payments and your FEDVIP Plan is secondary to your FEHB Plan. See Section 9. *Coordinating Benefits with Medicare and Other Coverage*.
- The calendar year deductible applies to almost all benefits in this Section. We added "(No deductible)" to show when the calendar year deductible does not apply.
  - The High Option calendar year deductibles are $300 per person (limited to $600 per Self Plus One or a Self and Family enrollment) for services of PPO providers and $300 per person (limited to $600 per Self Plus One or a Self and Family enrollment) for services of Non-PPO providers.
  - The Standard Option calendar year deductibles are $350 per person (limited to $700 per Self Plus One enrollment or $900 per Self and Family enrollment) for services of PPO providers and $350 per person (limited to $700 per Self Plus One enrollment or $900 per Self and Family enrollment) for services of Non-PPO providers.
- Be sure to read Section 4, *Your Costs for Covered Services*, for valuable information about how cost-sharing works. Also, read Section 9 for information about how we pay if you have other coverage, or if you are age 65 or over.
- If you are enrolled in the SAMBA Health Benefit Plan and have Medicare Part A and Part B and it is primary, we offer the UnitedHealthcare Medicare Advantage (PPO) for the SAMBA Health Benefit Plan to our members. This plan enhances your SAMBA coverage by reducing or eliminating cost-sharing for services and adding benefits at no additional cost. **It includes a Medicare Part B subsidy of $100 per month for High Option and $75 per month for Standard Option.** The UnitedHealthcare Medicare Advantage (PPO) for the SAMBA Health Benefit Plan is subject to Medicare rules. (See Section 9 for additional details.)
- Note: We cover hospitalization for dental procedures only when a non-dental physical impairment exists which makes hospitalization necessary to safeguard the health of the patient. We do not cover the dental procedure. See Section 5(c) for inpatient hospital benefits.

Benefit Description	You Pay After the calendar year deductible...	
Accidental injury benefit	**High Option**	**Standard Option**
We cover surgical and dental treatment of an accidental injury to sound natural teeth. Treatment must be rendered within 24 months of the accident. A sound, natural tooth is a tooth that is whole or properly restored and is without impairment, periodontal or other conditions and is not in need of the treatment provided for any reason other than an accidental injury. For purposes of this Plan, a tooth previously restored with a crown, inlay, onlay, or porcelain restoration or treated by endodontics is not considered a sound natural tooth. Note: An injury to the teeth while chewing and/or eating is not considered to be an accidental injury.	PPO: 15% of the Plan allowance Non-PPO: 35% of the Plan allowance and any difference between our allowance and the billed amount	PPO: 20% of the Plan allowance Non-PPO: 45% of the Plan allowance and any difference between our allowance and the billed amount

Benefit Description	You Pay After the calendar year deductible...	
Dental benefits	**High Option**	**Standard Option**
Orthodontic treatment • We cover charges for an orthodontist for treatment after surgery for closure of a cleft palate or cleft lip, or for correction of prognathism or micrognathism. Lifetime benefits per person are: • Cleft palate or cleft palate with cleft lip limited to $2,500 • Cleft lip, prognathism or micrognathism limited to $1,000	PPO: 15% of the Plan allowance Non-PPO: 35% of the Plan allowance and any difference between our allowance and the billed amount Note: You pay charges above the Plan's limit.	All charges
Dental prosthetic appliances • We will pay covered charges for dental prosthetic appliances to treat conditions due to a congenital anomaly or defect up to a maximum lifetime benefit of $3,000 per person.	PPO: 15% of the Plan allowance Non-PPO: 35% of the Plan allowance and any difference between our allowance and the billed amount Note: You pay charges above the Plan's limit.	All charges
Not covered: • *Dental appliances, study models, splints and other devices or services associated with the treatment of temporomandibular joint (TMJ) dysfunction* • *Routine and preventive dental services* • *Dental implants*	*All charges*	*All charges*

Section 5(h). Wellness and Other Special Features

Special feature	Description
Flexible benefits option	Under the flexible benefits option, we determine the most effective way to provide services. • We may identify medically appropriate alternatives to regular contract benefits as a less costly alternative. If we identify a less costly alternative, we will ask you to sign an alternative benefits agreement that will include all of the following terms in addition to other items as necessary. Until you sign and return the agreement, regular contract benefits will continue. • Alternative benefits will be made available for a limited time period and are subject to our ongoing review. You must cooperate with the review process. • By approving an alternative benefit, we do not guarantee you will get it in the future. • The decision to offer an alternative benefit is solely ours, and except as expressly provided in the agreement, we may withdraw it at any time and resume regular contract benefits. • If you sign the agreement, we will provide the agreed-upon alternative benefits for the stated time period (unless circumstances change). You may request an extension of the time period, but regular contract benefits will resume if we do not approve your request. • Our decision to offer or withdraw alternative benefits is not subject to OPM review under the disputed claims process. However, if at the time we make a decision regarding alternative benefits, we also decide that regular contract benefits are not payable, then you may dispute our regular contract benefits decision under the OPM disputed claim process (see Section 8).
Travel benefit/services overseas	For covered services rendered by a hospital or by a doctor outside of the United States, the Plan will pay eligible charges at PPO benefit levels, limited to the Plan's allowance established for the Washington, D.C. Metropolitan area. The member is responsible for the difference between the Plan's allowance and the provider's charge. See page 96, *Section 7. Filing a Claim for Covered Services*.
Services for deaf and hearing impaired	SAMBA has a TTY line for the hearing-impaired: 301-984-4155 (TTY equipment is needed).
Telehealth services	Telehealth services are available through Teladoc Health where you can receive quality healthcare anytime, anywhere – at work, in the comfort of your home or while traveling. As a Teladoc Health member, you will have access to a national network of U.S. board-certified physicians. With an average of over 20 years of clinical experience, Teladoc Health doctors can diagnose, treat and prescribe medication for your non-emergency conditions such as the flu, sore throat, eye infections, bronchitis, and allergies. Whenever you need care, a doctor is available within minutes by phone or video, 24 hours a day, 7 days a week. For more information, visit www.TeladocHealth.com or call 800-Teladoc (835-2362). Note: You may also choose to receive telehealth services, if available, from PPO or Non-PPO providers. See Sections 5(a) and 5(e) for the amounts you will pay.

Special feature	Description
Catapult Health's VirtualCheckup®	Catapult Health is a preventive healthcare program that offers comprehensive health assessments and virtual consultations designed to identify health risks early and connect members with appropriate care. As a convenient and accessible way to receive a health checkup from the comfort of your home, Catapult Health's VirtualCheckup® combines at-home testing with face-to-face video consultations with licensed healthcare providers. Each VirtualCheckup includes: • Simple and convenient in-home testing via a home kit that is mailed to participants with everything they need • Live, face-to-face video consultation with a board-certified nurse practitioner to review testing results and develop a Personal Action Plan • Referral into optimal health improvement programs • Test results are securely sent to the participant's primary care provider Note: The Catapult Health VirtualCheckup® benefit is in addition to the annual routine physical exam benefit covered by the plan under *Preventive care, adult* in Section 5(a). For more information, call or text Catapult Health at 855-509-1211 or you can email them at support@virtualcheckup.com. To encourage you to complete your VirtualCheckup®, the Plan will apply a $25 credit toward your calendar year deductible once your VirtualCheckup® is completed. This deductible credit is available for one VirtualCheckup® per person, per calendar year.
Online resources	Visit our website at www.SambaPlans.com to view your claim history, access prescription information and find many health resources, such as: • a Hospital Quality Ratings Guide and Treatment Cost Estimator tool, • an electronic Health Library to obtain information about a specific disease or medical condition, • preventive care tips, and • tools to quit smoking, lose weight and live a healthier life.
Priority Health Coaching	Through our relationship with Cigna, you and your eligible dependents have access to the Priority Health Coaching Program. This Program is designed to support and empower members in maintaining and improving their overall health. If you're living with a chronic or on-going condition such as asthma, diabetes, low back pain, COPD, or heart disease, Priority Health Coaching offers holistic, whole-person support through personalized, one-on-one coaching tailored to your needs. For a complete list of conditions supported by Priority Health Coaching or to get more information, visit our website at www.SambaPlans.com or call 800-887-9735.
24-hour nurse line	Through SAMBA's relationship with Cigna Healthcare and Evernorth Health Services, our members have access to 24/7 Nurseline℠, an easy to use resource with anytime access to the information you need to make smart health decisions. With 24/7 Nurseline℠ you get: • Health information in language that is easy to understand and use • Help deciding the best method to treat a minor injury or illness, including over-the-counter or home remedies • Peace of mind by having a registered nurse available around the clock Get expert health advice anytime, anywhere by calling 800-887-9735.

Special feature	Description
Healthy Rewards Program	Through our relationship with Cigna Healthcare and Evernorth Health Services, SAMBA members can participate in the Healthy Rewards Program, a health and wellness discount program. Members will have access to discounts on treatments and items not covered under the Plan. For example: • **Fitness club memberships** – Gym and fitness club membership discounts available through Active&Fit Direct plus access to free digital workouts just for creating an account with Active&Fit Direct. - **Base Gym Network:** Access to over 12,700 standard gyms, such as LA Fitness, 24 Hour Fitness, and Crunch Fitness, for $28 per month + one time Active & Fit enrollment fee. - **Premium Studios:** Discounts of 20% to 70% at 9,800+ locations of premium exercise studios including YogaSix, Pure Barre, and Club Pilates. Must enroll in the base gym membership to access. - **Digital:** Free access to 18,000+ on-demand workout videos, just for creating an account. Meaning access to the full 18,000+ video library is for registered members, even before enrolling in a paid gym membership Once enrolled, members can enroll their spouse or domestic partner. All Cigna customers that are 18+ years old can sign up by accessing Active&Fit direct from their own myCigna account. • **Nutritional home delivery meal service** – Mom's Meals are refrigerated meals that can be purchased for you or a loved one and tailored to specific health needs (wellness, diabetic friendly, heart healthy, etc.). Free shipping on meals delivered right to your home. In addition, Healthy Rewards offers Vision and Hearing Care discounts including eye exams, eye wear, Lasik correction, hearing aids, and free on-line hearing screening. Visit www.SambaPlans.com for more information.
Health Risk Assessment	The Health Risk Assessment (HRA) tool is available online at www.SambaPlans.com. The tool is designed to assess the member's health profile, analyze the responses and suggest how they could achieve or maintain better health. This is an excellent tool to assist you in achieving your personal health goals. To encourage you and your covered family members over age 18 to complete an HRA, the Plan will apply a $50 credit toward the individual's calendar year deductible. This incentive is limited to two individuals per family and allowed only once per calendar year.
Gaps in Care	The Gaps in Care program uses clinical rule-based software, together with integrated medical, pharmacy, behavioral, and lab data to address members' gaps in care. Gaps in care occur when individuals do not receive or adhere to care that is consistent with medically proven guidelines for prevention or treatment. The Gaps in Care program provides coaching, integrated with Case Management, to identify any gaps or barrier preventing necessary medical care. Simple, easy to understand profiles are sent to members to increase their understanding of potential gaps and improve adherence to existing treatment plans. The program also generates patient reminders for medications and preventative appointments.

