

Foreign Service Benefit Plan

www.AFSPA.org/FSBP
Customer Service: 202-833-4910

2013

A fee-for-service Plan (high option) with a preferred provider organization

Sponsored and administered by: the American Foreign Service Protective Association - "*Caring for Your Health Worldwide®*"

Who may enroll in this Plan: You must be, or become, a member of the American Foreign Service **Protective Association**.

To become a member: When you enroll in the **FOREIGN SERVICE BENEFIT PLAN**, you become a member of the **Protective Association**. New membership in the **Protective Association** is limited to American Foreign Service personnel and direct hire employees (i.e., eligible for FEHB insurance) working for:

- (1) the Department of State;
- (2) the Department of Defense;
- (3) the Agency for International Development;
- (4) the Foreign Commercial Service;
- (5) Foreign Agricultural Service; and to
- (6) Executive Branch civilian employees assigned overseas or to U.S. possessions and territories; and the direct hire domestic employees assigned to support those activities. Executive Branch includes all Federal civilian employees except those working for the Legislative (Congress) or Judicial (Courts) Branches of the Federal government.

Direct hire employees and Executive Branch civilian employees must enroll in the **Foreign Service Benefit Plan** when actively employed to retain or choose the Plan in retirement. Only annuitants who are eligible under the Foreign Service Retirement System may enroll in this Plan as annuitants.

Membership dues: There are no membership dues. Membership is for life.

Enrollment codes for this Plan:

401 High Option - Self Only

402 High Option - Self and Family

Coventry Health Care (underwriter): URAC accredited for Health Utilization Review and Disease and Case Management Programs; JCAHO, NCQA, URAC and CMS credentialed and recertified for Coventry Health Care National Network (PPO). See the 2013 Guide for more information.

Express Scripts (ESI – Pharmacy Benefit Manager): URAC accredited for Pharmacy Benefit Management; NCQA for Disease Management/Systems for RationalMed Program; National Association of Boards of Pharmacy for Verified Internet Pharmacy Practice Site. See the 2013 Guide for more information.

IMPORTANT

- Rates: Back Cover
- Changes for 2013: Page 13
- Summary of benefits: Page 108



Authorized for distribution by the:



United States
Office of Personnel Management

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

**Important Notice from the Foreign Service Benefit Plan About
Our Prescription Drug Coverage and Medicare**

The Office of Personnel Management (OPM) has determined that the **Foreign Service Benefit Plan's** prescription drug coverage is, on average, expected to pay out as much as the standard Medicare prescription drug coverage will pay for all Plan participants and is considered Creditable Coverage. Thus you do not need to enroll in Medicare Part D and pay extra for prescription drug benefit coverage. If you decide to enroll in Medicare Part D later, you will not have to pay a penalty for late enrollment as long as you keep your FEHB coverage.

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

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

Please be advised

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

Medicare's Low Income Benefits

For people with limited income and resources, extra help paying for a Medicare prescription drug plan is available. Information regarding this program is available through the Social Security Administration (SSA) online at www.socialsecurity.gov, or call the SSA at 1-800-772-1213 (TTY 1-800-325-0778).

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

- Visit www.medicare.gov for personalized help.
- Call 1-800-MEDICARE (1-800-633-4227) (TTY 1-877-486-2048).

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Introduction

This brochure describes the benefits of the **Foreign Service Benefit Plan** under our contract (CS 1062) with the United States Office of Personnel Management, as authorized by the Federal Employees Health Benefits law. This Plan is underwritten by the First Health Life & Health Insurance Company/Cambridge Life Insurance Company, which are Coventry Health Care Companies. Customer service may be reached at 1-202-833-4910 or through our Web site: www.AFSPA.org/FSBP. The address for the **Foreign Service Benefit Plan** administrative office is:

Foreign Service Benefit Plan

1716 N Street, NW

Washington, DC 20036-2902

Phone: 202-833-4910 (members); 202-833-5751 (providers)

Fax: 202-833-4918

E-mail:

- **Non-secure:** health@AFSPA.org and enrollment@AFSPA.org;
- **Secure e-mail and secure claim submission instructions:** Visit our Web site (www.AFSPA.org/FSBP) and click on the “Send a Secure FSBP E-mail” tab on the right. Then, choose the appropriate action.

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

If you are enrolled in this Plan, you are entitled to the benefits described in this brochure. If you are enrolled in Self and Family coverage, each eligible family member is also entitled to these benefits. You do not have a right to benefits that were available before January 1, 2013, unless those benefits are also shown in this brochure.

OPM negotiates benefits and rates with each plan annually. Benefit changes are effective January 1, 2013, and changes are summarized on pages 13 and 14. Rates are shown on the back cover 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 or family member, “we” means the **Foreign Service Benefit Plan**.
- We limit acronyms to ones you know. FEHB is the Federal Employees Health Benefits Program. OPM is the United States Office of Personnel Management. If we use others, we tell you what they mean first.
- Our brochure and other FEHB plans’ brochures have the same format and similar descriptions to help you compare plans.

Stop Health Care Fraud!

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

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

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

- Do not give your Plan identification (ID) number over the telephone or to people you do not know, except for your health care provider, authorized health benefits Plan or OPM representative.
- Let only the appropriate medical professionals review your medical record or recommend services.

- Avoid using health care providers who say that an item or service is not usually covered, but they know how to bill us to get it paid.
- Carefully review explanations of benefits (EOBs) statements that you receive from us.
- Periodically review your claim history for accuracy to ensure we have not been billed for services that you did not receive.
- Do not ask your doctor to make false entries on certificates, bills or records in order to get us to pay for an item or service.
- If you suspect that a provider has charged you for services you did not receive, billed you twice for the same service, or misrepresented any information, do the following:
 - Call the provider and ask for an explanation. There may be an error.
 - If the provider does not resolve the matter, call us at 202-833-4910 and explain the situation.
 - If we do not resolve the issue:

CALL -- THE HEALTH CARE FRAUD HOTLINE

877-499-7295

OR go to www.opm.gov/oig

You can also write to:

United States Office of Personnel Management

Office of the Inspector General Fraud Hotline

1900 E Street, NW, Room 6400

Washington, 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 he/she was disabled and incapable of self-support prior to age 26).
- If you have any questions about the eligibility of a dependent, check with your personnel office if you are employed, with your retirement office (such as OPM) if you are retired, or with the National Finance Center if you are enrolled under Temporary Continuation of Coverage.
- Fraud or intentional misrepresentation of material fact is prohibited under the Plan. You can be prosecuted for fraud and your agency may take action against you. Examples of fraud include, falsifying a claim to obtain FEHB benefits, trying to or obtaining service or coverage for yourself or someone who is not eligible for coverage, or enrolling in the Plan when you are no longer eligible.
- If your enrollment continues after you are no longer eligible for coverage (i.e., you have separated from Federal service) and premiums are not paid, you will be responsible for all benefits paid during the period in which premiums were not paid. You may be billed by your provider for services received. You may be prosecuted for fraud for knowingly using health insurance benefits for which you have not paid premiums. It is your responsibility to know when you or a family member is no longer eligible to use your health insurance coverage.

Preventing Medical Mistakes

An influential report from the Institute of Medicine estimates that up to 98,000 Americans die every year from medical mistakes in hospitals alone. That's about 3,230 preventable deaths in the FEHB Program a year. While death is the most tragic outcome, medical mistakes cause other problems such as permanent disabilities, extended hospital stays, longer recoveries, and even additional treatments. By asking questions, learning more and understanding your risks, you can improve the safety of your own health care, and that of your family members. Take these simple steps:

1. Ask questions if you have doubts or concerns.

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

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

- Bring the actual medicines or give your doctor and pharmacist a list of all the medicines and dosage that you take, including non-prescription (over-the-counter) medicines and nutritional supplements.
- Tell your doctor and pharmacist about any drug allergies you have.
- Ask about any risks or side effects of the medication and what to avoid while taking it. Be sure to write down what your doctor or pharmacist says.
- Make sure your medicine is what the doctor ordered. Ask the pharmacist about your medicine if it looks different than you expected.
- Read the label and patient package insert when you get your medicine, including all warnings and instructions.
- Know how to use your medicine. Especially note the times and conditions when your medicine should and should not be taken.
- Contact your doctor or pharmacist if you have any questions.

3. Get the results of any test or procedure.

- Ask when and how you will get the results of tests or procedures.
- Don't assume the results are fine if you do not get them when expected, be it in person, by phone, or by mail.
- Call your doctor and ask for your results.
- Ask what the results mean for your care.

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

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

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

- Make sure you, your doctor, and your surgeon all agree on exactly what will be done during the operation.
- Ask your doctor, "Who will manage my care when I am in the hospital?"
- Ask your surgeon:
 - "Exactly what will you be doing?"
 - "About how long will it take?"
 - "What will happen after surgery?"
 - "How can I expect to feel during recovery?"

- Tell the surgeon, anesthesiologist, and nurses about any allergies, bad reactions to anesthesia, and any medications you are taking.

Patient Safety Links

- www.ahrq.gov/consumer/. The Agency for Healthcare Research and Quality makes available a wide-ranging list of topics not only to inform consumers about patient safety but to help choose quality health care providers and improve the quality of care you receive.
- www.npsf.org. The National Patient Safety Foundation has information on how to ensure safer health care for you and your family.
- www.talkaboutrx.org . The National Council on Patient Information and Education is dedicated to improving communication about the safe, appropriate use of medicines.
- www.leapfroggroup.org. The Leapfrog Group is active in promoting safe practices in hospital care.
- www.ahqa.org. The American Health Quality Association represents organizations and health care professionals working to improve patient safety.

Never Events

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

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

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

FEHB Facts

Coverage information

- **No pre-existing condition limitation**

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

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

See www.opm.gov/insure/health for enrollment information as well as:

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

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

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

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

- **Types of coverage available for you and your family**

Self Only coverage is for you alone. Self and Family coverage is for you, your spouse, and your dependent children under age 26, including any foster children your employing or retirement office authorizes coverage for. Under certain circumstances, you may also continue coverage for a disabled child 26 years of age or older who is incapable of self-support.

If you have a Self Only enrollment, you may change to a Self and Family enrollment if you marry, give birth, or add a child to your family. You may change your enrollment 31 days before to 60 days after that event. The Self and Family enrollment begins on the first day of the pay period in which the child is born or becomes an eligible family member. When you change to Self and Family because you marry, the change is effective on the first day of the pay period that begins after your employing office receives your enrollment form; benefits will not be available to your spouse until you marry.

Your employing or retirement office will not notify you when a family member is no longer eligible to receive benefits, nor will we. Please tell us immediately of changes in family member status, including your marriage, divorce, annulment, or when your child turns age 26.

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

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

- **Family Member Coverage**

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

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

You can find additional information at www.opm.gov/insure.

- **Children’s Equity Act**

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

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

- If you have no FEHB coverage, your employing office will enroll you for Self and Family coverage in the Blue Cross and Blue Shield Service Benefit Plan’s Basic Option;
- If you have a Self Only enrollment in a fee-for-service plan or in an HMO that serves the area where your children live, your employing office will change your enrollment to Self and Family in the same option of the same plan; or
- If you are enrolled in an HMO that does not serve the area where the children live, your employing office will change your enrollment to Self and Family in the Blue Cross and Blue Shield Service Benefit Plan’s Basic Option.

As long as the court/administrative order is in effect, and you have at least one child identified in the order who is still eligible under the FEHB Program, you cannot cancel your enrollment, change to Self Only, or change to a plan that doesn't serve the area in which your children live, unless you provide documentation that you have other coverage for the children. If the court/administrative order is still in effect when you retire, and you have at least one child still eligible for FEHB coverage, you must continue your FEHB coverage into retirement (if eligible) and cannot cancel your coverage, change to Self Only, or change to a plan that doesn't serve the area in which your children live as long as the court/administrative order is in effect. Contact your employing office for further information.

- **When benefits and premiums start**

The benefits in this brochure are effective January 1. If you joined this Plan during Open Season, your coverage begins on the first day of your first pay period that starts on or after January 1. **If you changed plans or plan options during Open Season and you receive care between January 1 and the effective date of coverage under your new plan or option, your claims will be paid according to the 2013 benefits of your old plan or option.** However, if your old plan left the FEHB Program at the end of the year, you are covered under that plan's 2012 benefits until the effective date of your coverage with your new plan. Annuitants' coverage and premiums begin on January 1. If you joined at any other time during the year, your employing office will tell you the effective date of coverage.

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

- **When you retire**

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

When you lose benefits

- **When FEHB coverage ends**

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

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

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

You may be eligible for spouse equity coverage or Temporary Continuation of Coverage (TCC), or a conversion policy (a non-FEHB individual policy).

- **Upon divorce**

If you are divorced from a Federal employee or annuitant, you may not continue to get benefits under your former spouse's enrollment. This is the case even when the court has ordered your former spouse to provide health coverage for you. However, you may be eligible for your own FEHB coverage under either the spouse equity law or Temporary Continuation of Coverage (TCC). If you are recently divorced or are anticipating a divorce, contact your ex-spouse's employing or retirement office to get RI 70-5, the Guide To Federal Benefits for Temporary Continuation of Coverage and Former Spouse Enrollees, or other information about your coverage choices. You also can download the guide from OPM's Web site, www.opm.gov/insure.