Special feature	Description
Tobacco Cessation Program	We know it isn't easy to quit smoking. It can take several attempts to quit before you're successful. The tobacco cessation program offered by the Plan helps you to develop a personal plan to become and remain tobacco-free from all forms of tobacco use, including cigarettes, E-cigarettes, and smokeless tobacco. Choose from two convenient options – a phone program featuring a dedicated wellness coach or online for a self-paced program – or use both. Get the support you need and the results you want. For more information or to enroll, visit www.SambaPlans.com or call 800-887-9735. Note: For group and individual counseling for tobacco cessation, see *Educational classes and programs* in Section 5(a).
Weight Management Program	Lose weight and improve your health through a personalized weight loss program. This program helps you change your behaviors by developing healthier eating habits and incorporating exercise into your schedule – helping you to feel better, look better and improve your overall health. As a participant, in addition to helping you develop a customized diet and exercise plan, you will receive: • One-on-one support and advice from a health coach – you can select from two convenient options, a telephone program or an online program – or use both, • A personal phone assessment that helps make sure your participation in the program will be safe and successful, • Tools developed by medical experts that provide your health coach with more detailed information about your heart health and eating habits, and • 24/7 access to a secure website with helpful articles, tools, trackers, and more. For more information or to enroll, visit www.SambaPlans.com or call 800-887-9735.
Back and Joint Care	Hinge Health, offered through our partnership with Express Scripts, provides support for members and their covered dependents dealing with musculoskeletal (MSK) issues, acute and chronic pain, and either taking opioids or trying to avoid opioids. For no additional cost, eligible participants will receive access to exercise therapy, motivational coaching, one-on-one support, and education that is tailored to your specific needs. Members can learn more and sign up at hinge.health/samba or call (855) 902-2777.
Healthy Pregnancies, Healthy Babies® Program	Through our relationship with Cigna, SAMBA is pleased to offer you and your covered dependents access to the Healthy Pregnancies, Healthy Babies® Program. This free program is designed to help you throughout your pregnancy and in the days and weeks following your baby's birth. When you enroll in Cigna's Healthy Pregnancies, Healthy Babies® Program, you get unlimited support for a healthier pregnancy. For more information and to enroll, contact Cigna Healthcare and Evernorth Health Services at 800-887-9735 or visit www.SambaPlans.com.

Special feature	Description
Maven	Maven is a maternity management program designed to provide comprehensive support for expectant and new parents throughout their pregnancy journey and beyond. The Maven program offers personalized care through digital tools and human support, connecting members with specialized healthcare providers, coaches, and resources. It aims to improve maternal health outcomes while reducing healthcare costs. Key features of the Maven program include: • 24/7 virtual access to a network of specialized healthcare providers, including OB/GYNs, midwives, doulas, mental health specialists, lactation consultants, and pediatricians • Personalized care plans based on individual needs and risk factors • Digital educational content covering pregnancy, childbirth, postpartum recovery, and early childcare • Care coordination with traditional healthcare providers • Return-to-work support for new parents • Mental health resources specialized for pregnancy and postpartum needs • Support for partners and families • Resources for fertility, adoption, and surrogacy journeys • Navigation for high-risk pregnancies and complex health concerns For more information on Maven or to enroll, visit www.mavenclinic.com/join/takecare or you can email the Maven Care Team at support@mavenclinic.com.
EncircleRx and Omada Health	Weight loss medications are covered by the Plan. Members obtaining weight loss medications are required to be enrolled in the Omada Virtual Health Program. Enroll and engage in Omada to get your medication covered, if clinically eligible. • Omada is a virtual health program that helps members create healthier habits to achieve long-lasting results • Omada is $0 cost to you • Filling your medication requires prior authorization from your doctor to confirm eligibility criteria is met Omada will help you on your journey by complementing the impact of your medication. • Support from a personal health coach • Easy monitoring with smart devices (you keep) • Motivation from a peer group and online communities • Tools to guide and support you with achieving long-term goals You will need to participate in the Omada program, meeting the following requirements each month: • Engage four times on the smart device (weight loss scale) provided by Omada • Use the Omada app four times, by doing lessons or engaging with your health coach, peer group or online community • Register or log in to esrx.com/healthsolutions to get your access code • Then sign up at omadahealth.com/esi or download the Omada mobile application For more information, see Section 5(f), page 78.

Special feature	Description
Personal Medication Coach (PMC)	Through our relationship with Express Scripts, SAMBA offers our eligible members the Personal Medication Coach (PMC) program. Through convenient phone consultations with a registered pharmacist, you can receive a full review of your current medications (including over-the-counter medications and supplements), ask the pharmacist any medication-related questions, discuss any side effects you may be experiencing or potentially harmful drug interactions, and determine if lower-cost medication alternatives are available (if requested). The pharmacist will also collaborate with your prescriber to discuss potential areas of concern and opportunities to optimize your therapy.

Non-FEHB Benefits Available to Plan Members

The benefits on this page are not part of the FEHB contract or premium, **and you cannot file an FEHB disputed claim about them.** Fees you pay for these services do not count toward FEHB deductibles or catastrophic protection out-of-pocket maximums. These programs and materials are the responsibility of the Plan, and all appeals must follow their guidelines. For additional information, contact the Plan at 800-638-6589 or 301-984-1440 (for TTY, use 301-984-4155) or visit their website at www. SambaPlans.com.

Dental and Vision Plan

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

- **DMO Plan –** Choose a primary care dentist from the Aetna Dental Network to manage your dental care. This Plan option features no claim forms, no deductible, no waiting period for benefits, and no annual maximum benefit.
- **PPO Plan –** Enjoy the flexibility to visit any licensed dentist for your care. You will generally pay less out-of-pocket when you use an Aetna PPO participating dentist. No referrals are needed for specialty care and out-of-network benefits are also available.
- **Vision Plan –** Regardless of the dental plan option you choose, vision benefits are automatically included. Through the EyeMed Select network, you have access to benefits for routine eye exams, eyeglasses, and contact lenses.

Life Insurance Plans

The plans described below are issued by The Prudential Insurance Company of America. ***You can enroll for coverage at any time*** with the exception of the Employee Benevolent Fund. Plan provisions, certain exclusions, eligibility requirements, and underwriting guidelines apply for each plan.

- **Term Life Insurance** – coverage from $25,000 to $750,000 for you and your spouse. Children are covered at $20,000 up to age 26. Includes member Accidental Death and Dismemberment coverage – benefit doubles in the event of an accidental death
- **Personal Accident Insurance** – Coverage from $10,000 to $500,000 for you and your family. Provides around-the-clock protection for a low premium. Additional benefits provided for mortgage payments, tuition reimbursement for spouse and children, and much more.
- **Long Term Disability –** A benefit that provides much needed income for you and your family when a long-term illness or disability occurs and you are not able to work. The plan pays up to 65% of your covered salary, tax-free. Also included is a survivor benefit paid in the event you die while receiving the disability benefit.
- **Employee Benevolent Fund** – provides an immediate death benefit to help sustain your loved ones until other survivor benefits can be paid. Two plan options; $17,500 or $35,000. The plan is open only to select agencies. To see a complete list of participating agencies, visit the SAMBA website at www. SambaPlans.com. If your agency does not currently participate, please speak to your agency representative about contacting SAMBA for more information.

Prudential Beneficiary Advocate Services are included in all of the above plans **at no additional cost.**

The above is a brief description of the non-FEHB plans available. All Plan benefits are subject to the definitions, limitations and exclusions set forth in the official Plan documents.

Section 6. General Exclusions – Services, Drugs and Supplies We Don't Cover

The exclusions in this section apply to all benefits. There may be other exclusions and limitations listed in Section 5 of this brochure. **Although we may list a specific service as a benefit, we will not cover it unless we determine it is medically necessary to prevent, diagnose, or treat your illness, disease, injury, or condition.** The fact that one of our covered providers has prescribed, recommended, or approved a service or supply does not make it medically necessary or eligible for coverage under this Plan. For information on obtaining prior approval for specific services, such as transplants, see Section 3 *When you need prior Plan approval for certain services*.

We do not cover the following:

- Services, drugs, or supplies you receive while you are not enrolled in this Plan
- Services, drugs, or supplies not medically necessary
- Services, drugs, or supplies not required according to accepted standards of medical, dental, or psychiatric practice in the United States
- Experimental or investigational procedures, treatments, drugs or devices (see specifics regarding transplants)
- Services, drugs, or supplies related to abortions, except when the life of the individual 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 sexual dysfunction or sexual inadequacy, e.g., Viagra, Muse, Caverject, penile prosthesis
- Services, drugs, or supplies you receive from a provider or facility barred from the FEHB Program
- Services or supplies for which no charge would be made if the covered individual had no health insurance coverage
- Services, drugs, or supplies you receive without charge while in active military service
- Services or supplies we are prohibited from covering under the Federal Law
- Services or supplies furnished by yourself, immediate relatives or household members, such as spouse, parents, children, brothers or sisters by blood, marriage or adoption
- Services or supplies furnished or billed by a non-covered facility, except that medically necessary prescription drugs and physical, speech and occupational therapy rendered by a qualified professional therapist on an outpatient basis are covered subject to Plan limits
- Services and supplies not specifically listed as covered
- Any portion of a provider's fee or charge ordinarily due from the enrollee but that has been waived. If a provider routinely waives (does not require the enrollee to pay) a deductible, copayment or coinsurance, the Carrier will calculate the actual provider fee or charge by reducing the fee or charge by the amount waived
- Charges which the enrollee or Plan has no legal obligation to pay, such as excess charges for an annuitant age 65 or older who is not covered by Medicare Parts A and/or B (see Section 9, page 109), doctor charges exceeding the amount specified by the Department of Health and Human Services when benefits are payable under Medicare (limiting charge, see page 110), or State premium taxes however applied
- Dental treatment, including X-rays and treatment by a dentist or oral surgeon except to the extent shown in Section 5(g)
- Dental appliances, study models, splints and other devices or services associated with the treatment of temporomandibular joint (TMJ) dysfunction
- Eyeglasses or hearing aids, or examinations for them, except as shown in Section 5(a)
- Treatment of learning disabilities and mental retardation
- Marital counseling
- Practitioners who do not meet the definition of covered provider on page 16, Section 3
- Services, drugs or supplies ordered or provided by a non-covered provider.
- Charges for services and supplies that exceed the Plan allowance

- Services in connection with custodial care as defined in Section 10, page 112
- Services in connection with: corns; calluses; toenails; weak, strained, or flat feet; any instability or imbalance of the foot; or any metatarsalgia or bunion, including related orthotic devices, except as listed on page 47, Section 5(a)
- Services by a massage therapist
- Naturopathic and homeopathic services such as naturopathic medicines
- Genetic counseling (except as indicated on page 33, Section 5(a)) and/or genetic screening
- Services and supplies for cosmetic purposes, e.g., Retin A, Minoxidil, Rogaine
- Treatment of obesity or weight reduction, except as indicated on page 51, Section 5(a), page 53, Section 5(b), and on page 90, Section 5(h)
- Safety, hygiene, convenience, and exercise equipment and supplies
- Fees for medical records not requested by the Plan
- Handling charges/administrative charges or late charges, missed appointment fees, including interest, billed by providers of care
- Home test kits including but not limited to HIV and drug home test kit
- "Never Events" – Are errors in patient care that can and should be prevented. We will follow the policy of the Centers for Medicare and Medicaid Services (CMS). The Plan will not cover care that falls under these policies (see details on page 6). For additional information, please visit www. cms.gov, enter Never Events into SEARCH.
- Any benefits or services required solely for your employment are not covered by this Plan.
- Chemical or surgical modification of an individual's sex traits through medical interventions (to include "gender transition" services).

Section 7. Filing a Claim for Covered Services

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

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

How to claim benefits

To obtain claim forms, claims filing advice or answers about our benefits, contact us at 800-638-6589 or 301-984-1440 (for TTY, use 301-984-4155), or at our website at www.SambaPlans.com.

In most cases, providers and facilities file HIPAA compliant electronic claims for you. In cases where a paper claim must be used, the provider must file on the form CMS-1500, Health Insurance Claim Form. Your facility will file on the UB-04 form.

When you must file a claim – such as for services you received overseas or when another group health plan is primary – submit it on the CMS-1500 or a claim form that includes the information shown below. Bills and receipts should be itemized and show:

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

Note: Canceled checks, cash register receipts, or balance due statements are not acceptable substitutes for itemized bills.

In addition:

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

Post-service claims procedures

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

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

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

Records

Keep a separate record of the medical expenses of each covered family member as deductibles and maximum allowances apply separately to each person. Save copies of all medical bills, including those you accumulate to satisfy a deductible. In most instances they will serve as evidence of your claim. We will not provide duplicate or year-end statements.

Deadline for filing your claim

Send us all the documents for your claim as soon as possible. You must submit the claim by December 31 of the year after the year you received the service. If you could not file on time because of Government administrative operations or legal incapacity, you must submit your claim as soon as reasonably possible. You are responsible to make certain that your claims are filed within the timely filing deadline. Once we pay benefits, there is a three-year limitation on the reissuance of uncashed checks.

Overseas claims

Charges for overseas (foreign) claims will be converted to U.S. dollars using the exchange rate applicable to the date the service was rendered. For inpatient hospital services, the exchange rate will be based on the date of admission. Send itemized bills for covered services provided by hospitals or doctors outside the United States to SAMBA, 11301 Old Georgetown Road, Rockville, MD 20852-2800.

When we need more information

Please reply promptly when we ask for additional information. We may delay processing or deny benefits for your claim if you do not respond. Our deadline for responding to your claim is stayed while we await all of the additional information needed to process your claim.

Authorized Representative

You may designate an authorized representative to act on your behalf for filing a claim or to appeal claims decisions to us. For urgent care claims, a healthcare professional with knowledge of your medical condition will be permitted to act as your authorized representative without your express consent. For the purposes of this section, we are also referring to your authorized representative when we refer to you.

Notice Requirements

The Secretary of Health and Human Services has identified counties where at least 10% of the population is literate only in certain non-English languages. The non-English languages meeting this threshold in certain counties are Spanish, Chinese, Navajo and Tagalog. If you live in one of these counties, we will provide language assistance in the applicable non-English language. You can request a copy of your Explanation of Benefits (EOB) statement, related correspondence, oral language services (such as telephone customer assistance), and help with filing claims and appeals (including external reviews) in the applicable non-English language. The English versions of your EOBs and related correspondence will include information in the non-English language about how to access language services in that non-English language.

Any notice of an adverse benefit determination or correspondence from us confirming an adverse benefit determination will include information sufficient to identify the claim involved (including the date of service, the healthcare provider, and the claim amount, if applicable), and a statement describing the availability, upon request, of the diagnosis and procedure codes and its corresponding meaning, and the treatment code and its corresponding meaning).

Section 8. The Disputed Claims Process

You may appeal directly to the Office of Personnel Management (OPM) if we do not follow required claims processes. For more information, or to make an inquiry about situations in which you are entitled to immediately appeal to OPM, including additional requirements not listed in Sections 3, 7 and 8 of this brochure, please call your plan's customer service representative at the phone number found on your enrollment card, plan brochure, or plan website.

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

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

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

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

Our reconsideration will not take into account the initial decision. The review will not be conducted by the same person, or their subordinate, who made the initial decision.

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

Step	Description
1	Ask us in writing to reconsider our initial decision. You must: a) Write to us within 6 months from the date of our decision; and b) Send your request to us at: SAMBA, 11301 Old Georgetown Road, Rockville, MD 20852-2800; and c) Include a statement about why you believe our initial decision was wrong, based on specific benefit provisions in this brochure; and d) Include copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms. e) Include your email address (optional for members), if you would like to receive our decision via email. Please note that by giving us your email, we may be able to provide our decision more quickly. We will provide you, free of charge and in a timely manner, with any new or additional evidence considered, relied upon, or generated by us or at our direction in connection with your claim and any new rationale for our claim decision. We will provide you with this information sufficiently in advance of the date that we are required to provide you with our reconsideration decision to allow you a reasonable opportunity to respond to us before that date. However, our failure to provide you with new evidence or rationale in sufficient time to allow you to timely respond shall not invalidate our decision on reconsideration. You may respond to that new evidence or rationale at the OPM review stage described in step 4.
2	In the case of a post-service claim, we have 30 days from the date we receive your request to: a) Pay the claim or b) Write to you and maintain our denial or c) Ask you or your provider for more information. You or your provider must send the information so that we receive it within 60 days of our request. We will then decide within 30 more days. If we do not receive the information within 60 days we will decide within 30 days of the date the information was due. We will base our decision on the information we already have. We will write to you with our decision.

Step	Description
3	If you do not agree with our decision, you may ask OPM to review it. You must write to OPM within • 90 days after the date of our letter upholding our initial decision; or • 120 days after you first wrote to us – if we did not answer that request in some way within 30 days; or • 120 days after we asked for additional information. Write to OPM at: United States Office of Personnel Management, Healthcare and Insurance, Federal Employees Insurance Operations, FEHB 2, 1900 E Street, NW, Washington, DC 20415-3620. Send OPM the following information: • A statement about why you believe our decision was wrong, based on specific benefit provisions in this brochure; • Copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms; • Copies of all letters you sent to us about the claim; • Copies of all letters we sent to you about the claim; and • Your daytime phone number and the best time to call. • Your email address, if you would like to receive OPM's decision via email. Please note that by providing your email address, you may receive OPM's decision more quickly. Note: If you want OPM to review more than one claim, you must clearly identify which documents apply to which claim. Note: You are the only person who has a right to file a disputed claim with OPM. Parties acting as your representative, such as medical providers, must include a copy of your specific written consent with the review request. However, for urgent care claims, a healthcare professional with knowledge of your medical condition may act as your authorized representative without your express consent. Note: The above deadlines may be extended if you show that you were unable to meet the deadline because of reasons beyond your control.
4	OPM will review your disputed claim request and will use the information it collects from you and us to decide whether our decision is correct. OPM will send you a final decision or notify you of the status of OPM's review within 60 days. There are no other administrative appeals. If you do not agree with OPM's decision, your only recourse is to file a lawsuit. If you decide to file a lawsuit, you must file the suit against OPM in Federal court by December 31 of the third year after the year in which you received the disputed services, drugs, or supplies or from the year in which you were denied precertification or prior approval. This is the only deadline that may not be extended. OPM may disclose the information it collects during the review process to support their disputed claim decision. This information will become part of the court record. You may not file a lawsuit until you have completed the disputed claims process. Further, Federal law governs your lawsuit, benefits, and payment of benefits. The Federal court will base its review on the record that was before OPM when OPM decided to uphold or overturn our decision. You may recover only the amount of benefits in dispute.