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

If you leave Federal service, or if you lose coverage because you no longer qualify as a family member, you may be eligible for 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 job, if you are a covered dependent child and you turn age 26, regardless of marital status, etc.

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

Enrolling in TCC. Get the RI 79-27, which describes TCC, and the RI 70-5, the Guide to Federal Benefits for Temporary Continuation of Coverage and Former Spouse Enrollees, from your employing or retirement office or from www.opm.gov/insure. It explains what you have to do to enroll.

- **Converting to individual coverage**

You may convert to a non-FEHB individual policy if:

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

If you leave Federal service, your employing office will notify you of your right to convert. You must apply in writing to us within 31 days after you receive this notice. However, if you are a family member who is losing coverage, the employing or retirement office will **not** notify you. You must apply in writing to us within 31 days after you are no longer eligible for coverage.

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

- **Getting a Certificate of Group Health Plan Coverage**

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is a Federal law that offers limited Federal protections for health coverage availability and continuity to people who lose employer group coverage. If you leave the FEHB Program, we will give you a Certificate of Group Health Plan Coverage that indicates how long you have been enrolled with us. You can use this certificate when getting health insurance or other health care coverage. Your new plan must reduce or eliminate waiting periods, limitations, or exclusions for health related conditions based on the information in the certificate, as long as you enroll within 63 days of losing coverage under this Plan. If you have been enrolled with us for less than 12 months, but were previously enrolled in other FEHB plans, you may also request a certificate from those plans.

For more information, get OPM pamphlet RI 79-27, Temporary Continuation of Coverage (TCC) under the FEHB Program. See also the FEHB Web site at www.opm.gov/insure/health; refer to the “TCC and HIPAA” frequently asked questions. These highlight HIPAA rules, such as the requirement that Federal employees must exhaust any TCC eligibility as one condition for guaranteed access to individual health coverage under HIPAA, and information about Federal and State agencies you can contact for more information.

Section 1. How this plan works

This Plan is a fee-for-service (FFS) plan. You can choose your own physicians, hospitals, and other health care providers.

We 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 Option

We have a Preferred Provider Organization (PPO):

Our fee-for-service Plan offers services through a national PPO network. The Plan uses the Coventry Health Care (Coventry) National Network as its PPO network in all states except Ohio and New Jersey. In Ohio, the network is administered by Medical Mutual of Ohio. In New Jersey, the network is administered by QualCare. This means that certain hospitals and other health care providers are “preferred providers”. When you use a PPO provider, generally you will receive covered services at reduced cost. Coventry is solely responsible for the selection of PPO providers in your area. Contact us for the names of PPO providers and to verify their continued participation. Access our PPO directory as a link through our Web site www.AFSPA.org/FSBP or call 202-833-4910 for information concerning the PPO. You can also go to our Web site, which you can reach through the FEHB Web site, www.opm.gov/insure.

The non-PPO benefits are the standard benefits of this Plan. PPO benefits apply only when you use a PPO provider.

Provider networks may be more extensive in some areas than others. PPO benefit levels also apply to providers outside the 50 United States. We cannot guarantee the availability of every specialty in all areas. The selection of PPO providers is solely Coventry’s responsibility. We cannot guarantee the continued participation of any specific provider. In the PPO Network, if no PPO provider is available or you do not use a PPO provider, the standard non-PPO benefits apply. **Follow these procedures when you use a PPO provider in order to receive PPO benefits:**

- **Verify that the provider is in the PPO Network when you make your appointment;**
- **Present your Foreign Service Benefit Plan Identification (ID) Card at the time you visit your health care provider, confirming your PPO participation in order to receive PPO benefits and the provider’s continued participation in our Network. If you do not present your ID Card, the provider may not give you the PPO discount; and**
- **Generally, you do not pay a PPO provider at the time of service. PPO providers must bill us directly. We must reimburse the provider directly. PPO providers will bill you for any balance after our payment to them.**

Consider the PPO cost savings when you review Plan benefits. Check with the Plan to find out which local facilities and providers are PPO providers. Also, check with your physician to see if he or she has admitting privileges at a PPO hospital.

Other participating providers:

This Plan offers you access to certain non-PPO health care providers that have agreed to discount their charges. These providers are available to you through Medical Mutual of Ohio (MMO) Traditional Contract, MultiPlan, Three Rivers Provider Network (TRPN and PMCS, networks that have contracted with the Plan. Covered services provided by these participating providers are considered at the negotiated rate subject to applicable deductibles, copayments and coinsurance. Since these participating providers are not considered in-network providers, non-PPO benefit levels will apply. Contact us at 202-833-4910 for more information about these participating providers.

How we pay providers

We generally reimburse our PPO providers based on an agreed-upon fee schedule. We do not offer them additional financial incentives based on care provided or not provided to you. Our standard provider agreements do not contain any contractual provisions that include incentives to restrict the providers’ ability to communicate with and advise you of any appropriate treatment options. Also, we have no compensation, ownership or other influential interests that are likely to affect provider advice or treatment decisions.

We may, through a negotiated arrangement with some health care providers, apply a discount to covered services that you receive from any such health care provider. To locate a provider from whom a discount may be available, call the number on your Identification Card.

For providers in the 50 United States, whether you use a PPO or a non-PPO provider, generally we will pay the provider directly unless payment is noted on the bill we receive. If you have made payment to the provider, please advise us when you submit your claim.

We use InterQual criteria (a standardized, nationally recognized set of criteria, which are in common use among both hospital providers and insurance payors, that address criteria for appropriate levels of care and criteria for procedures, surgeries, and durable medical equipment) and other recognized clinical guidelines in making determinations regarding inpatient hospital, acute rehabilitation, residential treatment precertification, and also skilled nursing facility stays, extended stay reviews, observation stay reviews, and reviews of procedures and therapies that require preauthorization (see Section 3, *You need prior Plan approval for certain services.*) These determinations can affect how we provide benefits.

We apply the National Correct Coding Initiative (NCCI) edits published by the Centers for Medicare and Medicaid Services (CMS) in reviewing billed services and making Plan benefit payments for them.

For providers outside the United States, except for providers in our International Hospital Direct Billing Arrangement (see Section 7, *Overseas claims*), generally we will pay you.

Your Rights

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

- **Years in existence and profit status** – The American Foreign Service **Protective Association**, which sponsors the **Foreign Service Benefit Plan**, was established in 1929 and was incorporated in 1951 as a 501(c)(9) not-for-profit organization. The **Foreign Service Benefit Plan** is provided in conjunction with the First Health Life & Health Insurance Company/Cambridge Life Insurance Company, which are Coventry Health Care Companies.
- **Licensing and certification** – The First Health Life & Health Insurance Company/Cambridge Life Insurance Company, which are Coventry Health Care Companies, meet all State and Federal licensing and certification requirements.
- **Fiscal solvency, confidentiality and transfer of medical records** – The First Health Life & Health Insurance Company/Cambridge Life Insurance Company, which are Coventry Health Care Companies, meet all requirements for fiscal solvency, confidentiality and transfer of medical records.

If you want more information about us, call 202-833-4910, or write to the **Foreign Service Benefit Plan**, 1716 N Street, NW, Washington, DC 20036-2902. You also may contact us by fax at 202-833-4918, by non-secure e-mail at health@AFSPA.org or enrollment@AFSPA.org, or by secure e-mail through our Web site at www.AFSPA.org/FSBP (click on "Send a Secure FSBP E-mail" tab on the right).

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.

You may view our Notice of Privacy Practice for more information about how we may use and disclose member information by visiting our Web site at www.AFSPA.org/FSBP.

Section 2. Changes for 2013

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

Program-wide changes

- Removed annual limits on essential health benefits as described in section 1302 of the Affordable Care Act.
- Plans must provide coverage for routine patient costs for items and services furnished in connection with participation in an approved clinical trial.
- Coverage with no cost sharing for additional preventive care and screenings for women provided in comprehensive guidelines adopted by the Health Resources and Services Administration (HRSA).
- Alaska and Kentucky were designated as a Medically Underserved Area in 2012, but will not be so designated for 2013. South Carolina is being added as a Medically Underserved Area for 2013.

Changes to this Plan

- Your share of the premium will increase by \$0.29 for Self Only or decrease by \$0.72 for Self and Family. See back cover.
- The Plan has reduced the calendar year deductible for PPO and Providers outside the 50 United States from \$300 per person to \$250 per person and \$600 per family to \$500 per family (see page 21 and the beginning of Sections 5(a), (b), (c), (d), (e), (f), and (g)).
- The Plan has added coverage for well-woman exams, screening and/or counseling for human immune-deficiency virus (HIV), sexually transmitted infections, interpersonal and domestic violence, gestational diabetes screening, breastfeeding support, supplies and counseling in compliance with the Affordable Care Act (see pages 29 and 32).
- The Plan has removed the age 40 limit for fecal occult blood test (see page 30).
- The Plan has eliminated the benefit maximum for Infertility services (see page 33).
- The Plan has increased the adult hearing screenings benefit to 100% of the Plan allowance (No deductible) (see page 35).
- The Plan has changed the foot orthotics benefit maximum to \$250 (No deductible) per device, per foot, per person, per calendar year with one replacement, per device, per foot, per person, per calendar year (see page 36).
- The Plan has increased the Wig benefit maximum to \$500 per wig (No deductible), per person, per calendar year (No deductible) (see page 37).
- The Plan has increased the Hearing aid benefit maximum to \$1,500 per device, per ear, per person, with one replacement per device, per ear, per person every five years (see page 37).
- The Plan has increased coverage for Augmentative and alternative communications (AAC) devices to up to the Plan allowance of \$1,000 per device, per person, per calendar year for PPO, Non-PPO and Providers outside the 50 United States (see pages 38 and 39)
- The Plan has increased the Chiropractic services benefit to \$60 (No deductible) per visit and to 40 visits per calendar year (see page 41).
- The Plan has increased the Acupuncture benefit to \$60 (No deductible) per visit and to 40 visits per calendar year (see page 41).
- The Plan has increased the Massage Therapy benefit to \$60 (No deductible) per visit and to 40 visits per calendar year (see page 41).
- The Plan has removed the \$500 per person, per calendar year limit for the Diabetic Education and pays at 90% for PPO providers and Providers outside the 50 United States and 70% for Non-PPO providers (see page 42).

- The Plan has removed the \$2,000 combined benefit maximum for the Nutritional counseling and Weight Management Program and pays Nutritional counseling at 90% of the Plan allowance for PPO providers and Providers outside the 50 United States and 70% of the Plan allowance for Non-PPO providers (see pages 42 and 43).
- The Plan has removed the \$2,000 combined benefit maximum for the Nutritional counseling and Weight Management Program and pays up to \$2,000 for one Weight Management Program per person, per calendar year for PPO, Non-PPO and Providers outside the 50 United States (see pages 42 and 43) .
- The Plan has removed the requirement for preauthorization of Hospice care and the lifetime maximum of \$4,500. The Plan pays at 90% of the Plan allowance (No deductible) for PPO providers and Providers outside the 50 United States and 70% (No deductible) for non-PPO providers (see page 54).
- The Plan has increased coverage for generic (Level I) and single source brand (Level II) prescription contraceptive drugs and devices. There is no member copayment (see pages 64).
- The Plan has changed the Orthodontic services benefit to 50% of the Plan allowance up to \$1,000 per course of treatment, per person. Courses of treatment are limited to one every five years (see page 69).
- The Plan has added a Health Risk Assessment (HRA) Wellness Incentive for completion of the HRA and meeting certain criteria. (see page 73).

Clarification to this Plan

- Express Scripts (ESI) and Medco Health Solutions, Inc. are now one company (Express Scripts). Express Scripts remains the Plan's Pharmacy Benefit Manager for prescription benefits. Our mail order pharmacy remains the Medco Pharmacy, which is now part of Express Scripts.

Section 3. How you get care

Identification cards

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

If you do not receive your ID card within 30 days after the effective date of your enrollment, or if you need replacement cards, call us at 202-833-4910 or write to us at 1716 N Street, NW, Washington, DC 20036-2902. You may also request replacement cards by secure e-mail through our Web site, www.AFSPA.org/FSBP (click on the “Send a Secure FSBP E-mail” tab on the right).

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. If you use our preferred providers, you will pay less.

• Covered providers

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

Medically underserved areas. Note: We cover any licensed medical practitioner for any covered service performed within the scope of that license in the states OPM determines are “medically underserved”. For 2013, the states are: Alabama, Arizona, Idaho, Illinois, Louisiana, Mississippi, Missouri, Montana, New Mexico, North Dakota, Oklahoma, South Carolina, South Dakota, and Wyoming.