Note: **If you have a serious or life threatening condition** (one that may cause permanent loss of bodily functions or death if not treated as soon as possible), and you did not indicate that your claim was a claim for urgent care, then call us at 800-638-6589 or 301-984-1440 (for TTY, use 301-984-4155). We will expedite our review (if we have not yet responded to your claim); or we will inform OPM so they can quickly review your claim on appeal. You may call OPM's FEHB 2 at 202-606-3818 between 8 a.m. and 5 p.m. Eastern Time.

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

Section 9. Coordinating Benefits with Medicare and Other Coverage

When you have other health coverage

You must tell us if you or a covered family member has coverage under any other health plan or has automobile insurance that pays healthcare expenses without regard to fault. This is called "double coverage."

When you have double coverage, one plan normally pays its benefits in full as the primary payor and the other plan pays a reduced benefit as the secondary payor. We, like other insurers, determine which coverage is primary according to the National Association of Insurance Commissioners' (NAIC) guidelines. For more information on NAIC rules regarding the coordinating of benefits, visit our website at www.SambaPlans.com.

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

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

Please see Section 4, *Your Costs for Covered Services*, for more information about how we pay claims.

- **TRICARE and CHAMPVA**

TRICARE is the healthcare program for eligible dependents of military persons, and retirees of the military. TRICARE includes the CHAMPUS program. CHAMPVA provides health coverage to disabled Veterans and their eligible dependents. IF TRICARE or CHAMPVA and this Plan cover you, we pay first. See your TRICARE or CHAMPVA Health Benefits Advisor if you have questions about these programs.

Suspended FEHB coverage to enroll in TRICARE or CHAMPVA: If you are an annuitant or former spouse, you can suspend your FEHB coverage to enroll in one of these programs, eliminating your FEHB premium. (OPM does not contribute to any applicable plan premiums.) For information on suspending your FEHB enrollment, contact your retirement or employing office. If you later want to re-enroll in the FEHB Program, generally you may do so only at the next Open Season unless you involuntarily lose coverage under TRICARE or CHAMPVA.

- **Workers' Compensation**

Every job-related injury or illness should be reported as soon as possible to your supervisor. Injury also means any illness or disease that is caused or aggravated by the employment as well as damage to medical braces, artificial limbs and other prosthetic devices. If you are a federal or postal employee, ask your supervisor to authorize medical treatment by use of form CA-16 before you obtain treatment. If your medical treatment is accepted by the Dept. of Labor Office of Workers' Compensation (OWCP), the provider will be compensated by OWCP. If your treatment is determined not job-related, we will process your benefit according to the terms of this Plan, including use of in-network providers. Take form CA-16 and form OWCP-1500/ HCFA-1500 to your provider, or send it to your provider as soon as possible after treatment, to avoid complications about whether your treatment is covered by this Plan or by OWCP.

We do not cover services that:

- You (or a covered family member) need because of a workplace-related illness or injury that the Office of Workers' Compensation Programs (OWCP) or a similar federal or state agency determines they must provide; or
- OWCP or a similar agency pays for through a third-party injury settlement or other similar proceeding that is based on a claim you filed under OWCP or similar laws.

- **Medicaid**

When you have this Plan and Medicaid, we pay first.

Suspended FEHB coverage to enroll in Medicaid or a similar state-sponsored program of medical assistance: If you are an annuitant or former spouse, you can suspend your FEHB coverage to enroll in one of these state programs, eliminating your FEHB premium. For information on suspending your FEHB enrollment, contact your retirement or employing office. If you later want to re-enroll in the FEHB Program, generally you may do so only at the next Open Season unless you involuntarily lose coverage under the state program.

When other Government agencies are responsible for your care

We do not cover services and supplies when a local, state, or federal government agency directly or indirectly pays for them.

When others are responsible for injuries

Our reimbursement and subrogation rights are both a condition of, and a limitation on, the benefit payments that you are eligible to receive from us. By accepting Plan benefits, you agree to the terms of this provision.

If you receive (or are entitled to receive) a monetary recovery from any source as the result of an injury or illness, we have the right to be reimbursed out of that recovery for any and all of our benefits paid to diagnose and treat that illness or injury to the full extent of the benefits paid or provided. The Plan's right of reimbursement extends to all benefit payments for related treatment incurred up to and including the date of settlement or judgment, regardless of the date that those expenses were submitted to the Plan for payment. This reimbursement right extends to any monetary recovery that your representatives (for example, heirs, estate) receive (or are entitled to receive) from any source as a result of an accidental injury or illness. This is known as our reimbursement right.

We may also, at our option, pursue recovery as successor to the rights of the enrollee or any covered family member who suffered an illness or injury, which includes the right to file suit and make claims in your name, and to obtain reimbursement directly from the responsible party, liability insurer, first party insurer, or benefit program. This is known as our subrogation right.

Examples of situations to which our reimbursement and subrogation rights apply include, but are not limited to, when you become ill or are injured due to (1) an accident on the premises owned by a third party, (2) a motor vehicle accident, (3) a slip and fall, (4) an accident at work, (5) medical malpractice, or (6) a defective product.

Our reimbursement and subrogation rights extend to all benefits available to you under any law or under any type of insurance or benefit program, including but not limited to:

- Third party liability coverage;
- Personal or business umbrella coverage;
- Uninsured and underinsured motorist coverage;
- Workers' Compensation benefits;
- Medical reimbursement or payment coverage;
- Homeowners or property insurance;
- Payments directly from the responsible party;
- Funds or accounts established through settlement or judgment to compensate injured parties; and
- No-fault insurance and other insurance that pays without regard to fault, including personal injury protection benefits, regardless of any election made by you to treat those benefits as secondary to us. When you are entitled to the payment of healthcare expenses under automobile insurance, including no-fault insurance and other insurance that pays without regard to fault, your automobile insurance is the primary payor and we are the secondary payor.

Our reimbursement right applies even if the monetary recovery may not compensate you fully for all of the damages resulting from the injuries or illness. In other words, we are entitled to be reimbursed for those benefit payments even if you are not "made whole" for all of your damages by the compensation you receive.

Our reimbursement right is not subject to reduction for attorney's fees under the "common fund" or any other doctrine. We are entitled to be reimbursed for 100% of the benefits we paid on account of the injuries or illness unless we agree in writing to accept a lesser amount.

We enforce our reimbursement right by asserting a first priority lien against any and all recoveries you receive by court order or out-of-court settlement, insurance or benefit program claims, or otherwise, regardless of whether medical benefits are specifically designated in the recovery and without regard to how it is characterized (for example as "pain and suffering"), designated, or apportioned. Our subrogation or reimbursement interest shall be paid from the recovery before any of the rights of any other parties are paid.

You agree to cooperate with our enforcement of our reimbursement right by:

- telling us promptly whenever you have filed a claim for compensation resulting from an accidental injury or illness and responding to our questionnaires;
- pursuing recovery of our benefit payments from the third party or available insurance company;
- accepting our lien for the full amount of our benefit payments;
- signing our Reimbursement Agreement when requested to do so;
- agreeing to assign any proceeds or rights to proceeds from third party claims or any insurance to us;
- keeping us advised of the claim's status;
- agreeing and authorizing us to communicate directly with any relevant insurance carrier regarding the claim related to your injury or illness;
- advising us of any recoveries you obtain, whether by insurance claim, settlement or court order; and
- agreeing that you or your legal representative will hold any funds from settlement or judgment in trust until you have verified our lien amount, and reimbursed us out of any recovery received to the full extent of our reimbursement right.

We also expect you to fully cooperate with us in the event we exercise our subrogation right.

Failure to cooperate with these obligations may result in the temporary suspension of your benefits and/or offsetting of future benefits.

For more information about this process, please call our Third Party Recovery Services unit at 202-683-9140 or 855-661-7973 (toll free). You also can email that unit at info@elgtprs.com.

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

Some FEHB Plans already cover some dental and vision services. When you are covered by more than one vision/dental plan, coverage provided under your FEHB Plan remains as your primary coverage. FEDVIP coverage pays secondary to that coverage. When you enroll in a dental and/or vision plan on www.BENEFEDS.gov or by phone 877-888-3337 (TTY 877-889-5680), you will be asked to provide information on your FEHB Plan so that your plans can coordinate benefits. Providing your FEHB information may reduce your out-of-pocket cost.

Clinical Trials

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

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

- Routine care costs – costs for routine services such as doctor visits, lab tests, X-rays and scans, and hospitalizations related to treating the patient's condition, whether the patient is in a clinical trial or is receiving standard therapy. These costs are covered by this Plan.

- Extra care costs – costs related to taking part in a clinical trial such as additional tests that a patient may need as part of the trial, but not as part of the patient's routine care. This Plan does not cover these costs.
- Research costs – costs related to conducting the clinical trial such as research physician and nurse time, analysis of results, and clinical tests performed only for research purposes. These costs are generally covered by the clinical trials. This Plan does not cover these costs.

When you have Medicare

For more detailed information on "What is Medicare?" and "Should I Enroll in Medicare?" please contact Medicare at 800-MEDICARE (800-633-4227), (TTY 877-486-2048) or at www. medicare.gov.

- **The Original Medicare Plan (Part A or Part B)**

The Original Medicare Plan (Original Medicare) is available everywhere in the United States. It is the way everyone used to get Medicare benefits and is the way most people get their Medicare Part A and Part B benefits now. You may go to any doctor, specialist, or hospital that accepts Medicare. The Original Medicare Plan pays its share and you pay your share.

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

When you are enrolled in Original Medicare along with this Plan, you still need to follow the rules in this brochure for us to cover your care.

Claims process when you have the Original Medicare Plan – You will probably not need to file a claim form when you have both our Plan and the Original Medicare Plan.