- **Physician** — Doctors of medicine (M.D.), osteopathy (D.O.), podiatric medicine (D.P.M.) and for certain specified services covered by this Plan, doctors of dental surgery (D.D.S.), medical dentistry (D.M.D.), optometry (O.D.), chiropractic (D.C.), and Oriental Medicine (O.M.D.).
- **Qualified Clinical Psychologist** — An individual who has earned either a Doctoral or Masters Clinical Degree in psychology or an allied discipline and who is licensed or certified in the state where services are performed (such as Licensed Professional Counselors).
- **Certified Registered Nurse Anesthetist** — A registered nurse qualified by advanced study in an accredited program in the specialty of nurse anesthesia to manage patient care during the administration of anesthesia in selected surgical situations.
- **Nurse Midwife** — A person who is certified by the American College of Nurse Midwives or is licensed or certified as a nurse midwife in states requiring licensure or certification.
- **Nurse Practitioner / Clinical Specialist** — A person who
 - Has an active R.N. license in the United States;
 - Has a baccalaureate or higher degree in nursing; and
 - Is licensed or certified as a nurse practitioner or clinical nurse specialist in states requiring licensure or certification.
- **Clinical Social Worker** — A social worker who
 - Has a Masters or Doctoral Degree in social work;
 - Has at least two years of clinical social work practice; and
 - In states requiring licensure, certification, or registration, is licensed, certified, or registered as a social worker where the services are rendered.
- **Nursing School Administered Clinic** — A clinic that is
 - Licensed or certified in the state where the services are performed; and
 - Provides ambulatory care in an outpatient setting – primarily in rural or inner city areas where there is a shortage of physicians. Services billed by these clinics are considered outpatient “office” services rather than facility charges.

- **Physician Assistant** — A person who is licensed, registered or certified in the state where services are performed.
- **Licensed Professional Counselor or Master's Level Counselor** — A person who is licensed, registered, or certified in the state where services are performed.
- **Licensed Physical Therapist** — A professional who is licensed or meets state requirements where the services are performed to provide physical therapy services.
- **Licensed Speech Therapist** — A professional who is licensed or meets state requirements where the services are performed to provide speech therapy services.
- **Licensed Occupational Therapist** — A professional who is licensed or meets state requirements where the services are performed to provide occupational therapy services.
- **Dietician** — A professional who, in states requiring licensure, certification or registration, is licensed, certified, or registered as a dietician where the services are performed.
- **Nutritionist** — A professional who, in states requiring licensure, certification or registration, is licensed, certified, or registered as a nutritionist where the services are performed.
- **Diabetic Educator** — A professional who, in states requiring licensure, certification or registration, is licensed, certified, or registered as a diabetic educator where the services are performed.
- **Audiologist** — A person who is licensed, certified, or registered in the state where services are performed.
- **Licensed Acupuncturist (L.Ac.)** — An individual who has completed the required schooling and licensure to perform acupuncture in the state where services are performed (see definition of acupuncture, page 41).
- **Massage Therapist** — An individual who has completed the required schooling and licensure or certification to perform massage therapy in the state where services are performed.

- **Covered facilities**

Covered facilities include:

- **Birth Center** — A licensed facility that is equipped and operated solely to provide prenatal care, to perform uncomplicated spontaneous deliveries and to provide immediate postpartum care.
- **Hospice Care Facility** — A facility providing hospice care services that is appropriately licensed or certified as such under the law of the jurisdiction in which it is located, and that:
 - Is certified (or is qualified and could be certified) under Medicare;
 - Is accredited by the Joint Commission on Accreditation of Healthcare Organizations;
 - Meets the standards established by the National Hospice Organization.
- **Hospital**
 - An institution that is accredited as a hospital under the hospital accreditation program of the Joint Commission on Accreditation of Healthcare Organizations (JCAHO); or
 - Any other institution that is operated pursuant to law, under the supervision of a staff of doctors and with 24-hour-a-day nursing services, and that is engaged primarily in providing:
 - (a) General inpatient care and treatment of sick and injured persons through medical, diagnostic and major surgical facilities, all of which facilities must be provided on its premises or under its control; or (b) Specialized inpatient medical care and treatment of sick or injured persons through medical and diagnostic facilities (including X-ray and laboratory) on its premises, under its control, or through a written agreement with a hospital (as defined above) or with a specialized provider of those facilities.
 - For inpatient and outpatient treatment of mental health and substance abuse, the term hospital also includes a free-standing residential treatment center facility approved by the JCAHO or the Commission for Accreditation of Rehabilitation Facilities (CARF).

- In no event shall the term hospital include a convalescent nursing home or institution or part thereof that: (a) Is used principally as a convalescent facility, rest 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.
- **Skilled Nursing Facility** — An institution or that part of an institution, which provides convalescent skilled nursing care 24-hours-a-day and is classified as a skilled nursing facility under Medicare.
- **Urgent Care Center** — A free-standing facility offering ambulatory medical service, which:
 - Is not part of a hospital; and
 - Is licensed by the proper authority in the jurisdiction in which it is located.

• **Transitional care**

Specialty care: If you have a chronic or disabling condition and

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

you may be able to continue seeing your specialist and receiving any PPO benefits for up to 90 days after you receive notice of the change. Contact us or, if we drop out of the Program, contact your new plan.

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

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

We pay for covered services from the effective date of your enrollment. However, if you are in the hospital when your enrollment in our Plan begins, call our customer service department immediately at 202-833-4910. 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.

• **Inpatient hospital admission**

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

In most cases, your physician or hospital will take care of requesting precertification. Because you are still responsible for ensuring that your care is precertified, you should always ask your physician or hospital whether they have contacted us.

Warning:

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

Exceptions:

You do not need precertification in these cases:

- You are admitted to a hospital or residential treatment center outside the 50 United States. However, the Plan will review all services to establish medical necessity. We may request medical records in order to determine medical necessity.
- You have another group health insurance policy that is the primary payor for the hospital stay.
- Medicare Part A is the primary payor for the hospital stay. Note: If you exhaust your Medicare hospital benefits and do not want to use your Medicare lifetime reserve days or you have no Medicare lifetime reserve days left, then we will become the primary payor and you must precertify.

• **Other services**

Other services require precertification, preauthorization, concurrent review or prior authorization, such as:

- All High End Radiology procedures, such as but not limited to CT Scan, PET Scan, MRI , except in the case of an accident or a medical emergency (see page 29);
- Chemotherapy and radiation therapy (see page 34);
- Home health care (see pages 39-41);
- Organ/tissue transplants (see pages 47-50);
- Extended care/Skilled nursing facility admission (pages 53-54);
- Mental health and substance abuse treatment (see pages 57-59); and
- Prescription drugs (see pages 61, 62 and 64). Some medications are not covered unless you receive approval through a coverage review (prior authorization). This review uses Plan rules based on FDA-approved prescribing and safety information, clinical guidelines and uses that are considered reasonable, safe, and effective.

If no one contacted us for specified services such as Home health care or Skilled nursing facility care we will pay a reduced benefit as referenced in the appropriate benefit section.

Note: We do not require precertification, preauthorization, or concurrent review if you receive treatment outside the 50 United States. However, the Plan will review all services to establish medical necessity. We may request medical records from you or your provider in order to determine medical necessity.

Note: We do not require precertification, preauthorization, or concurrent review when Medicare Part A and/or Part B or another group health insurance policy is the primary payor. Precertification, preauthorization and concurrent review are required, however, when Medicare or the other group health insurance policy stops paying benefits for any reason.

Note: We do not require prior authorization for the purchase of certain prescription drugs when Medicare Part B or Part D is the primary payor for the drugs or you are outside the 50 United States and purchase them from a retail pharmacy outside the 50 United States.

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

First, you, your representative, your physician, or your hospital must call us at 1-800-593-2354 before admission or medical/surgical services requiring preauthorization or prior authorization are rendered.

Next, provide the following information:

- enrollee's name and Plan identification number;

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

For prescription medications that require prior authorization, you, your representative, your physician, or your hospital must call Express Scripts (ESI), the Plan's Pharmacy Benefit Manager at 1-800-818-6717 (TDD: 1-800-759-1089 for the hearing impaired).

- **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 it is an urgent care claim by applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine.

If you fail to provide sufficient information, we will contact you within 24 hours after we receive the claim to provide notice of the specific information we need to complete our review of the claim. We will allow you up to 48 hours from the receipt of this notice to provide the necessary information. We will make our decision on the claim within 48 hours of (1) the time we received the additional information or (2) the end of the timeframe, 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 202-833-4910. You may also call OPM's Health Insurance II at 202-606-3818 between 8 a.m. and 5 p.m. eastern time to ask for the simultaneous review. We will cooperate with OPM so they can quickly review your claim on appeal. In addition, if you did not indicate that your claim was a claim for urgent care, then call us at 202-833-4910. If it is determined that your claim is an urgent care claim, we will hasten our review (if we have not yet responded to your 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* on the next page.

- **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 your physician or the hospital must contact us for precertification of additional days. Further, if your baby stays after you are discharged, then your physician or the hospital must contact us for precertification of additional days for your baby.
 - **If your hospital stay needs to be extended**

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

 - For the part of the admission that was medically necessary, we will pay inpatient benefits, but
 - For the part of the admission that was not medically necessary, we will pay only medical services and supplies otherwise payable on an outpatient basis and will not pay inpatient benefits.
 - **If your treatment needs to be extended**

If you request an extension of an ongoing course of treatment at least 24 hours prior to the expiration of the approved time period and this is also an urgent care claim, then we will make a decision within 24 hours after we receive the claim.
- If you disagree with our pre-service claim decision**
- If you have a **pre-service claim** and you do not agree with our decision regarding precertification of an inpatient admission or prior approval of other services, you may request a review in accord with the procedures detailed below.
- If you have already received the service, supply, or treatment, then you have a **post-service claim** and must follow the entire disputed claims process detailed in Section 8.
- **To reconsider a non-urgent care claim**

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

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

 1. Precertify your hospital stay, or, if applicable, arrange for the health care provider to give you the care or grant your request for prior approval for a service, drug, or supply; or
 2. Ask you or your provider for more information.
 - You or your provider must send the information so that we receive it within 60 days of our request. We will then decide within 30 more days.
 - If we do not receive the information within 60 days we will decide within 30 days of the date the information was due. We will base our decision on the information we already have. We will write to you with our decision.
 3. Write to you and maintain our denial.
 - **To reconsider an urgent care claim**

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

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

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

Section 4. Your costs for covered services

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.

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

Example:

- When you purchase prescriptions from the Medco Pharmacy®, you pay a copayment of \$10 for generic, or \$55 for single-source brand name, or \$70 for multi-source brand name prescriptions.
- When you go in a non-PPO hospital, you pay \$200 per person, per hospital stay.

We do not reimburse you for copayments.

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.

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. We do not reimburse you for the deductible. Benefits paid by us do not count towards the deductible. Copayments and coinsurance amounts do not count toward any deductible. When a covered service or supply is subject to a deductible, only the Plan allowance for the service or supply counts toward the deductible.

The calendar year deductible is \$250 per person for PPO and Providers outside the 50 United States or \$300 per person for non-PPO providers. Under a family enrollment, the deductible is satisfied for all family members when the combined covered expenses applied to the calendar year deductible for family members reach \$500 for PPO and Providers outside the 50 United States or \$600 for non-PPO providers. Expenses are “incurred” on the date on which the service or supply is received.

If the billed amount or the 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, 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 (\$250 for PPO and providers outside the 50 United States or \$300 for non-PPO providers) has been satisfied.

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

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

Coinsurance Coinsurance is the percentage of our allowance that you must pay for your care.

Example: You pay 10% of the Plan allowance for surgery performed by a PPO provider.

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 non-PPO physician ordinarily charges \$100 for a service but routinely waives your 30% coinsurance, the actual charge is \$70. We will pay \$49 (70% of the actual charge of \$70).

Waivers

In some instances, a PPO provider may ask you to sign a "waiver" prior to receiving care. This waiver may state that you accept responsibility for the total charge, including any charges above the negotiated amount, for any care that is not covered by your health plan. If you sign such a waiver, whether you are responsible for the total charge depends on the contracts that the Plan has with its providers. If you are asked to sign this type of waiver, please be aware that, if benefits are denied for the services, you could be legally liable for the related expenses. If you would like more information about waivers, please contact us at 202-833-4910.

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, *Definitions*.

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.

You should use a PPO provider. The following two examples explain how we will handle your bill when you go to a PPO provider and when you go to a non-PPO provider. When you use a PPO provider, the amount you pay is much less.

- **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. Here is an example about coinsurance: You see a PPO physician who charges \$150, but our allowance is \$100. If you have met your deductible, you are only responsible for your coinsurance. That is, you pay just 10% of our \$100 allowance (\$10). Because of the agreement, your PPO physician will not bill you for the \$50 difference between our allowance and his/her bill. **Follow these procedures when you use a PPO provider in order to receive PPO benefits:**
 - **Verify that the provider is in the PPO Network when you make your appointment;**
 - **Present your Foreign Service Benefit Plan Identification (ID) card at the time you visit your health care provider, confirming your PPO participation in order to receive PPO benefits and the provider's continued participation in our Network. If you do not present your ID card, the provider may not give you the PPO discount; and**
 - **Generally, you do not pay a PPO provider at the time of service. PPO providers must bill us directly. We must reimburse the provider directly. PPO providers will bill you for any balance after our payment to them.**

- **Non-PPO providers**, on the other hand, have no agreement to limit what they will bill you. For instance:
 - **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. If you have met your deductible, you are responsible for your coinsurance, so you pay 30% of our \$100 allowance (\$30). Plus, because there is no agreement between the non-PPO physician and us, the physician can bill you for the \$50 difference between our allowance and his/her bill.
- **Other participating providers (See Section 1, *Facts about this fee-for-service Plan*)** agree to limit what they will bill you. You still will have to pay your deductible and the non-PPO benefit level. These providers have agreed not to bill you for the difference between the billed charges and the discounted amount.
- **Providers outside the 50 United States** charges generally are not subject to a Plan allowance, that is, our Plan allowance is the amount billed by the provider or as part of our Direct Billing Arrangements. Similar to the PPO example on the previous page, when you use a provider outside the 50 United States and you have met your deductible, you are responsible for your coinsurance. You will pay just 10% of the charge (\$15).

The table below illustrates the examples of how much you have to pay out-of-pocket for medical services from a PPO physician vs. a non-PPO physician vs. a physician outside the 50 United States. The table uses our example of a service for which the physician charges \$150 and our allowance is \$100. The table shows the amount you pay if you have met your calendar year deductible.

EXAMPLE	PPO physician	Non-PPO physician	Physician outside the 50 United States
Physician's charge	\$150	\$150	\$150
Our allowance	We set it at: 100	We set it at: 100	We set it at: 150
We pay	90% of our allowance: 90	70% of our allowance: 70	90% of our allowance: 135
You owe: Coinsurance	10% of our allowance: 10	30% of our allowance: 30	10% of our allowance: 15
+Difference up to charge?	No: 0	Yes: 50	No: 0
TOTAL YOU PAY	\$10	\$80	\$15

Regardless of the provider you choose, we subject benefits to all provisions of the Plan. Also, we do not supervise, control or guarantee the health care services of a preferred provider or any other provider.

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

For those services with coinsurance, we pay 100% of the Plan allowance for the remainder of the calendar year when out-of-pocket expenses for coinsurance, deductibles and inpatient hospital copayments in that calendar year exceed:

- \$4,000 for Self Only and \$4,500 for Self and Family enrollment (PPO providers and providers outside the 50 United States; or
- \$6,000 for Self Only and \$6,500 for Self and Family enrollment (non-PPO providers).

This catastrophic protection out-of-pocket maximum is combined for medical/surgical and mental health/substance abuse.

The following cannot be counted toward catastrophic protection out-of-pocket expense:

- Expenses in excess of Plan allowances, maximum benefit or visit limitations;
- Expenses for a transplant above the \$400,000 maximum PPO benefit or expenses at a non-PPO facility;
- Expenses for dental care;
- Any amounts you pay because benefits have been reduced for non-compliance with precertification or preauthorization requirements (see Section 3, *How you get care*);
- Coinsurance and copayments you pay for prescription drugs obtained through the Plan's retail network or mail order pharmacy;
- Expenses for prescriptions purchased at pharmacies in the 50 United States without using the Plan's identification card or purchased from a source other than the Plan's mail order pharmacy; and
- Non-covered services and supplies.

Carryover

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

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.

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 to pay for certain services and charges. Contact the government facility directly for more information.

High Option Benefits

See pages 13-14 for how our benefits changed this year. Pages 108 - 111 are a benefits summary of our High Option.

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High Option Overview

"Caring for Your Health Worldwide®"

This Plan offers a High Option. The benefit package is described in Section 5.

This Section 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 Option benefits, contact us by phone at 202-833-4910 (members) or 202-833-5751 (health care providers), by fax at 202-833-4918, or by secure e-mail through our Web site at www.AFSPA.org/FSBP (click on the "Send a Secure FSBP E-mail" tab on the right).

The **High Option** offers unique features, many designed specifically for our members outside the 50 United States.

- Benefits available worldwide
- Electronic Funds Transfer (EFT) of claim payments to your U.S. bank account
- Secure method to submit claims and correspondence via the Internet or fax – eliminate lengthy mail time
 - Visit our Web site (www.AFSPA.org/FSBP) and click on the "Send a Secure FSBP E-mail" tab on the right. You can attach a scanned copy (as a PDF) of your claim to a message you send to us through this secure method. This tool also allows you to send secure claims to specific customer service representatives.
- Charges from providers outside the 50 United States generally considered at the billed amount
- Plan translates claims and uses currency exchange rates provided by member
- Reduced calendar year deductible for using PPO providers
- Direct billing arrangements with hospitals in several foreign countries
- Overseas second opinion program
- Wellness and preventive care benefits for children and adults payable at 100% of Plan allowance with no deductible (PPO and outside the 50 United States)
- Healthy Pregnancy Program
- Health Risk Assessment and Incentive
- 24-Hour FSBP Nurse Advice and Translation Lines
- Enhanced Alternative treatments benefits for massage therapy, acupuncture and chiropractic
- Nutritional counseling, Weight Management Program and Diabetic education benefits
- Mediterranean Wellness Program and Incentive
- Enhanced Orthotic benefit
- Orthodontic benefits
- Web based customer service
 - *My Online Services* Web site allows members access to Web based claim information (electronic copies of Explanations of Benefits), PPO provider search, health information, digital coaching programs and other tools.
 - Prescription management Web site allows members to refill and renew prescriptions, obtain prescription information, locate Network pharmacies, compare costs of prescriptions, obtain refill reminders and use other tools.

Section 5(a). Medical services and supplies provided by physicians and other health care professionals

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- The calendar year deductible is: \$250 per person for PPO and Providers outside the 50 United States or \$300 for non-PPO providers (\$500 per family for PPO and Providers outside the 50 United States or \$600 per family for non-PPO providers). The calendar year deductible applies to almost all benefits in this Section. We added “(No deductible)” to show when the calendar year deductible does not apply.
- The non-PPO benefits are the standard benefits of this Plan. PPO benefits apply only when you use a PPO provider or when you use a provider outside the 50 United States. When no PPO provider is available in the PPO Network, 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.
- **YOU MUST GET PREAUTHORIZATION FOR ALL HIGH END RADIOLOGY PROCEDURES (SUCH AS, BUT NOT LIMITED TO, CT SCAN, PET SCAN OR MRI).** Please refer to the preauthorization information shown in Section 3, *Other services*, for additional details on preauthorization and to this Section (*Lab, X-ray and other diagnostic tests*).
- **YOU MUST GET PREAUTHORIZATION FOR CHEMOTHERAPY AND RADIATION THERAPY.** Please refer to the preauthorization information shown in Section 3, *Other services*, for additional details on preauthorization and to this Section (*Treatment therapies*).

Benefits Description	You pay After the calendar year deductible...
Note: The calendar year deductible applies to almost all benefits in this Section. We say “(No deductible)” when it does not apply.	
Diagnostic and treatment services	
<ul style="list-style-type: none"> • Professional services of physicians during a hospital stay, skilled nursing facility stay, in the physician’s office, at home, or consultations (including video conferencing if performed when a member is hospitalized outside the United States) • Office consultation including second opinion • Psychological tests and pharmacological visits • Drugs and medical supplies billed by a physician 	<p>PPO: 10% of the Plan allowance</p> <p>Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount</p> <p>Providers outside the 50 United States: 10% of the Plan allowance</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Telephone consultations</i> • <i>Procedures, services, drugs, and supplies related to impotency, sex transformations, sexual dysfunction, or sexual inadequacy</i> • <i>Office visits by a dentist in relation to the removal of impacted teeth and other dental services. Office visits by a dentist in relation to covered oral and maxillofacial surgical procedures are covered.</i> 	<i>All charges</i>

Benefits Description	You pay After the calendar year deductible...
Lab, X-ray and other diagnostic tests	
<p>Tests, such as:</p> <ul style="list-style-type: none"> • Blood tests • Urinalysis • Non-routine Pap tests • Pathology • X-rays • Non-routine mammograms • CT Scan/PET Scan/MRI <p>Note: Preauthorization is required for all High End Radiology procedures, such as but not limited to, CT Scans, PET Scans and MRIs except in the case of an accident or a medical emergency. See Section 3, <i>Other services</i>.</p> <ul style="list-style-type: none"> • Ultrasound • Electrocardiogram and EEG • Hearing exam for non-auditory illness or disease • FDA recommended pharmacogenetic testing to optimize prescription drug therapies used to treat certain conditions, such as: <ul style="list-style-type: none"> - For prevention of major adverse cardiovascular events (Plavix) - For prevention of blood clots (Warfarin) <p>Note: These tests are covered also under Section 5(f), <i>Prescription drug benefits</i></p> <p>Note: The Plan may add tests as they are recommended by the FDA.</p>	<p>PPO: 10% of the Plan allowance</p> <p>Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount</p> <p>Providers outside the 50 United States: 10% of the Plan allowance</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Automated laboratory professional fee charges</i> 	<i>All charges</i>
Preventive care, adult	
<p>One routine physical examination to include a history and physical, chest X-ray, urinalysis, blood tests such as general health panel basic or comprehensive metabolic test, CBC, and EKG (electrocardiogram) per person, per calendar year</p> <p>Note: This includes a separate gynecological exam once per calendar year for women.</p>	<p>PPO: Nothing (No deductible)</p> <p>Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount</p> <p>Providers outside the 50 United States: Nothing (No deductible)</p>
<p>Well woman benefits including:</p> <ul style="list-style-type: none"> • Routine pap test on an annual basis • Human papillomavirus testing for women age 30 and up once every three years • Counseling for sexually transmitted infections • Counseling and screening for human immune-deficiency virus on an annual basis • Contraceptive methods and counseling • Screening and counseling for interpersonal and domestic violence 	<p>PPO: Nothing (No deductible)</p> <p>Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount</p> <p>Providers outside the 50 United States: Nothing (No deductible)</p>

Preventive care, adult - continued on next page

Benefits Description	You pay After the calendar year deductible...
Preventive care, adult (cont.)	
<p>In addition Routine Cancer Screenings, including:</p> <ul style="list-style-type: none"> • Colorectal Cancer Screening: <ul style="list-style-type: none"> - Fecal occult blood test – one annually - Sigmoidoscopy, screening – one every five years for members age 50 and older - Colonoscopy, screening, including facility and anesthesia charges related to the colonoscopy exam – one every 10 years for members age 50 and older - Double Contrast Barium Enema (DCBE) – one every five years for members age 50 and older <p>Note: Age and frequency limitations do not apply to colorectal cancer screenings if there is a family history or high risk factor that indicates the need for screenings.</p> <ul style="list-style-type: none"> • Breast Cancer Screening (Mammogram) – one annually for women age 35 and older <p>Note: Age and frequency limitations do not apply to breast cancer screenings if there is a family history or high risk factor that indicates the need for screenings.</p> <ul style="list-style-type: none"> • Cervical Cancer Screening <ul style="list-style-type: none"> - Pap smear – once per calendar year for women • Prostate Cancer Screening <ul style="list-style-type: none"> - Prostate Specific Antigen (PSA) – one annually for men age 40 and older <p>Other Routine Services, including:</p> <ul style="list-style-type: none"> • Blood cholesterol and/or lipid panel/profile – one per person, per calendar year • One-time ultrasonography for abdominal aortic aneurysm screening for males between the ages of 65 to 75 who have smoked • Annual chlamydial screening • Fasting lipoprotein profile test – one per person, per calendar year • Annual osteoporosis routine screening for members age 60 and older 	<p>PPO: Nothing (No deductible)</p> <p>Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount</p> <p>Providers outside the 50 United States: Nothing (No deductible)</p>

Preventive care, adult - continued on next page

Benefits Description	You pay After the calendar year deductible...
Preventive care, adult (cont.)	
<p>Adult routine immunizations (including administration) endorsed by the Centers for Disease Control and Prevention (CDC) per their Recommended Adult Immunization Schedule by Vaccine and Age Group.</p> <p>Note: The Plan has no age limitations on Influenza, Pneumococcal, Human Papillomavirus (HPV) and Zostavax (Shingles) vaccines.</p> <p>Note: These benefits do not apply to children under age 22 (See <i>Preventive care, children</i>).</p>	<p>PPO: Nothing (No deductible)</p> <p>Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount</p> <p>Providers outside the 50 United States: Nothing (No deductible)</p>
Preventive care, children	
<p>Immunizations for children (including administration) are limited to:</p> <ul style="list-style-type: none"> • Childhood immunizations recommended by the American Academy of Pediatrics are covered for members under age 22. 	<p>PPO: Nothing (No deductible)</p> <p>Non-PPO: Only the difference between our allowance and the billed amount (No deductible)</p> <p>Providers outside the 50 United States: Nothing (No deductible)</p>
<p>Preventive care for children is limited to:</p> <ul style="list-style-type: none"> • All healthy newborn visits including routine screening (inpatient or outpatient) • Retinal screening exam performed by an ophthalmologist for infants with low birth weight, less than 1 year of age and with an unstable clinical course • Screening, testing, diagnosis and treatment (including hearing aids) for hearing loss • Body Mass Index measurements beginning at age 24 months • The following routine services as recommended by the American Academy of Pediatrics for children up to the age of 22, including children living, traveling or adopted from outside the 50 United States: <ul style="list-style-type: none"> - Routine physical examinations - Routine hearing tests - Laboratory tests - Related office visits <p>Note: A gynecological exam and Pap smear once per calendar year for women under the age of 22, if medically recommended, are covered under Preventive care, adult.</p> <p>Note: Dependent children 22 and older are covered under Preventive care, adult.</p>	<p>PPO: Nothing (No deductible)</p> <p>Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount (No deductible)</p> <p>Providers outside the 50 United States: Nothing (No deductible)</p>