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

When Original Medicare is the primary payor, Medicare processes your claim first. In most cases, your claim will be coordinated automatically and we will then provide secondary benefits for covered charges. To find out if you need to do something to file your claim, call us at 800-638-6589 or 301-984-1440 (for TTY, use 301-984-4155) or see our website at www.SambaPlans.com.

We waive some costs if the Original Medicare Plan is your primary payor – We will waive some out-of-pocket costs as follows:

- If you are enrolled in Medicare Part A, we will waive the following:
  - the per confinement copayment for inpatient hospital confinements
  - the coinsurance for inpatient hospital benefits
- If you are enrolled in Medicare Part B, we will waive the deductibles, copayments and coinsurances for:
  - Surgery and anesthesia services
  - Mental health and substance use disorder benefits
  - Medical services and supplies provided by physicians and other healthcare professionals
  - Outpatient services by a hospital and other facilities and ambulance services
  - Dental benefits

Note: All Plan benefit limitations and exclusions still apply. In cases where we cover a service that is not covered by Medicare, we are the primary payor. In these cases, we do not waive any out-of-pocket costs.

Please review the following examples which illustrate your cost share if you are enrolled in Medicare Part B. If you purchase Medicare Part B, your provider is in our network and participates in Medicare, then we waive some costs because Medicare will be the primary payor.

Benefit Description: Deductible
You pay without Medicare: In-Network: High Option: $300 Self Only; $600 Self Plus One or Self and Family / Standard Option: $350 Self Only; $700 Self Plus One; $900 Self and Family
You pay without Medicare: Out-of-Network: High Option: $300 Self Only; $600 Self Plus One or Self and Family / Standard Option: $350 Self Only; $700 Self Plus One; $900 Self and Family
You pay with Medicare Part B: In-Network: High Option: $0 / Standard Option: $0
You pay with Medicare Part B: Out-of-Network: High Option: $0 / Standard Option: $0

Benefit Description: Catastrophic Protection Out-of-Pocket Maximum
You pay without Medicare: In-Network: High Option: $5,000 Self Only; $10,000 Self Plus One or Self and Family / Standard Option: $6,000 Self Only; $12,000 Self Plus One or Self and Family
You pay without Medicare: Out-of-Network: High Option: $6,000 Self Only; $12,000 Self Plus One; $14,000 Self and Family / Standard Option: $8,500 Self Only; $14,000 Self Plus One or Self and Family
You pay with Medicare Part B: In-Network: High Option: $0 / Standard Option: $0
You pay with Medicare Part B: Out-of-Network: High Option: $0 / Standard Option: $0

Benefit Description: Part B Premium Reimbursement Offered
You pay without Medicare: In-Network: High Option: NA / Standard Option: NA
You pay without Medicare: Out-of-Network: High Option: NA / Standard Option: NA
You pay with Medicare Part B: In-Network: High Option: NA / Standard Option: NA
You pay with Medicare Part B: Out-of-Network: High Option: NA / Standard Option: NA

Benefit Description: Primary Care Provider
You pay without Medicare: In-Network: High Option: $15 / Standard Option: $20
You pay without Medicare: Out-of-Network: High Option: 35% / Standard Option: 45%
You pay with Medicare Part B: In-Network: High Option: $0 / Standard Option: $0
You pay with Medicare Part B: Out-of-Network: High Option: $0 / Standard Option: $0

Benefit Description: Specialist
You pay without Medicare: In-Network: High Option: $25 / Standard Option: $30
You pay without Medicare: Out-of-Network: High Option: 35% / Standard Option: 45%
You pay with Medicare Part B: In-Network: High Option: $0 / Standard Option: $0
You pay with Medicare Part B: Out-of-Network: High Option: $0 / Standard Option: $0

Benefit Description: Inpatient Hospital
You pay without Medicare: In-Network: High Option: $250 copay per admission plus 15% / Standard Option: $250 copay per admission plus 20%
You pay without Medicare: Out-of-Network: High Option: $350 copay per admission plus 35% / Standard Option: $450 copay per admission plus 45%
You pay with Medicare Part B: In-Network: High Option: $0 / Standard Option: $0
You pay with Medicare Part B: Out-of-Network: High Option: $0 / Standard Option: $0

Benefit Description: Outpatient Hospital
You pay without Medicare: In-Network: High Option: 15% / Standard Option: 20%
You pay without Medicare: Out-of-Network: High Option: 35% / Standard Option: 45%
You pay with Medicare Part B: In-Network: High Option: $0 / Standard Option: $0
You pay with Medicare Part B: Out-of-Network: High Option: $0 / Standard Option: $0

Benefit Description: Incentives offered
You pay without Medicare: In-Network: High Option: NA / Standard Option: NA
You pay without Medicare: Out-of-Network: High Option: NA / Standard Option: NA
You pay with Medicare Part B: In-Network: High Option: NA / Standard Option: NA
You pay with Medicare Part B: Out-of-Network: High Option: NA / Standard Option: NA

You can find more information about how our plan coordinates benefits with Medicare at www.SambaPlans.com.

- **Tell us about your Medicare coverage**

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

- **Private contract with your physician**

If you are enrolled in Medicare Part B, a physician may ask you to sign a private contract agreeing that you can be billed directly for services ordinarily covered by Original Medicare. Should you sign an agreement, Medicare will not pay any portion of the charges, and we will not increase our payment. We will still limit our payment to the amount we would have paid after Original Medicare's payment. You may be responsible for paying the difference between the billed amount and the amount we paid.

- **Medicare Advantage (Part C)**

If you are eligible for Medicare, you may choose to enroll in and get your Medicare benefits from a Medicare Advantage plan. These are private healthcare choices (like HMOs and regional PPOs) in some areas of the country. To learn more about Medicare Advantage plans, contact Medicare at 800-MEDICARE (800-633-4227), (TTY: 877-486-2048) or at www.medicare.gov.

If you enroll in a Medicare Advantage plan, the following options are available to you:

This Plan and our Medicare Advantage plan: You may enroll in our Medicare Advantage plan and also remain enrolled in our SAMBA Health Benefit Plan. For more information on our Medicare Advantage plan, please contact 866-794-6791. Enrollment in UnitedHealthcare Medicare Advantage (PPO) for the SAMBA Health Benefit Plan is voluntary. Members must complete an application for enrollment. Eligible enrollees voluntarily opt-in to UnitedHealthcare Medicare Advantage (PPO) for the SAMBA Health Benefit Plan and may opt-out at any time. You may enroll in the UnitedHealthcare Medicare Advantage (PPO) for the SAMBA Health Benefit Plan if:

- You are an annuitant enrolled in either the High Option or Standard Option and have both Medicare Part A and Part B.
- You are a United States citizen or are lawfully present in the United States.
- You do NOT have End-Stage Renal Disease (ESRD). Enrollees who have ESRD cannot enroll until after the 30-month grace period has expired. Members diagnosed with ESRD while enrolled in UnitedHealthcare Medicare Advantage (PPO) for the SAMBA Health Benefit Plan may remain enrolled and ESRD services will be covered.
- You complete an application for enrollment in the UnitedHealthcare Medicare Advantage (PPO) for the SAMBA Health Benefit Plan.

When you are enrolled in the SAMBA Health Benefit Plan under the FEHB Program and the Enhanced Benefit Opportunity through UnitedHealthcare Medicare Advantage (PPO), you receive additional benefits that include the following:

- No deductibles, copays, or coinsurance for covered care other than for prescription drugs and added dental benefits
- A four-tier prescription drug formulary with overall lower out-of-pocket cost for your medication purchases
- 100 days for Skilled Nursing Facility
- Post-Discharge Transportation and Meal Delivery Program after inpatient hospitalization
- Renew Active™ helping annuitants maintain functional mobility and cognitive health
- A monthly subsidy towards your Medicare Part B premium; $100 under High Option / $75 under Standard Option
- Nationwide network of providers

Medicare Part B Premium Credit: If you are enrolled in the SAMBA Health Benefit Plan and enroll in the UnitedHealthcare Medicare Advantage (PPO) for the SAMBA Health Benefit Plan, you will receive a credit toward your Medicare Part B monthly premium; $100 under the High Option and $75 under the Standard Option. This will be credited directly from the Centers for Medicare and Medicaid Services (CMS).

This Plan and another plan's Medicare Advantage plan: You may enroll in another plan's Medicare Advantage plan and also remain enrolled in our FEHB Plan. We will still provide benefits when your Medicare Advantage plan is primary, even out of the Medicare Advantage plan's network and/or service area. However, we will not waive any of our copayments, coinsurance, or deductibles. If you enroll in a Medicare Advantage plan, tell us. We will need to know whether you are in the Original Medicare Plan or in a Medicare Advantage plan so we can correctly coordinate benefits with Medicare.

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

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

When we are the primary payor, we process the claim first. If you enroll in Medicare Part D and we are the secondary payor, we will review claims for your prescription drug costs that are not covered by Medicare Part D and consider them for payment under the FEHB Plan.

- **Medicare Prescription Drug Plan Employer Group Waiver Plan (PDP EGWP)**

If you are enrolled in Medicare, and are not enrolled in a Medicare Advantage Plan (Part C), you will be automatically enrolled in the Medicare Prescription Drug Plan (PDP) Employer Group Waiver Plan (EGWP). The PDP EGWP is a prescription drug benefit for FEHB covered annuitants and their FEHB covered family members who are eligible for Medicare. This allows you to receive benefits that will never be less than your coverage that is available to members with only FEHB but more often you will receive benefits that are better than members with only FEHB.

This Plan and our PDP EGWP: SAMBA offers the Express Scripts Medicare® (PDP) for the SAMBA Health Benefit Plan to Medicare eligible annuitants and Medicare eligible family members covered under the Plan. The PDP meets requirements applicable to Medicare Part D and is actuarially equal to or better than our prescription drug benefits.