Benefits Description	You pay After the calendar year deductible...
Maternity care <p>Complete maternity (obstetrical) care, such as:</p> <ul style="list-style-type: none"> • Prenatal care (including laboratory tests) <p>Note: See Section 5(h), <i>Special features</i> for information on the Plan's Healthy Pregnancy Program</p> <ul style="list-style-type: none"> • Emergency room and specialty visits for complication of pregnancy • Delivery • Postnatal care • Sonograms • Amniocentesis • Gestational diabetes screening – once per pregnancy • Breastfeeding support, supplies and counseling for each birth <p>Note: Here are some things to keep in mind:</p> <p>You do not need to precertify your normal delivery; see Section 3, <i>How you get care</i> for other circumstances when you must precertify, such as extended stays for you or your baby.</p> <p>You may remain in the hospital up to 48 hours after a regular delivery and 96 hours after a cesarean delivery. We will cover an extended stay if medically necessary. See Section 3, <i>How you get care</i> for other circumstances.</p>	<p>PPO: Nothing (No deductible)</p> <p>Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount (No deductible)</p> <p>Providers outside the 50 United States: Nothing (No deductible)</p>
<ul style="list-style-type: none"> • For facility care related to maternity, including care at birthing facilities, we pay at the inpatient hospital rate in accordance with Section 5(c), <i>Inpatient hospital</i> of the brochure. • We consider bassinet or nursery charges during the covered portion of the mother's maternity stay to be the expenses of the mother and not expenses of the newborn child. We consider expenses of the child after the mother's discharge to be the expenses of the child. We cover these expenses only if the child is covered by a Self and Family enrollment. <i>Surgical benefits</i>, not <i>Maternity benefits</i>, apply to circumcision. <p>Note: Maternity care expenses incurred by a Plan member serving as a surrogate mother are covered by the Plan subject to reimbursement from the other party to the surrogacy contract or agreement. The involved Plan member must execute our Reimbursement Agreement against any payment she may receive under a surrogacy contract or agreement. Expenses of the new-born child are not covered under this or any other benefit in a surrogate mother situation.</p>	<p>Note: If your child stays after your discharge and is covered under a Self and Family enrollment, you must pay a separate hospital copayment of \$200 for non-PPO facilities. <i>If your child is not covered under a Self and Family enrollment, you pay all of your child's charges after your discharge.</i></p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Procedures, services, drugs, and supplies related to abortions except when the life of the mother would be endangered if the fetus were carried to term or when the pregnancy is the result of an act of rape or incest</i> 	<p><i>All charges</i></p>

Benefits Description	You pay After the calendar year deductible...
Family planning	
<p>A range of voluntary family planning services, including patient education and counseling, limited to:</p> <ul style="list-style-type: none"> • Voluntary sterilization (See Section 5(b), <i>Surgical procedures</i>) • Injection of contraceptive drugs (such as Depo-Provera) • Surgically implanted contraceptives to include fitting, inserting or removing intrauterine devices (IUDs) (See Section 5(b), <i>Surgical procedures</i>) <p>Note: We cover oral contraceptive drugs, diaphragms, cervical caps, vaginal rings, and contraceptive hormonal patches (see Section 5(f), <i>Prescription Drug Benefits</i>).</p>	<p>PPO: Nothing (No deductible)</p> <p>Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount (No deductible)</p> <p>Providers outside the 50 United States: Nothing (No deductible)</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Reversal of voluntary surgical sterilization</i> • <i>Genetic counseling, testing or screening</i> • <i>Contraceptive management</i> 	<p><i>All charges</i></p>
Infertility services	
<p>Diagnosis and treatment of infertility, except as shown in <i>Not covered</i>, includes:</p> <ul style="list-style-type: none"> • Initial diagnostic tests and procedures done only to identify the cause of infertility; • Fertility drugs, hormone therapy and related services; and • Medical or surgical procedures done to create or enhance fertility. <p>Note: Prescription drugs may not be purchased through the Plan's Prescription drug benefit. You must file a claim for them under this benefit.</p>	<p>PPO: 10% of the Plan allowance</p> <p>Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount</p> <p>Providers outside the 50 United States: 10% of the Plan allowance</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Infertility services after voluntary sterilization</i> • <i>Assisted reproductive technology (ART) procedures, such as:</i> <ul style="list-style-type: none"> - <i>Artificial insemination</i> - <i>In vitro fertilization</i> - <i>Embryo transfer and gamete intrafallopian transfer (GIFT)</i> - <i>Zygote intrafallopian transfer (ZIFT)</i> - <i>Intracytoplasmic sperm injection (ICSI)</i> - <i>Intravaginal insemination (IVI)</i> - <i>Intracervical insemination (ICI)</i> - <i>Intrauterine insemination (IUI)</i> • <i>Services and supplies related to ART procedures</i> • <i>Infertility drugs used in conjunction with ART Procedures</i> • <i>Costs of donor sperm and donor egg</i> 	<p><i>All charges</i></p>

Benefits Description	You pay After the calendar year deductible...
Allergy care	
<p>Testing, treatment and injections including materials (such as allergy serum)</p>	<p>PPO: 10% of the Plan allowance</p> <p>Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount</p> <p>Providers outside the 50 United States: 10% of the Plan allowance</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Provocative food testing, end point titration techniques, sublingual allergy desensitization, RAST tests and hair analysis</i> 	<p><i>All charges</i></p>
Treatment therapies	
<ul style="list-style-type: none"> • Chemotherapy and radiation therapy (includes radium and radioactive isotopes) <p>Note: Chemotherapy and radiation therapy require preauthorization. See Section 3, <i>Other services</i>.</p> <p>Note: High dose chemotherapy in association with autologous bone marrow transplants is limited to those transplants listed in Section 5(b), <i>Organ/tissue transplants</i>.</p> <p>Note: See Section 5(h), <i>Special features</i> for more information on how you can take advantage of the Plan's Cancer Management Program that provides education and nursing support for cancer patients.</p> <ul style="list-style-type: none"> • Intravenous (IV)/Infusion Therapy (supplies) – Home IV and antibiotic therapy (supplies) <p>Note: See also <i>Home health services</i> this Section.</p> <ul style="list-style-type: none"> • Growth hormone therapy • Respiratory and inhalation therapies (includes oxygen and equipment for its administration) • Cardiac rehabilitation therapy <p>Note: The Plan provides benefits only for Phase 1 and Phase 2 cardiac rehabilitation therapy.</p> <ul style="list-style-type: none"> • Renal dialysis (includes other covered charges associated with the dialysis treatment) 	<p>PPO: 10% of the Plan allowance</p> <p>Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount</p> <p>Providers outside the 50 United States: 10% of the Plan allowance</p>

Benefits Description	You pay After the calendar year deductible...
Physical, occupational and speech therapies	
<p>125 total combined outpatient physical, occupational and speech therapy visits per calendar year for all three listed therapies provided by:</p> <ul style="list-style-type: none"> • Licensed physical therapists • Licensed physicians • Licensed occupational therapists • Licensed speech therapists <p>Note: We only cover physical, occupational and speech therapy when a physician:</p> <ul style="list-style-type: none"> • orders the care; • identifies the specific professional skills the patient requires and the medical necessity for skilled services; and • indicates the frequency and length of time the services are needed. <p>Note: We only cover physical and occupational therapy to restore bodily function when there has been a total or partial loss of bodily function due to illness or injury.</p> <p>Note: We cover physical, occupational and speech therapy for the diagnosis of autism.</p> <p>Note: Physical, occupational and speech therapies rendered in a home health care setting are included in this benefit and do not require preauthorization.</p>	<p>PPO: 10% of the Plan allowance</p> <p>Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount</p> <p>Providers outside the 50 United States: 10% of the Plan allowance</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Custodial care (see Section 10, Definitions)</i> • <i>Exercise programs</i> 	<p><i>All charges</i></p>
Hearing services (testing, treatment, and supplies)	
<ul style="list-style-type: none"> • For treatment related to illness or injury, including evaluation and diagnostic hearing tests performed by an M.D., D.O., or audiologist <p>Note: For benefits for the devices, see this Section, <i>Orthopedic and prosthetic devices</i>.</p> <p>Note: For child hearing aid exams and child hearing aids see this Section, <i>Preventive care, children</i>.</p>	<p>PPO: Nothing (No deductible)</p> <p>Non-PPO: Nothing up to the Plan allowance and any difference between our allowance and the billed amount</p> <p>Providers outside the 50 United States: Nothing (No deductible)</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Hearing services that are not shown as covered</i> 	<p><i>All charges</i></p>

Benefits Description	You pay After the calendar year deductible...
Vision services (testing, treatment, and supplies)	
<p>One pair of eyeglasses or contact lenses and refractions per incident if required to correct an impairment directly caused by:</p> <ul style="list-style-type: none"> • Accidental ocular injury • Intraocular surgery for removal of cataracts • Keratoconus • Glaucoma <p>Note: Expenses in relation to an accident or intraocular surgery for removal of cataracts must be incurred within one year of the date of the accident or surgery.</p>	<p>PPO: 10% of the Plan allowance</p> <p>Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount</p> <p>Providers outside the 50 United States: 10% of the Plan allowance</p>
<p>Not covered:</p> <ul style="list-style-type: none"> • Routine eye examinations, except when needed for covered eyeglasses or contact lenses above • Deluxe lens features for eyeglasses or contact lenses such as special coating, polarization, UV treatment, etc. • Multifocal, accommodating, toric, or other premium intraocular lenses (IOLs) including Crystalens, ReStor, and ReZoom • Eyeglasses or contact lenses, except as shown above • Eye exercises and visual training (orthoptics) • Refractions, except as noted above • All refractive surgeries, except as noted above 	<i>All charges</i>
Foot care	
<p>Routine foot care when you are under active treatment for a metabolic or peripheral vascular disease, such as diabetes</p>	<p>PPO: 10% of the Plan allowance</p> <p>Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount</p> <p>Providers outside the 50 United States: 10% of the Plan allowance</p>
<p>Foot orthotic devices prescribed by a physician and custom fitted for the feet, including necessary repair and adjustment</p> <p>Note: Foot orthotic devices for the feet include, but are not limited to:</p> <ul style="list-style-type: none"> • Impression casting; and • Corrective shoes for treatment of malformation and weakness of the foot. 	<p>PPO, Non-PPO and Providers outside the 50 United States: Nothing (No deductible) up to \$250 per device, per foot, per person, per calendar year and all charges after \$250 per device, per foot, per person, per calendar year and then one replacement per device, per foot, per person, per calendar year</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>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</i> • <i>Treatment of flat feet</i> 	<i>All charges</i>

Benefits Description	You pay After the calendar year deductible...
Orthopedic and prosthetic devices	
<ul style="list-style-type: none"> • Artificial limbs and eyes • Stump hose • Externally worn breast prostheses and surgical bras, including necessary replacements following a mastectomy • Corrective orthopedic appliances for non-dental treatment of temporomandibular joint (TMJ) pain dysfunction syndrome • Internal prosthetic devices, such as artificial joints, pacemakers, and surgically implanted breast implant following mastectomy • Elastic stockings and support hose that require a physician's written prescription <p>Note: For information on the professional charges for the surgery to insert an implant, see Section 5(b), <i>Surgical and anesthesia services</i>. For information on the hospital and/or ambulatory surgery center benefits, see Section 5(c), <i>Services provided by a hospital or other facility, and ambulance services</i>.</p> <p>Note: A prosthetic device is surgically inserted or physically attached to the body to restore a bodily function or replace a physical portion of the body.</p> <p>Note: See Section 5(b), <i>Surgical and anesthesia services</i> for coverage of the surgery to insert the device and Section 5(c), <i>Services provided by a hospital or other facility, and ambulance services</i>, if billed by the facility.</p>	<p>PPO: 10% of the Plan allowance</p> <p>Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount</p> <p>Providers outside the 50 United States: 10% of the Plan allowance</p>
<ul style="list-style-type: none"> • Wigs needed as a result of chemotherapy or radiation treatment for cancer 	<p>PPO, Non-PPO and Providers outside the 50 United States: Nothing (No deductible) up to \$500 per wig limited to one wig per person, per calendar year and all charges after \$500 per wig, per person, per calendar year</p>
<ul style="list-style-type: none"> • One adult hearing aid device, per ear and related devices, including implanted hearing-related devices such as bone anchored hearing aids (BAHA) and cochlear implants – one replacement per device, per ear, per person every 5 consecutive years <p>Note: Child hearing aid exams and child hearing aids are covered under Preventive care, children.</p>	<p>PPO, Non-PPO and Providers outside the 50 United States: Nothing (No deductible) up to the Plan maximum of \$1,500 per device, per ear, per person with one replacement per device, per ear, per person every 5 years and all charges after the Plan maximum</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Orthopedic and corrective shoes, arch supports, heel pads and heel cups except as listed in Foot care, page 36</i> • <i>Lumbosacral supports</i> • <i>Corsets, trusses, elastic stockings, support hose, and other supportive devices except as noted above</i> • <i>Prosthetic replacements provided less than 3 years after the last one we covered unless a replacement is needed for medical reasons</i> • <i>Foot orthotics, except as provided under Foot care, page 36</i> 	<p><i>All charges</i></p>

Benefits Description	You pay After the calendar year deductible...
<p>Durable medical equipment (DME)</p> <p>Durable medical equipment (DME) is equipment and supplies that:</p> <ul style="list-style-type: none"> • Are prescribed by your attending physician (i.e., the physician who is treating your illness or injury) • Are medically necessary • Are primarily and customarily used only for a medical purpose • Are generally useful only to a person with an illness or injury • Are designed for prolonged use • Serve a specific therapeutic purpose in the treatment of an illness or injury <p>We cover rental, up to the purchase price, or purchase (at our option), including necessary repair and adjustment, of durable medical equipment such as:</p> <ul style="list-style-type: none"> • Wheelchairs • Hospital beds • Oxygen and equipment for its administration • Dialysis equipment • Crutches • Braces • Casts, splints, and trusses • Walkers <p>Seat lift mechanisms for lift chairs based on the following criteria:</p> <ul style="list-style-type: none"> • The patient must have severe arthritis of the hip or knee or a severe neuromuscular disease. • The seat lift mechanism must be a part of the physician's course of treatment and be prescribed to affect movement, or arrest or retard deterioration in the patient's condition. • The patient must be completely incapable of standing up from a regular armchair or any chair in their home. • Once standing, the patient must have the ability to walk. • Coverage is limited to seat lift mechanism even if incorporated into a chair. <p>Also included are:</p> <ul style="list-style-type: none"> • Medical supplies, appliances, medical equipment, and any covered items billed by a hospital for use at home (Note: calendar year deductible applies). 	<p>PPO: 10% of the Plan allowance</p> <p>Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount</p> <p>Providers outside the 50 United States: 10% of the Plan allowance</p>
<p>Augmentative and alternative communications (AAC) devices such as:</p> <ul style="list-style-type: none"> • Computer story boards • Light talkers • Enhanced vision systems • Speech aid prostheses for pediatrics • Speech aid prostheses for adults • Magnifier Viewing System • Script Talk reader devices 	<p>PPO, Non-PPO and Providers outside the 50 United States: Nothing (No deductible) up to one device per person, per calendar year up to the Plan allowance of \$1,000 per device, per person, per calendar year and all charges after \$1,000 per device</p>

Durable medical equipment (DME) - continued on next page

Benefits Description	You pay After the calendar year deductible...
Durable medical equipment (DME) (cont.)	
<p>Note: For surgical insertion of speech aid prostheses, see Section 5(b), <i>Surgical procedures</i>.</p>	<p>PPO, Non-PPO and Providers outside the 50 United States: Nothing (No deductible) up to one device per person, per calendar year up to the Plan allowance of \$1,000 per device, per person, per calendar year and all charges after \$1,000 per device</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Other items that do not meet the definition of durable medical equipment such as sun or heat lamps, whirlpool baths, heating pads, cold therapy units, air purifiers, humidifiers, air conditioners, and exercise devices</i> • <i>Charges for service contracts for purchased or rented equipment, except for purchased oxygen concentrators</i> • <i>Equipment replacements provided less than 3 years after the last one we covered unless damaged or defective and unrepairable</i> 	<p><i>All Charges</i></p>
Home health services	
<p>For services provided on a part-time basis (less than an 8-hour shift):</p> <p>If you preauthorize your home health care, 90 visits per calendar year when:</p> <ul style="list-style-type: none"> • a Registered Nurse (R.N.) or Licensed Practical Nurse (L.P.N.) provides the services; • a licensed social worker provides the services (limited to two visits per calendar year); • a home health aide provides services under the supervision of a Registered Nurse (R.N.) consisting of mainly medical care and therapy provided solely for the care of the insured person; • the attending physician orders the care; and • the physician identifies the specific professional skills required by the patient and the medical necessity for skilled services; and indicates the length of time the services are needed. • A home health agency (or visiting nurses where services of a home health agency are not available) must furnish the care in accord with a home health care plan (see definition below). The home health care plan must be certified by your physician and furnished in your home. <p>Note: We define home health agency as a public or private agency or organization appropriately licensed, qualified and operated under the law of the state in which it is located.</p> <p>Note: We define home health care plan as a written plan, approved in writing by a physician, for continued care and treatment of a Plan member:</p> <ul style="list-style-type: none"> • who is under the care of a physician; and • who would need a continued stay in a Hospital or Skilled Nursing Facility without the home health care. 	<p>For preauthorized home health care:</p> <p>PPO: 10% of Plan allowance and any visits above 90 visits per calendar year (No deductible); and all charges above one visit per day</p> <p>Non-PPO: 30% of Plan allowance and any difference between our allowance and the billed amount and any visits above 90 visits per calendar year (No deductible); and all charges above one visit per day</p> <p>Providers outside the 50 United States: 10% of Plan allowance and any visits above 90 visits per calendar year (No deductible); and all charges above one visit per day. Preauthorization not required.</p>

Home health services - continued on next page

Benefits Description	You pay After the calendar year deductible...
Home health services (cont.)	
<p>Note: Physical, occupational and/or speech therapy services performed in an outpatient setting and/or at home will count toward the 125-therapy visit limitation per calendar year, as listed in Section 5(a), <i>Physical, occupational and speech therapy</i>.</p> <p>Note: Home health services rendered outside the 50 United States do not require preauthorization.</p>	<p>For preauthorized home health care:</p> <p>PPO: 10% of Plan allowance and any visits above 90 visits per calendar year (No deductible); and all charges above one visit per day</p> <p>Non-PPO: 30% of Plan allowance and any difference between our allowance and the billed amount and any visits above 90 visits per calendar year (No deductible); and all charges above one visit per day</p> <p>Providers outside the 50 United States: 10% of Plan allowance and any visits above 90 visits per calendar year (No deductible); and all charges above one visit per day. Preauthorization not required.</p>
<p>For services provided on a part-time basis (less than an 8-hour shift):</p> <p>If you do not preauthorize your home health care, 40 visits per calendar year subject to the provisions on the previous page.</p> <p>Note: Preauthorized and Non-preauthorized visits are combined. Visit limit not to exceed 90 visits per calendar year.</p> <p>Note: Home health services rendered outside the 50 United States do not require preauthorization. See benefit for preauthorized care on previous page.</p>	<p>For non-preauthorized home health care:</p> <p>PPO: 10% of Plan allowance and any visits above 40 visits per calendar year (No deductible); and all charges above one visit per day</p> <p>Non-PPO: 30% of Plan allowance and any difference between our allowance and the billed amount and any visits above 40 visits per calendar year (No deductible); and all charges above one visit per day</p> <p>Providers outside the 50 United States: Preauthorization not required. See benefit for preauthorized home health care.</p>
<p>For private duty nursing we pay \$12 per hour when provided on a full-time basis (more than an 8-hour shift) by a Registered Nurse (R.N.) or Licensed Practical Nurse (L.P.N.) when:</p> <ul style="list-style-type: none"> the care is ordered by the attending physician; and your physician identifies the specific professional nursing skills that you require, as well as the length of time needed. 	<p>Nothing (No deductible) up to \$12 per hour and all charges above \$12 per hour; and all charges after 500 hours per calendar year</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <i>Nursing care requested by, or for the convenience of, the patient or the patient's family</i> <i>Home care primarily for personal assistance that does not include a medical component and is not diagnostic, therapeutic, or rehabilitative</i> <i>Custodial care (see Section 10, Definitions)</i> 	<p><i>All charges</i></p>

Benefits Description	You pay After the calendar year deductible...
Chiropractic Covered services are limited to 40 visits per person, per calendar year: <ul style="list-style-type: none"> • Manipulation of the spine and extremities Note: Chiropractic is a system of therapy that attributes disease to abnormal function of the nervous system and attempts to restore normal function by manipulation of the spinal column and other body structures. Note: Initial consultation and X-rays are covered under, Section 5(a) <i>Diagnostic and treatment services</i> and also <i>Lab, X-ray and other diagnostic tests</i> .	PPO: Nothing (No deductible) up to the Plan maximum of \$60 per visit and then all charges up to the Plan allowance; and all charges above 40 visits per person, per calendar year Non-PPO and Providers outside the 50 United States: Nothing (No deductible) up to the Plan maximum of \$60 per visit; and all charges above \$60 per visit and/or 40 visits per person, per calendar year
Alternative treatments Acupuncture only when performed by an M.D., D.O., O.M.D., or L.Ac., limited to 40 visits per person, per calendar year Note: The Plan defines acupuncture as the practice of insertion of needles into specific exterior body locations to relieve pain, to induce surgical anesthesia, or for therapeutic purposes. Note: These providers are required to submit itemized bills and their Federal Tax I.D. Number (if a United States provider) as outlined in Section 7, <i>Filing a claim for covered services</i> .	PPO: Nothing (No deductible) up to the Plan maximum of \$60 per visit and then all charges up to the Plan allowance; and all charges above 40 visits per person, per calendar year Non-PPO and Providers outside the 50 United States: Nothing (No deductible) up to the Plan maximum of \$60 per visit; and all charges above \$60 per visit and/or 40 visits per person, per calendar year
Massage therapy only when performed by a Licensed Massage Therapist (LMT) or a Certified Massage Therapist (CMT), limited to 40 visits per person, per calendar year Note: These providers are required to submit itemized bills and their Federal Tax I.D. Number (if a United States provider) as outlined in Section 7, <i>Filing a claim for covered services</i> .	PPO: Nothing (No deductible) up to the Plan maximum of \$60 per visit and then all charges up to the Plan allowance; and all charges above 40 visits per person, per calendar year Non-PPO and Providers outside the 50 United States: Nothing (No deductible) up to the Plan maximum of \$60 per visit; and all charges above \$60 per visit and/or 40 visits per person, per calendar year
<i>Note covered:</i> <ul style="list-style-type: none"> • <i>Chelation therapy except for acute arsenic, gold, mercury or lead poisoning; or use of Desferoxamine in iron poisoning</i> • <i>Naturopathic services and medicines</i> • <i>Homeopathic services and medicines</i> <i>(Note: Services of certain alternative treatment providers may be covered in medically underserved areas. See Section 3, How you get care.)</i>	<i>All charges</i>

Benefits Description	You pay After the calendar year deductible...
Educational classes and programs	
<p>Coverage is limited to:</p> <p>Tobacco Cessation Program</p> <ul style="list-style-type: none"> Two quit attempts per calendar year as part of the Plan's Tobacco Cessation Program. The quit attempts include proactive telephone counseling and up to four tobacco cessation counseling sessions of at least 30 minutes each in each quit attempt. Over-the-counter (OTC) medications approved by the FDA to treat tobacco dependence can be obtained through the Tobacco Cessation Program at no charge (see Section 5(f), <i>Prescription drug benefits</i> for more details). <p>Note: If you would like to contact the Plan for more information or to enroll in the Tobacco Cessation Program, there are two ways to do this:</p> <ul style="list-style-type: none"> Online: Go to www.AFSPA.org/FSBP. Select "My Online Services". Log-in or register for "MyOnlineServices." Once you log on MOS, select "Wellness Tools", select "WellBeing Solutions" and then select "Quitnet Tobacco Cessation". After you view a description of the services, click the button to "ENROLL ONLINE NOW...." Phone: Call 1-866-577-8210 or 419-329-4683. A representative will ask you for an Authentication code (your 11 digit Plan ID number) and will assist you in completing the registration process. 	<p>PPO, Non-PPO and Providers outside the 50 United States: Nothing (No deductible)</p>
<p>Coverage is limited to:</p> <ul style="list-style-type: none"> Diabetic Education or training 	<p>PPO and Providers outside the 50 United States: 10% of the Plan allowance (No deductible)</p> <p>Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount (No deductible)</p>
<p>Coverage is limited to:</p> <ul style="list-style-type: none"> Nutritional counseling <p>Note: We cover dieticians and nutritionists who bill independently for nutritional counseling.</p> <p>Note: In addition, see the Plan's Mediterranean Wellness Program and Incentive in Section 5(h), <i>Special features</i>. This Program is designed to assist you with weight management. You may enroll in the Program and receive reimbursement for its expense upon completion of 80% of the Program. Upon completion of the program, you will be eligible to receive the Wellness Incentive described in Section 5(h), <i>Special features</i>.</p> <p>Note: See the Plan's benefit, TherapEase, in Section 5(h), <i>Special features</i>. This Program is tailored specifically to assist patients with cancer to achieve proper nutrition. There is no cost to you.</p>	<p>PPO, and Providers outside the 50 United States: 10% of the Plan allowance (No deductible)</p> <p>Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount (No deductible)</p> <p>Note: The Plan's Mediterranean Wellness Program is reimbursed at 100% (No deductible) once you complete at least 80% of the Program (see Section 5(h), <i>Special features</i>).</p> <p>Note: TherapEase is reimbursed at 100% (No deductible)</p>

Educational classes and programs - continued on next page

Benefits Description	You pay After the calendar year deductible...
Educational classes and programs (cont.)	
<p>Weight Management Program</p> <p>\$2,000 maximum benefit per program, per person, per calendar year</p> <p>Includes non-surgical outpatient treatment when diagnosed by a physician as having a Body Mass Index (BMI) over 30. Benefits are payable for the following medically necessary services:</p> <ul style="list-style-type: none"> • Initial evaluation by your physician • Follow-up visits to your physician • Individual or group behavioral counseling • Initial and follow-up lab tests • Maintenance counseling and follow-up visits for maintenance. <p>Expenses incurred for prescription drugs for weight loss and/or maintenance are payable only as shown under Section 5(f), <i>Prescription drug benefits</i> and are not applied to the maximum benefit limitation.</p>	<p>PPO, Non-PPO and Providers outside the 50 United States: Nothing (No deductible) up to \$2,000 per person, per calendar year and all charges after \$2,000 per person, per calendar year</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Body composition analysis</i> • <i>Nutritional supplements or food</i> • <i>Non-prescription items</i> • <i>Exercise or weight loss programs or equipment</i> • <i>Services that are not considered medically necessary</i> 	<p><i>All charges</i></p>

Section 5(b). Surgical and anesthesia services provided by physicians and other health care professionals

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- The calendar year deductible is: \$250 per person for PPO and Providers outside the 50 United States or \$300 for non-PPO providers (\$500 per family for PPO and Providers outside the 50 United States or \$600 per family for non-PPO providers). The calendar year deductible does not apply to any benefits in this Section. We added “(No deductible)” to show when the calendar year deductible does not apply.
- The non-PPO benefits are the standard benefits of this Plan. PPO benefits apply only when you use a PPO provider or when you use a provider outside the 50 United States. When no PPO provider is available in the PPO Network, 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.
- The amounts listed below are for the charges billed by a physician or other health care professional for your surgical care. Look in Section 5(c) for charges associated with the facility (i.e., hospital, surgical center, etc.).