If you are an annuitant or a covered family member who is enrolled in either Medicare Part A or Part B or both Parts A and B (provided you are not enrolled in our UnitedHealthcare Medicare Advantage (PPO) for the SAMBA Health Benefit Plan), you will be automatically enrolled in our PDP EGWP and continue to remain enrolled in our FEHB Plan. Participation in the PDP EGWP is voluntary, and **you have the choice to opt out of PDP EGWP enrollment at any time**. Simply contact SAMBA at 800-638-6589 or 301-984-1440 (for TTY, use 301-984-4155) if you wish to opt-out. Note: If you choose to disenroll and then want to re-enroll in this program, the ability to do so is limited to one time per calendar year.

We will pay the Medicare premium for the Part D drug plan coverage except any additional premium imposed due to exceeding the income threshold as defined by the Social Security Administration. In the case of those with higher incomes you may have a separate premium payment for your PDP EGWP benefit. Please refer to the Part D-IRMAA section of the Medicare website: https://www.medicare.gov/drug-coverage-part-d/costs-for-medicare-drug-coverage/monthly-premium-for-drug-plans to see if you would be subject to an additional premium.

Benefit Description

As a member of the Express Scripts Medicare® PDP for the SAMBA Health Benefit Plan you may purchase up to a 30 or 90-day supply of covered drugs and supplies from either a participating network retail or network mail order pharmacy. Note: Specialty medications are limited to a 30-day supply per purchase.

The Plan's copayments/coinsurance per prescription or refill are listed below:

High Option

Retail (30-day supply):

Tier 1 – Generic: $5
Tier 2 – Preferred Brand: 20% ($100 maximum)
Tier 3 – Non-Preferred Brand: 25% ($300 maximum)
Tier 4 – Specialty: 25% ($160 maximum)

Mail Order (90-day supply):

Tier 1 – Generic: $10
Tier 2 – Preferred Brand: 20% ($200 maximum)
Tier 3 – Non-Preferred Brand: 25% ($400 maximum)
Tier 4 – Specialty: 25% ($160 maximum / limited to 30-day supply)

Standard Option

Retail (30-day supply):

Tier 1 – Generic: $7
Tier 2 – Preferred Brand: 25% ($150 maximum)
Tier 3 – Non-Preferred Brand: 25% ($300 maximum)
Tier 4 – Specialty: 25% ($240 maximum)

Mail Order (90-day supply):

Tier 1 – Generic: $12
Tier 2 – Preferred Brand: 25% ($300 maximum)
Tier 3 – Non-Preferred Brand: 25% ($400 maximum)
Tier 4 – Specialty: 25% ($240 maximum / limited to 30-day supply)

Eligible members will receive additional Plan details via U.S. mail. You may also visit www.express-scripts.com or contact Express Scripts Medicare Customer Service at 800-473-0694 24 hours a day, 7 days a week, for more information.

Medicare always makes the final determination as to whether they are the primary payor. The following chart illustrates whether Medicare or this Plan should be the primary payor for you according to your employment status and other factors determined by Medicare. It is critical that you tell us if you or a covered family member has Medicare coverage so we can administer these requirements correctly. **(Having coverage under more than two health plans may change the order of benefits determined on this chart.)**

Primary Payor Chart		
A. When you - or your covered spouse - are age 65 or over and have Medicare and you...	**The primary payor for the individual with Medicare is...**	
	Medicare	**This Plan**
1) Have FEHB coverage on your own as an active employee		✓
2) Have FEHB coverage on your own as an annuitant or through your spouse who is an annuitant	✓	
3) Have FEHB through your spouse who is an active employee		✓
4) Are a reemployed annuitant with the Federal government and your position is excluded from the FEHB (your employing office will know if this is the case) and you are not covered under FEHB through your spouse under #3 above	✓	
5) Are a reemployed annuitant with the Federal government and your position is not excluded from the FEHB (your employing office will know if this is the case) and...		
• You have FEHB coverage on your own or through your spouse who is also an active employee		✓
• You have FEHB coverage through your spouse who is an annuitant	✓	
6) Are a Federal judge who retired under title 28, U.S.C., or a Tax Court judge who retired under Section 7447 of title 26, U.S.C. (or if your covered spouse is this type of judge) and you are not covered under FEHB through your spouse under #3 above	✓	
7) Are enrolled in Part B only, regardless of your employment status	✓ for Part B services	✓ for other services
8) Are a Federal employee receiving Workers' Compensation	✓*	
9) Are a Federal employee receiving disability benefits for six months or more	✓	
B. When you or a covered family member...		
1) Have Medicare solely based on end stage renal disease (ESRD) and...		
• It is within the first 30 months of eligibility for or entitlement to Medicare due to ESRD **(30-month coordination period)**		✓
• It is beyond the 30-month coordination period and you or a family member are still entitled to Medicare due to ESRD	✓	
2) Become eligible for Medicare due to ESRD while already a Medicare beneficiary and...		
• This Plan was the primary payor before eligibility due to ESRD **(for 30 month coordination period)**		✓
• Medicare was the primary payor before eligibility due to ESRD	✓	
3) Have Temporary Continuation of Coverage (TCC) and...		
• Medicare based on age and disability	✓	
• Medicare based on ESRD **(for the 30 month coordination period)**		✓
• Medicare based on ESRD **(after the 30 month coordination period)**	✓	
C. When either you or a covered family member are eligible for Medicare solely due to disability and you...		
1) Have FEHB coverage on your own as an active employee or through a family member who is an active employee		✓
2) Have FEHB coverage on your own as an annuitant or through a family member who is an annuitant	✓	
D. When you are covered under the FEHB Spouse Equity provision as a former spouse	✓	

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

When you are age 65 or over and do not have Medicare

Under the FEHB law, we must limit our payments for inpatient hospital care and physician care to those payments you would be entitled to if you had Medicare. Your physician and hospital must follow Medicare rules and cannot bill you for more than they could bill you if you had Medicare. You and the FEHB benefit from these payment limits. Outpatient hospital care and non-physician based care are not covered by this law; regular Plan benefits apply. The following chart has more information about the limits.

If you:

- are age 65 or over, and
- do not have Medicare Part A, Part B, or both; and
- have this Plan as an annuitant or as a former spouse, **or** as a family member of an annuitant or former spouse; and
- are not employed in a position that gives FEHB coverage. (Your employing office can tell you if this applies.)

Then, for your inpatient hospital care:

- The law requires us to base our payment on an amount - the "equivalent Medicare amount" - set by Medicare's rules for what Medicare would pay, not on the actual charge.
- You are responsible for your applicable deductibles, coinsurance, or copayments under this Plan.
- You are not responsible for any charges greater than the equivalent Medicare amount; we will show that amount on the explanation of benefits (EOB) form that we send you.
- The law prohibits a hospital from collecting more than the "equivalent Medicare amount."

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

- an amount set by Medicare and called the "Medicare approved amount," or
- the actual charge if it is lower than the Medicare approved amount.

If your physician: Participates with Medicare or accepts Medicare assignment for the claim and is a member of our PPO network,
Then you are responsible for: your deductibles, coinsurance, and copayments.

If your physician: Participates with Medicare and is not in our PPO network,
Then you are responsible for: your deductibles, coinsurance, copayments, and any balance up to the Medicare approved amount.

If your physician: Does not participate with Medicare,
Then you are responsible for: your deductibles, coinsurance, copayments, and any balance up to 115% of the Medicare approved amount.

If your physician: Does not participate with Medicare and is not a member of our PPO network,
Then you are responsible for: your out-of-network deductibles, coinsurance, and any balance up to 115% of the Medicare approved amount.

If your physician: Opts-out of Medicare via private contract,
Then you are responsible for: your deductibles, coinsurance, copayments, and any balance your physician charges.

It is generally to your financial advantage to use a physician who participates with Medicare. Such physicians are permitted to collect only up to the Medicare approved amount.

Physicians Who Opt-Out of Medicare

A physician may have opted-out of Medicare and may or may not ask you to sign a private contract agreeing that you can be billed directly for services ordinarily covered by Original Medicare. This is different than a non-participating doctor, and we recommend you ask your physician if they have opted-out of Medicare. Should you visit an opt-out physician, the physician will not be limited to 115% of the Medicare approved amount. You may be responsible for paying the difference between the billed amount and our regular in-network/out-of-network benefits.

Our explanation of benefits (EOB) form will tell you how much the physician or hospital can collect from you. If your physician or hospital tries to collect more than allowed by law, ask the physician or hospital to reduce the charges. If you have paid more than allowed, ask for a refund. If you need further assistance, call us.

When you have the original Medicare Plan (Part A, Part B, or both)	We limit our payment to an amount that supplements the benefits that Medicare would pay under Medicare Part A (Hospital insurance) and Medicare Part B (Medical insurance), regardless of whether Medicare pays. Note: We pay our regular benefits for emergency services to an institutional provider, such as a hospital, that does not participate with Medicare and is not reimbursed by Medicare. We use the Department of Veterans Affairs (VA) Medicare-equivalent Remittance Advice (MRA) when the statement is submitted to determine our payment for covered services provided to you if Medicare is primary, when Medicare does not pay the VA facility. If you are covered by Medicare Part B and it is primary, your out-of-pocket costs for services that both Medicare Part B and we cover depend on whether your physician accepts Medicare assignment for the claim. If your physician **accepts** Medicare assignment, we waive some of your deductibles, copayment and coinsurance for covered charges. If your physician **does not accept** Medicare assignment, you pay the difference between the "limiting charge" or the physician's charge (whichever is less) and our payment combined with Medicare's payment. It is important to know that a physician who does not accept Medicare assignment may not bill you for more than 115% of the amount Medicare bases its payment on, called the "limiting charge." The Medicare Summary Notice (MSN) that Medicare will send you will have more information about the limiting charge. If your physician tries to collect more than allowed by law, ask the physician to reduce the charges. If the physician does not, report the physician to the Medicare carrier that sent you the MSN form. Call us if you need further assistance.

Section 10. Definitions of Terms We Use in This Brochure

Accidental injury

A bodily injury sustained solely through violent, external and accidental means such as broken bones, animal bites and poisonings. Note: An injury to teeth while chewing and/or eating is not considered to be an accidental injury.