Benefits Description	You pay
Note: The calendar year deductible does not apply to benefits in this Section. We say “(No deductible)” when it does not apply.	
Surgical procedures	
<p>A comprehensive range of services, such as:</p> <ul style="list-style-type: none"> • Operative procedures • Treatment of fractures, including casting • Normal post-operative care by the surgeon • Correction of amblyopia and strabismus • Endoscopy procedures • Biopsy procedures • Removal of tumors and cysts • Surgical treatment of morbid obesity (bariatric surgery) – a condition in which an individual has: 1) a Body Mass Index (BMI) equal to or greater than 40 or a BMI equal to or greater than 35 with comorbidities such as hypertension, heart disease, diabetes, sleep apnea, or hyperlipidemia which has persisted for a minimum of 5 years; and 2) has been under at least one physician supervised weight loss program for at least 6 months. The program should be multi-disciplinary by combining diet and nutritional counseling with an exercise program and a behavior modification program. Eligible members must be age 18 and older. • Insertion of internal prosthetic devices. See Section 5(a), <i>Orthopedic and prosthetic devices</i> for device coverage information. • Voluntary sterilization for men (e.g., vasectomy) • Treatment of burns <p>Note: Second opinion is covered under Section 5(a), <i>Diagnostic and treatment services</i> and in Section 5(h), <i>Special features, Overseas Second Opinion</i>.</p>	<p>PPO: 10% of the Plan allowance (No deductible)</p> <p>Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount (No deductible)</p> <p>Providers outside the 50 United States: 10% of the Plan allowance (No deductible)</p>

Surgical procedures - continued on next page
High Option Section 5(b)

Benefits Description	You pay
Surgical procedures (cont.)	
<ul style="list-style-type: none"> • Voluntary sterilization for women (e.g., tubal ligation) • Surgical implantation and removal of intrauterine devices (IUDs) • Surgical implantation and removal of contraceptive devices • Routine circumcision of a newborn child (only when the child is covered under a Self and Family enrollment) <p>For related services, see the applicable benefits section (i.e., for inpatient hospital benefits, see Section 5(c)).</p> <p>Note: Includes related services including anesthesia.</p>	<p>PPO: Nothing (No deductible)</p> <p>Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount (No deductible)</p> <p>Providers outside the 50 United States: Nothing (No deductible)</p>
<p>When multiple or bilateral surgical procedures are performed during the same operative session by the same surgeon, the Plan's benefit is determined as follows:</p> <ul style="list-style-type: none"> • For the primary procedure, the Plan's allowance • For the secondary procedure and any other subsequent procedures: <ul style="list-style-type: none"> - One-half of the Plan's allowance (unless the provider is a PPO or other participating provider in the United States and their contract provides for a different amount) <p>Note: This does not apply to providers outside the 50 United States.</p> <p>Note: For certain surgical procedures, we may apply a value of less than 50% for subsequent procedures.</p> <p>Note: Multiple or bilateral surgical procedures performed through the same incision are “incidental” to the primary surgery. That is, the procedure would not add time or complexity to patient care. We do not pay extra for incidental procedures.</p>	<p>PPO: Nothing (No deductible)</p> <p>Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount (No deductible)</p> <p>Providers outside the 50 United States: Nothing (No deductible)</p>
<ul style="list-style-type: none"> • Assistant Surgeon <p>Assistant surgical services provided by a surgeon when medically necessary to assist the primary surgeon. When a surgery requires an assistant surgeon, the Plan's allowance for the assistant surgeon is 16% of the allowance for the surgery (unless the provider is a PPO or other participating provider in the United States and their contract provides for a different amount).</p> <p>Note: This does not apply to providers outside the 50 United States.</p>	<p>PPO: 20% of the Plan allowance (No deductible)</p> <p>Non-PPO: 20% of the Plan allowance and any difference between our allowance and the billed amount (No deductible)</p> <p>Providers outside the 50 United States: 20% of the Plan allowance (No deductible)</p>
<ul style="list-style-type: none"> • Co-surgeons (inpatient/outpatient) <p>Note: When the surgery requires two surgeons with different skills to perform the surgery, the Plan's allowance for each surgeon is 62.5% of what it would allow for a single surgeon for the same procedure(s) (unless the provider is a PPO or other participating provider in the United States and their contract provides for a different amount).</p> <p>Note: This does not apply to providers outside the 50 United States.</p>	<p>PPO: 10% of the Plan allowance (No deductible)</p> <p>Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount (No deductible)</p> <p>Providers outside the 50 United States: 10% of the Plan allowance (No deductible)</p>

Surgical procedures - continued on next page

Benefits Description	You pay
Surgical procedures (cont.)	
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Cosmetic surgery except for the repair of accidental injuries; to correct a congenital anomaly; or for the reconstruction of a breast following a mastectomy</i> <p><i>Note: We define cosmetic surgery as any operative procedure or any portion of a procedure performed primarily to improve physical appearance and/or treat a mental condition through change in bodily form.</i></p> <ul style="list-style-type: none"> • <i>Providers: Certified Registered Nurse First Assistant (CRNFA) and a Certified Surgical Technologist (CST)</i> • <i>All refractive surgeries, except as noted in Section 5(a), Vision Services</i> • <i>Routine surgical treatment of conditions of the foot (see Section 5(a), Foot care,)</i> • <i>Services of a standby surgeon</i> • <i>Reversal of voluntary sterilization</i> • <i>Surgeries related to impotency, sex transformation, sexual dysfunction or sexual inadequacy</i> 	<p><i>All charges</i></p>
Reconstructive surgery	
<ul style="list-style-type: none"> • Surgery to correct a functional defect • Surgery to correct a condition caused by injury or illness if: <ul style="list-style-type: none"> - 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 (congenital anomaly). Examples of congenital anomalies are: protruding ear deformities; cleft lip; cleft palate; birth marks; webbed fingers and toes; and other conditions that we may determine to be congenital anomalies. We will not consider the term congenital anomaly to include conditions relating to teeth or intra-oral structures supporting the teeth. • All stages of breast reconstruction surgery following a mastectomy, such as: <ul style="list-style-type: none"> - 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), <i>Orthopedic and prosthetic devices</i> for coverage) <p><i>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 procedure.</i></p>	<p>PPO: 10% of the Plan allowance (No deductible)</p> <p>Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount (No deductible)</p> <p>Providers outside the 50 United States: 10% of the Plan allowance (No deductible)</p>

Reconstructive surgery - continued on next page

Benefits Description	You pay
Reconstructive surgery (cont.)	
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Cosmetic surgery except for repair of accidental injuries; to correct a congenital anomaly; or for reconstruction of a breast following mastectomy</i> <p><i>Note: We define cosmetic surgery as any operative procedure or any portion of a procedure performed primarily to improve physical appearance and/or treat a mental condition through change in bodily form.</i></p> <ul style="list-style-type: none"> • <i>Surgeries related to impotency, sex transformation, sexual dysfunction or sexual inadequacy</i> 	<p><i>All charges</i></p>
Oral and maxillofacial surgery	
<p>Oral surgical procedures, limited to:</p> <ul style="list-style-type: none"> • Reduction of fractures of the jaws or facial bones • Surgical correction of severe functional malocclusion only when we determine the correction of the malocclusion to be medically necessary • Removal of stones from salivary ducts • Excision of leukoplakia or malignancies • Excision of non-dentigerous cysts and incision of non-dentigerous abscesses • Surgical correction of temporomandibular joint (TMJ) dysfunction to include initial consultation and post operative medical exam • Surgical removal of impacted teeth, including anesthesia charges • Other surgical procedures not involving the teeth or their supporting structures 	<p>PPO: 10% of the Plan allowance (No deductible)</p> <p>Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount (No deductible)</p> <p>Providers outside the 50 United States: 10% of the Plan allowance (No deductible)</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Oral implants, transplants and related services except those required to treat accidental injuries as described under Section 5(g), Dental benefits</i> • <i>Procedures that involve the teeth or their supporting structures (such as the periodontal membrane, gingival and alveolar bone) except as provided under Section 5(g), Dental benefits</i> • <i>Excision of non-impacted teeth</i> 	<p><i>All charges</i></p>
Organ/tissue transplants	
<p>Solid organ transplants are subject to medical necessity and experimental/investigational review. Refer to Section 3, <i>Other services</i> for preauthorization procedures. The medical necessity limitation is considered satisfied for other tissue transplants if the patient meets the staging description. Solid organ transplants are limited to:</p> <ul style="list-style-type: none"> • Cornea • Heart • Heart/lung • Intestinal transplants <ul style="list-style-type: none"> - Small intestine - Small intestine with the liver - Small intestine with multiple organs, such as the liver, stomach, and pancreas 	<p>Plan-designated transplant network (see Centers of Excellence, Section 5(h), <i>Special features</i>) for organ/tissue transplant facility: 10% of the Plan allowance (No deductible)</p> <p>PPO: 20% of the Plan allowance (No deductible) subject to a maximum payable of \$400,000 per transplant (No catastrophic coverage)</p> <p>Non-PPO: 100% of all charges (No catastrophic coverage)</p> <p>Providers outside the 50 United States: 10% of the Plan allowance (No deductible)</p>

Organ/tissue transplants - continued on next page

Benefits Description	You pay
Organ/tissue transplants (cont.)	
<ul style="list-style-type: none"> Kidney Liver Lung single/bilateral/lobar Pancreas Autologous pancreas islet cell transplant (as an adjunct to total or near total pancreatectomy) only for patients with chronic pancreatitis <p>The tandem blood or marrow stem cell transplants for covered transplants below are subject to medical necessity review by the Plan. Refer to Section 3, <i>Other services</i> for preauthorization procedures.</p> <ul style="list-style-type: none"> Autologous tandem transplants for: <ul style="list-style-type: none"> AL Amyloidosis Multiple myeloma (de novo and treated) Recurrent germ cell tumors (including testicular cancer) <p>Blood or marrow stem cell transplants limited to the stages of the following diagnoses. For the diagnoses listed below, the medical necessity limitation is considered satisfied if the patient meets the staging description.</p> <ul style="list-style-type: none"> Allogeneic transplants for: <ul style="list-style-type: none"> Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia Advanced Hodgkin's lymphoma with reoccurrence (relapsed) Advanced non-Hodgkin's lymphoma with reoccurrence (relapsed) Acute myeloid leukemia Advanced Myeloproliferative Disorders (MPDs) Amyloidosis Chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL) Hemoglobinopathy Marrow failure and related disorders (i.e., Fanconi's, PNH, Pure Red Cell Aplasia) Myelodysplasia/Myelodysplastic syndromes Paroxysmal Nocturnal Hemoglobinuria Phagocytic/Hemophagocytic deficiency diseases (e.g., Wiskott-Aldrich syndrome) Severe combined immunodeficiency Severe or very severe aplastic anemia Autologous transplants for: <ul style="list-style-type: none"> Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia Advanced Childhood kidney cancers Advanced Ewing sarcoma Advanced Hodgkin's lymphoma with reoccurrence (relapsed) Advanced non-Hodgkin's lymphoma with reoccurrence (relapsed) Amyloidosis Breast cancer 	<p>Plan-designated transplant network (see Centers of Excellence, Section 5(h), <i>Special features</i>) for organ/tissue transplant facility: 10% of the Plan allowance (No deductible)</p> <p>PPO: 20% of the Plan allowance (No deductible) subject to a maximum payable of \$400,000 per transplant (No catastrophic coverage)</p> <p>Non-PPO: 100% of all charges (No catastrophic coverage)</p> <p>Providers outside the 50 United States: 10% of the Plan allowance (No deductible)</p>