Admission

The period from entry (admission) into a hospital or other covered facility until discharge. In counting days of inpatient care, the date of entry and the date of discharge are counted as the same day.

Artificial insemination

Artificial Insemination (AI) is an infertility procedure where specially prepared sperm are inserted into the woman's uterus. Sometimes the woman is also treated with medicines that stimulate ovulation before the procedure. AI is often used to treat mild male factor infertility and couples with unexplained infertility.

Artificial Insemination includes the following procedures: Intrauterine insemination (IUI), Intravaginal insemination (IVI), and Intracervical insemination (ICI).

Assignment

An authorization by you (the enrollee or covered family member) that is approved by us (the Carrier), for us to issue payment of benefits directly to the provider.

- We reserve the right to pay you directly for all covered services. Benefits payable under the contract are not assignable by you to any person without express written approval from us, and in the absence of such approval, any assignment shall be void.
- Your specific written consent for a designated authorized representative to act on your behalf to request reconsideration of a claim decision (or, for an urgent care claim, for a representative to act on your behalf without designation) does not constitute an Assignment.
- OPM's contract with us, based on federal statute and regulation, gives you a right to seek judicial review of OPM's final action on the denial of a health benefits claim but it does not provide you with authority to assign your right to file such a lawsuit to any other person or entity. Any agreement you enter into with another person or entity (such as a provider, or other individual or entity) authorizing that person or entity to bring a lawsuit against OPM, whether or not acting on your behalf, does not constitute an Assignment, is not a valid authorization under this contract, and is void.

Assisted Reproductive Technology (ART)

Assisted Reproductive Technology (ART) includes all fertility treatments in which either eggs or embryos are handled outside of the body. In general, ART procedures involve surgically removing mature eggs from a woman's ovaries, combining the eggs with sperm in the laboratory, and returning the embryos to the woman's body or donating them to another woman.

Behavioral health integration

The care approach that merges mental health and substance use services with primary care, creating a "whole-person" treatment model. It utilizes a team-based approach to improve patient access, outcomes, and satisfaction while reducing overall healthcare costs.

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.

Certified doula

A professional who has met the necessary education, training and experience requirements of a doula certifying organization to provide non-clinical emotional, physical and informational support before, during and after labor.

Clinical Trials Cost Categories

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

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

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

Coinsurance

See Section 4, page 24.

Collaborative Care Management (CoCM)

An evidence-based, patient-centered, team-based healthcare model that integrates mental health services into primary care.

Confinement

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

Congenital anomaly

A condition existing at or from birth, which is a significant deviation from the common form or norm. For purposes of this Plan, congenital anomalies include protruding ear deformities, cleft lips, cleft palates, birthmarks, webbed fingers or toes, and other conditions that the Carrier may determine to be congenital anomalies. In no event will the term congenital anomaly include conditions relating to teeth or intra-oral structures supporting the teeth except for the Dental prosthetic appliances benefit and Orthodontic treatment covered under *Section 5(g). Dental Benefits.*

Convenient care clinic

A small healthcare clinic, usually located in a high-traffic retail outlet with a limited pharmacy, that treats uncomplicated minor illnesses and provides preventative healthcare services on a walk-in basis. Examples of a convenient care clinic include MinuteClinic in CVS pharmacy locations and Take Care Clinic℠ in Walgreens pharmacy locations. Convenient care clinics are different from Urgent care centers (see page 117) that primarily provide treatment to patients who have an illness or injury that requires immediate care but is not serious enough to warrant a visit to the emergency room.

Copayment

See Section 4, page 23.

Cosmetic surgery

Any surgical procedure (or any portion of a procedure) performed primarily to improve physical appearance through change in bodily form, except repair of accidental injury.

Cost-sharing

See Section 4, page 23.

Covered services

Services we provide benefits for, as described in this brochure.

Custodial care

Treatment or services, regardless of who recommends them or where they are provided, that could be rendered safely and reasonably by a person not medically skilled, or that are designed mainly to help the patient with daily living activities. These activities include but are not limited to:

1. personal care such as help in: walking; getting in and out of bed; bathing; eating by spoon, tube or gastrostomy; exercising; dressing;
2. homemaking, such as preparing meals or specials diets;
3. moving the patient;
4. acting as companion or sitter;
5. supervising medication that can usually be self-administered; or
6. treatment or services that any person may be able to perform with minimal instruction, including but not limited to recording temperature, pulse, and respirations, or administration and monitoring of feeding systems.

Custodial care that lasts 90 days or more is sometimes known as long term care. The Plan determines which services are custodial care.

Deductible See Section 4, page 23.

Durable medical equipment Equipment and supplies that:

1. Are prescribed by your attending physician (i.e., the physician who is treating your illness or injury);
2. Are medically necessary;
3. Are primarily and customarily used only for a medical purpose;
4. Are generally useful only to a person with an illness or injury;
5. Are designed for prolonged use; and
6. Serve a specific therapeutic purpose in the treatment of an illness or injury.

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

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

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

Genetic counseling Genetic counseling is a process of communication between patients and trained professionals intended to provide patients who have a genetic disease, or risk of such a disease, with information about their condition and its effect on their family. This allows patients and their families to make informed reproductive and other medical decisions.

Genetic screening The diagnosis, prognosis, management, and prevention of genetic disease for those patients who have no current evidence or manifestation of a genetic disease and those who have not been determined to have an inheritable risk of genetic disease.

Genetic testing The diagnosis and management of genetic disease for those patients with current signs and symptoms, and for those who have been determined to have an inheritable risk of genetic disease.

Group health coverage Healthcare 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 healthcare 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.

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

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

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

Inborn Errors of Metabolism

Conditions associated with an inborn error of metabolism interfere with the metabolism of specific nutrients. Examples of an inherited metabolic disorder (inborn errors of metabolism) include, but are not limited to:

- Phenylketonuria (PKU)
- Maple syrup urine disease (MSUD)
- Homocystinuria
- Urea cycle disorders
- Organic acidemias
- Histidinemia
- Tyrosinemia

Incurred

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

Infertility

Infertility is defined as not being able to conceive after 1 year (or longer) of egg sperm contact. Because infertility in females (or individuals with female reproductive organs) is known to decline steadily with age, some providers evaluate and treat individuals aged 35 or older after 6 months of egg sperm contact. Infertility may also be established through an evaluation based on medical history and diagnostic testing.

Intensive outpatient program

A comprehensive outpatient treatment program that includes extended periods of individual or group therapy sessions designed to assist members with mental health and/or substance use disorder conditions. It is an intermediate setting between traditional outpatient therapy and partial hospitalization. Program sessions may occur more than one day per week.

Medical foods

A medical food, as defined by the Orphan Drug Act (21 U.S.C. 360ee (b) (3)), is a food which is formulated to be consumed or administered enterally under the supervision of a physician and which is intended for the specific dietary management of a disease or condition for which distinctive nutritional requirements, based on recognized scientific principles, are established by medical evaluation. In general, to be considered a medical food, a product must, at a minimum, meet the following criteria: the product must be a food for oral or tube feeding; the product must be labeled for the dietary management of a specific medical disorder, disease, or condition for which there are distinctive nutritional requirements; and the product must be intended to be used under medical supervision.

Modified grocery item foods, even if categorized as medical foods by the manufacturer, are not considered a covered benefit.

Medical necessity

Services, drugs, supplies or equipment provided by a hospital or covered provider of healthcare services that we determine:

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

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

Mental conditions/ substance use disorder

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

Morbid obesity

A diagnosed condition in which the body mass index is 40 or greater or 35 or greater with co-morbidities such as diabetes, coronary artery disease, hypertension, hyperlipidemia, obstructive sleep apnea, pulmonary hypertension, weight related degenerative joint disease, or lower extremity venous or lymphatic obstruction.

Observation services

Hospital observation care has a well-defined set of specific, clinically appropriate services that are billed hourly. Although you may stay overnight in a hospital room and receive meals and other hospital services, some services and overnight stays – including "observation services" – are actually outpatient care. Observation care includes care provided to members who require a significant period of treatment or monitoring before a physician can decide whether to admit them to the hospital on an inpatient basis or discharge them to home. The provider may need 6 to 24 hours or more to make that decision.

If you are in the hospital more than a few hours, always ask your physician or the hospital staff if your stay is considered inpatient or outpatient.

Orthopedic device

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

Partial hospitalization

A time-limited, ambulatory, active treatment program used to treat mental illness and substance use disorder. The patient continues to reside at home, but commutes to a treatment center that offers intensive clinical services that are coordinated and structured in a stable therapeutic environment. Provides at least 20 hours of scheduled programs extended over a minimum of five days per week in a licensed or JCAHO accredited facility.

Plan allowance

Our Plan allowance is the amount we use to determine our payment and your coinsurance for covered services. Fee-for-service plans determine their allowances in different ways. We determine our allowance as follows:

- PPO providers: For services rendered by a covered provider who participates in the Plan's PPO network, our allowance is based on a negotiated rate agreed to under the providers' network agreement.

  Note: You will not be responsible for any amount above the providers' negotiated rate; PPO providers accept the Plan's allowance as payment in full.
- Non-PPO providers: When you receive care from a Non-PPO provider, we determine our allowance based on the following rules in order:
- **Rule One**

  When a Non-PPO provider has agreed to discount their charges, our allowance is the amount that the provider has negotiated and agreed to accept for the services or supplies. **You are not responsible for the difference between the allowance and the provider's billed charges.**

  If the provider has not agreed to discount their charges, we will access Rule Two.
- **Rule Two**

  An amount equal to 200% of the current Medicare rate for professional and facility expenses. **You may be responsible for the difference between the allowance and the provider's billed charges**.

  If there is no Medicare rate for the service(s) billed, we will access Rule Three.
- **Rule Three**

  We will utilize outside sources, such as Fair Health, Inc., to determine the allowance for certain services and supplies in a specific geographic area. **You may be responsible for the difference between the allowance and the provider's billed charges**

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

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

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

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

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

You should also see *Important Notice About Surprise Billing - Know Your Rights* in Section 4 that describes your protections against surprise billing under the No Surprises Act.

Post-service claims

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

Pre-service claims

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

Primary care provider

For purposes of the office visit copayment, primary care providers are individual doctors (M.D. or D.O.) whose medical practice is limited to family practice, general practice, internal medicine, pediatrics, adolescent medicine, obstetrics/gynecology, or geriatrics. Also considered primary care providers for the purpose of this benefit are psychiatrists, licensed clinical psychologists, licensed clinical social workers, licensed professional counselors, or licensed marriage and family therapists. Doctors listed in provider directories and/or advertisements under any other medical specialty or sub-specialty area (such as internal medicine doctors also listed under endocrinology, or pediatric sub-specialties such as pediatric cardiology) are considered specialists, not primary care providers.

Prosthetic device

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

Reimbursement

A carrier's pursuit of a recovery if a covered individual has suffered an illness or injury and has received, in connection with that illness or injury, a payment from any party that may be liable, any applicable insurance policy, or a workers' compensation program or insurance policy, and the terms of the carrier's health benefits plan require the covered individual, as a result of such payment, to reimburse the carrier out of the payment to the extent of the benefits initially paid or provided. The right of reimbursement is cumulative with and not exclusive of the right of subrogation.

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.

Remote Physiologic Monitoring (RPM)

A digital health technology that uses connected medical devices to collect and automatically transmit patient physiological data such as blood pressure, weight, or glucose levels, to healthcare providers for analysis outside traditional clinical settings.

Remote Therapeutic Monitoring (RTM)

A digital healthcare service using FDA-approved devices or apps to track non-physiological data such as pain levels, therapy adherence, and functional progress between in-person sessions.

Routine services

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

Sound natural tooth

A sound, natural tooth is a tooth that is whole or properly restored and is without impairment, periodontal or other conditions and is not in need of the treatment provided for any reason other than an accidental injury. For purposes of this Plan, a tooth previously restored with a crown, inlay, onlay, or porcelain restoration or treated by endodontics is not considered a sound natural tooth.

Subrogation

A carrier's pursuit of a recovery from any party that may be liable, any applicable insurance policy, or a workers' compensation program or insurance policy, as successor to the rights of a covered individual who suffered an illness or injury and has obtained benefits from that carrier's health benefits plan.

Surprise bill

An unexpected bill you receive for:

- emergency care – when you have little or no say in the facility or provider from whom you receive care, or for
- non-emergency services furnished by nonparticipating providers with respect to patient visits to participating health care facilities, or for
- air ambulance services furnished by nonparticipating providers of air ambulance services.

Urgent care center

An ambulatory care center, outside of a hospital emergency department, that provides treatment for medical conditions that are not life-threatening, but need quick attention, on a walk-in basis. Urgent care centers are different from convenient care clinics, see page 112.

Urgent care claims

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

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

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

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

Us/We

Us and We refer to SAMBA.

You

You refers to the enrollee and each covered family member.

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Do not rely on this page; it is for your convenience and may not show all pages where the terms appear.

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Notes

Summary of Benefits for the High Option of the SAMBA Health Benefit Plan - 2027

Do not rely on this chart alone. This is a summary. All benefits are subject to the definitions, limitations, and exclusions in this brochure. Before making a final decision, please read this FEHB brochure. You can also obtain a copy of our Summary of Benefits and Coverage as required by the Affordable Care Act at www. SambaPlans.com/health-benefit-plan/sbc/.

If you want to enroll or change your enrollment in this Plan, be sure to put the correct enrollment code from the cover on your enrollment form.

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

High Option Benefits	You pay	Page
Medical services provided by physicians • Diagnostic and treatment services provided in the office	PPO: $15 copayment per office visit to primary care providers; $25 copayment per office visit to specialists Non-PPO: 35%* of the Plan allowance	32
Services provided by a hospital: • Inpatient	PPO: $250 copayment per confinement, nothing for room & board and 15% for other hospital services Non-PPO: $350 copayment per confinement and 35% of the Plan allowance	64
• Outpatient	PPO: 15% of the Plan allowance Non-PPO: 35%* of the Plan allowance	65
Emergency benefits: • Accidental injury	Nothing within 24 hours	68
• Medical emergency	Regular benefits apply	69
Mental health and substance use disorder treatment	Regular cost-sharing	70
Prescription drugs • Retail pharmacy	$10 generic, 30% of the Plan allowance ($100 maximum) preferred brand name or 45% of the Plan allowance ($300 maximum) non-preferred brand name; limited to the initial fill (not to exceed a 30-day supply) and one refill	81
• Mail order	$15 generic, 30% of the Plan allowance ($200 maximum) preferred brand name or 45% of the Plan allowance ($400 maximum) non-preferred brand name	81
Dental care:	PPO: 15%* of the Plan allowance for certain covered services Non-PPO: 35%* of the Plan allowance for certain covered services	85
Wellness and other special features:	Flexible benefits option; Travel benefit/services overseas; Services for deaf and hearing impaired; Telehealth services; Catapult Health's VirtualCheckup®; Online resources; Priority Health Coaching; 24-hour nurse line; Healthy Rewards Program; Health Risk Assessment; Gaps in Care; Tobacco Cessation Program; Weight Management Program; Back and Joint Care; Healthy Pregnancies, Healthy Babies® Program; Maven; EncircleRx℠ and Omada Health; Personal Medication Coach (PMC)	87
Protection against catastrophic costs (out-of-pocket maximum)**:** Some costs do not count toward this protection	PPO: Nothing after $5,000 per person, per calendar year/$10,000 per Self Plus One or Self and Family enrollment, per calendar year Non-PPO: Nothing after $6,000 per person, per calendar year/$12,000 per Self Plus One enrollment/$14,000 per Self and Family enrollment, per calendar year	25

Summary of Benefits for the Standard Option of the SAMBA Health Benefit Plan - 2027

Do not rely on this chart alone. This is a summary. All benefits are subject to the definitions, limitations, and exclusions in this brochure. Before making a final decision, please read this FEHB brochure. You can obtain a copy of our Summary of Benefits and Coverage as required by the Affordable Care Act at www. SambaPlans.com/health-benefit-plan/sbc/.

If you want to enroll or change your enrollment in this Plan, be sure to put the correct enrollment code from the cover on your enrollment form.

Below, an asterisk (*) means the item is subject to the $350 calendar year deductible. And, after we pay, you generally pay any difference between our allowance and the billed amount if you use a Non-PPO physician or other healthcare professional.

Standard Option Benefits	You Pay	Page
Medical services provided by physicians: • Diagnostic and treatment services provided in the office	PPO: $20 copayment per office visit to primary care providers; $30 copayment per office visit to specialists Non-PPO: 45%* of the Plan allowance	32
Services provided by a hospital: • Inpatient	PPO: $250 copayment per confinement, nothing for room & board and 20% for other hospital services Non-PPO: $450 copayment per confinement and 45% of the Plan allowance	64
• Outpatient	PPO: 20%* of the Plan allowance Non-PPO: 45%* of the Plan allowance	65
Emergency benefits: • Accidental injury	Nothing within 24 hours	68
• Medical emergency	Regular benefits apply	69
Mental health and substance use disorder treatment:	Regular cost-sharing	70
Prescription drugs • Retail pharmacy	$12 generic, 35% of the Plan allowance ($150 maximum) preferred brand name or 50% of the Plan allowance ($300 maximum) non-preferred brand name; limited to the initial fill (not to exceed a 30-day supply) and one refill	81
• Mail order	$20 generic, 35% of the Plan allowance ($300 maximum) preferred brand name or 50% of the Plan allowance ($400 maximum) non-preferred brand name	81
Dental care:	We cover surgical and dental treatment of accidental injury to sound natural teeth. Treatment must be rendered within 24 months of the accident. Regular benefits apply.	85
Wellness and other special features:	Flexible benefits option; Travel benefit/services overseas; Services for deaf and hearing impaired; Telehealth services; Catapult Health's VirtualCheckup®; Online resources; Priority Health Coaching; 24 hour nurse line; Healthy Rewards Program; Health Risk Assessment; Gaps in Care; Tobacco Cessation Program; Weight Management Program; Back and Joint Care; Healthy Pregnancies, Healthy Babies® Program; Maven; EncircleRx℠ and Omada Health; Personal Medication Coach (PMC)	87
Protection against catastrophic costs (out-of-pocket maximum)**:** Some costs do not count toward this protection	PPO: Nothing after $6,000 per person, per calendar year/$12,000 per Self Plus One or Self and Family enrollment, per calendar year Non-PPO: Nothing after $8,500 per person, per calendar year/$14,000 per Self Plus One or Self and Family enrollment, per calendar year	25

2027 Rate Information for the SAMBA Health Benefit Plan

To compare your FEHB health plan options please go to www. opm.gov/fehbcompare.

To review premium rates for all FEHB health plan options please go to **www. opm.gov/FEHBpremiums** or **www. opm.gov/Tribalpremium.**

Premiums for Tribal employees are shown under the Monthly Premium Rate column. The amount shown under employee contribution is the maximum you will pay. Your Tribal employer may choose to contribute a higher portion of your premium. Please contact your Tribal Benefits Officer for exact rates.

Type of Enrollment	Enrollment Code	Premium Rate			
		Biweekly		Monthly	
		Gov't Share	Your Share	Gov't Share	Your Share
Nationwide					
High Option Self Only	441	$352.04	$308.98	$762.75	$669.46
High Option Self Plus One	443	$767.53	$686.75	$1,662.98	$1,487.96
High Option Self and Family	442	$843.82	$742.68	$1,828.28	$1,609.14
Standard Option Self Only	444	$352.04	$135.87	$762.75	$294.39
Standard Option Self Plus One	446	$767.53	$264.64	$1,662.98	$573.39
Standard Option Self and Family	445	$841.98	$280.66	$1,824.29	$608.10