Organ/tissue transplants - continued on next page

Benefits Description	You pay
Organ/tissue transplants (cont.)	
<ul style="list-style-type: none"> - Childhood rhabdomyosarcoma - Epithelial ovarian cancer - Mantle Cell (non-Hodgkin lymphoma) - Multiple myeloma - Neuroblastoma - Testicular, mediastinal, retroperitoneal, and ovarian germ cell tumors <p>Mini-transplants performed in a clinical trial setting (non-myeloablative, reduced intensity conditioning or RIC) for members with a diagnosis listed below are subject to medical necessity review by the Plan.</p> <p>Refer to Section 3, <i>Other services</i> for preauthorization procedures:</p> <ul style="list-style-type: none"> • Allogeneic transplants for: <ul style="list-style-type: none"> - Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia - Acute myeloid leukemia - Advanced Myeloproliferative Disorders (MPDs) - Advanced Hodgkin's lymphoma with reoccurrence (relapsed) - Advanced non-Hodgkin's lymphoma with reoccurrence (relapsed) - Amyloidosis - Chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL) - Hemoglobinopathy - Marrow failure and related disorders (i.e., Fanconi's, PNH, Pure Red Cell Aplasia) - Myelodysplasia/Myelodysplastic syndromes - Paroxysmal Nocturnal Hemoglobinuria - Severe combined immunodeficiency - Severe or very severe aplastic anemia • Autologous transplants for: <ul style="list-style-type: none"> - Acute lymphocytic or nonlymphocytic (i.e., myelogenous) leukemia - Advanced Hodgkin's lymphoma with reoccurrence (relapsed) - Advanced non-Hodgkin's lymphoma with reoccurrence (relapsed) - Amyloidosis - Neuroblastoma <p>Note: We cover related medical and hospital expenses of the donor when we cover the recipient. You are a recipient when you surgically receive a body organ(s) transplant. You are a donor when you surgically donate a body organ(s) for transplant surgery. Transplant surgery means transfer of a body organ(s) from the donor to the recipient.</p> <p>Note: We cover donor screening test for up to four potential bone marrow/stem cell transplant donors per year from individuals unrelated to the patient, in addition to testing of family members.</p>	<p>Plan-designated transplant network (see Centers of Excellence, Section 5(h), <i>Special features</i>) for organ/tissue transplant facility: 10% of the Plan allowance (No deductible)</p> <p>PPO: 20% of the Plan allowance (No deductible) subject to a maximum payable of \$400,000 per transplant (No catastrophic coverage)</p> <p>Non-PPO: 100% of all charges (No catastrophic coverage)</p> <p>Providers outside the 50 United States: 10% of the Plan allowance (No deductible)</p>

Organ/tissue transplants - continued on next page

Benefits Description	You pay
Organ/tissue transplants (cont.)	
<p>Note: The Plan has special arrangements with facilities (Centers of Excellence) to provide services for tissue and organ transplants (see Section 5(h), <i>Special features</i>). The network was designed to give you an opportunity to access providers that demonstrate high quality medical care for transplant patients. We also may assist you and one family member or caregiver with travel and lodging arrangements if you use one of our Centers of Excellence. Your physician can coordinate arrangements by calling a case manager in the Plan's Medical Management Department at 1-800-593-2354. For additional information regarding the transplant network, please call this number.</p>	<p>Plan-designated transplant network (see Centers of Excellence, Section 5(h), <i>Special features</i>) for organ/tissue transplant facility: 10% of the Plan allowance (No deductible)</p> <p>PPO: 20% of the Plan allowance (No deductible) subject to a maximum payable of \$400,000 per transplant (No catastrophic coverage)</p> <p>Non-PPO: 100% of all charges (No catastrophic coverage)</p> <p>Providers outside the 50 United States: 10% of the Plan allowance (No deductible)</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • Donor screening tests and donor search expenses, except those performed for the actual donor or as specified on the previous page • Services or supplies for, or related to, surgical transplant procedures for artificial or human organ transplants not listed as covered • Transplants not listed as covered • Services or supplies for, or related to, surgical transplant procedures performed at non-PPO facilities 	<p><i>All charges</i></p>
Anesthesia	
<p>Professional services provided in:</p> <ul style="list-style-type: none"> • Hospital (inpatient) • Hospital outpatient department • Skilled nursing facility • Ambulatory surgical center • Office <p>Note: Anesthesia rendered by a dentist only in relation to covered oral and maxillofacial surgery is also covered (see <i>Oral and maxillofacial surgery</i> this Section).</p>	<p>PPO: 10% of the Plan allowance (No deductible)</p> <p>Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount (No deductible)</p> <p>Providers outside the 50 United States: 10% of the Plan allowance (No deductible)</p>

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 other subsections in Section 5, the calendar year deductible applies to only a few benefits. We added “(calendar year deductible applies)”. The calendar year deductible is: \$250 per person for PPO and Providers outside the 50 United States or \$300 for non-PPO providers (\$500 per family for PPO and Providers outside the 50 United States or \$600 per family for non-PPO providers).
- The non-PPO benefits are the standard benefits of this Plan. PPO benefits apply only when you use a PPO provider or when you use a provider outside the 50 United States. When no PPO provider is available in the PPO Network, non-PPO benefits apply.
- When you use a PPO facility, keep in mind that the healthcare professionals who provide services to you in the facility may not be preferred providers in our PPO network. We will pay up to the Plan allowance at the preferred provider percentage for services you receive from non-PPO anesthesiologists (including Certified Registered Nurse Anesthetists), radiologists, pathologists, emergency room physicians and neonatologists. This provision also applies when a non-PPO surgeon’s immediate or emergency care is required. You will be responsible to pay the PPO coinsurance and any difference between the Plan allowance and billed amount for these non-PPO providers. When non-emergency care by non-PPO surgeons is provided, regular 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.
- 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), (b), (d) or (e).
- **YOU MUST GET PRECERTIFICATION FOR HOSPITAL STAYS; FAILURE TO DO SO WILL RESULT IN A \$500 PENALTY.** Please refer to the precertification information shown in Section 3 for additional details on precertification.
- **YOU ALSO MUST GET PREAUTHORIZATION FOR CARE YOU RECEIVE IN SKILLED NURSING FACILITIES, and HOME HEALTH CARE.** Please refer to this Section, *Extended care benefits/Skilled nursing care facility benefits* and Section 5(a) and *Home health services* for details on how your benefits are affected if you do not preauthorize. Also, please refer to the preauthorization information shown in Section 3 for additional details on preauthorization.

Note: We do not require precertification or preauthorization services you receive outside the 50 United States. However, the Plan will review all services to establish medical necessity. We may request medical records in order to determine medical necessity before and/or during continued treatment.

Note: We do not require precertification or preauthorization when Medicare Part A and/or B, or another group health insurance policy is the primary payor. Precertification or preauthorization is required, however, when Medicare or the other group health insurance policy stops paying benefits for any reason.

Benefits Description	You pay
Note: The calendar year deductible applies ONLY when we say below: “(calendar year deductible applies)”.	
Inpatient hospital	
<p>Room and board, such as:</p> <ul style="list-style-type: none"> • Ward, semiprivate, or intensive care accommodations • General nursing care • Meals and special diets <p>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, then we will consider the private room rate.</p> <p>Note: Staying overnight in a hospital does not always mean you are an inpatient. You are considered an inpatient the day a doctor formally admits you to a hospital with a doctor’s order. Confinement as an inpatient or an outpatient affects your out-of-pocket expenses. Always ask if you are an inpatient or an outpatient.</p> <p>Other services and supplies you receive while in a hospital, such as:</p> <ul style="list-style-type: none"> • Use of operating, recovery, maternity, and other treatment rooms • Rehabilitative services • Prescribed drugs and medicines for use in the hospital • X-ray, laboratory and pathology services and machine diagnostic tests • Blood or blood plasma, if not donated or replaced, and its administration • Dressings, splints, casts and sterile tray services • Medical supplies and equipment, including oxygen • Anesthetics, including nurse anesthetist services • Drugs, medical supplies, medical equipment, prosthetic and orthopedic devices and any covered items billed by a hospital for use at home (Note: We cover these items only under Section 5(a), <i>Medical services and supplies</i>, and the calendar year deductible and coinsurance apply.) • Special Overseas Benefit – Inpatient private duty nursing services by an R.N. or L.P.N. when the services are rendered outside of North America <p>Note: We provide specified benefits for professional services of a physician, even when billed by the hospital. For example, when the hospital bills for such professional services as surgery, anesthesiology, medical or therapy services, etc., we pay the specific surgery, anesthesia, medical or therapy benefit.</p> <p>Note: We cover hospital services and supplies related to dental procedures when necessitated by a non-dental physical impairment to safeguard the health of the patient, even though we may not cover the services of dentists or physicians in connection with the dental treatment.</p>	<p>PPO: Nothing</p> <p>Non-PPO: \$200 copayment per hospital stay and 20% of the covered charges</p> <p>Providers outside the 50 United States: Nothing</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Admission to nursing homes, rest homes, places for the aged, convalescent homes, or any place that is not a hospital, skilled nursing care facility, or hospice (see Section 3, Covered providers and Covered facilities)</i> 	<p><i>All charges</i></p>

Inpatient hospital - continued on next page

Benefits Description	You pay
Inpatient hospital (cont.)	
<ul style="list-style-type: none"> • Custodial care (see Section 10, Definitions) • Any part of a hospital admission that is not medically necessary (see Section 10, Definitions), 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 we would have covered if provided in an alternative setting. • Inpatient private duty nursing except as provided above • Personal comfort items, such as radio, television, beauty and barber services, identification tags, baby beads, footprints, guest cots and meals, newspapers and similar items • Inpatient hospital services/supplies for surgery we do not cover except as noted on the previous page for non-covered dental procedures 	All charges
Outpatient hospital or ambulatory surgical center	
<ul style="list-style-type: none"> • Operating, recovery, and other treatment rooms • Prescribed drugs and medicines for use in the facility • X-ray, laboratory and pathology services and machine diagnostic tests • Blood and blood plasma, if not donated or replaced, and its administration • Dressings, casts and sterile tray services • Medical supplies and equipment, including oxygen • Anesthetics and anesthesia service • Drugs, medical supplies, medical equipment, prosthetic and orthopedic devices and any covered items billed by a hospital for use at home (Note: We cover these items only under Section 5(a), <i>Medical services and supplies</i>, and the calendar year deductible and coinsurance apply.) <p>Note: We cover hospital services and supplies related to dental procedures when necessitated by a non-dental physical impairment to safeguard the health of the patient, even though we may not cover the services of dentists or physicians in connection with the dental treatment.</p>	<p>PPO: 10% of the Plan allowance (calendar year deductible applies)</p> <p>Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount (calendar year deductible applies)</p> <p>Providers outside the 50 United States: 10% of the Plan allowance (calendar year deductible applies)</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • Outpatient hospital services/supplies for surgery we do not cover except as noted above for non-covered dental procedures 	All charges
Extended care benefits/Skilled nursing care facility benefits	
<p>If you preauthorize your admission, we cover semiprivate room, board, services and supplies in a Skilled Nursing Facility (SNF) for up to 90 days per calendar year when the admission is:</p> <ul style="list-style-type: none"> • medically necessary; and • under the supervision of a physician. <p>Note: Admissions rendered outside the 50 United States do not require preauthorization.</p>	For preauthorized care: Nothing up to the Plan allowance for up to 90 days per calendar year and all charges after 90 days. Preauthorization not required for admissions outside the 50 United States.

Extended care benefits/Skilled nursing care facility benefits - continued on next page

Benefits Description	You pay
Extended care benefits/Skilled nursing care facility benefits (cont.)	
<p>Note: When Medicare A is primary, the initial days paid in full by Medicare are considered part of the 90 day per calendar year benefit.</p>	<p>For preauthorized care: Nothing up to the Plan allowance for up to 90 days per calendar year and all charges after 90 days. Preauthorization not required for admissions outside the 50 United States.</p>
<p>If you do not preauthorize your admission, we cover semiprivate room, board, services and supplies in a Skilled Nursing Facility (SNF) for up to 45 days per calendar year subject to the above conditions.</p> <p>Note: When Medicare A is primary, the initial days paid in full by Medicare are considered part of the 45 day per calendar year benefit.</p> <p>Note: Admissions rendered outside the 50 United States do not require preauthorization. See benefit for preauthorized admission.</p> <p>Note: Preauthorized and non-preauthorized days are combined. Day limit not to exceed 90 days per calendar year.</p>	<p>For non-preauthorized care: 20% up to the Plan allowance for up to 45 days per calendar year and all charges after 45 days. Preauthorization not required for admissions outside the 50 United States. See benefit for preauthorized admissions.</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <i>Custodial care (see Section 10, Definitions)</i> 	<p><i>All charges</i></p>
Hospice care	
<p>Note: This benefit does not apply to services covered under any other provisions of the Plan.</p> <p>Note: We define Hospice Care Program as a coordinated program of home or inpatient pain control and supportive care for a terminally ill patient and the patient's family. Care must be provided by a medically supervised team under the direction of an independent hospice administration that we approve.</p>	<p>PPO: 10% of Plan allowance (No deductible)</p> <p>Non-PPO: 30% of Plan allowance (No deductible) and any difference between our allowance and the billed amount</p> <p>Providers outside the 50 United States: 10% of Plan allowance (No deductible)</p>
Ambulance	
<ul style="list-style-type: none"> Professional ambulance service to the nearest facility equipped to handle your medical condition, including air ambulance, when medically necessary. 	<p>PPO: 10% of the Plan allowance</p> <p>Non-PPO: 10% of the Plan allowance and any difference between our allowance and the billed amount</p> <p>Providers outside the 50 United States: 10% of the Plan allowance</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <i>Ambulance transport for you or your family's convenience</i> 	<p><i>All charges</i></p>

Section 5(d). Emergency services/accidents

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- The calendar year deductible is: \$250 per person for PPO and Providers outside the 50 United States or \$300 for non-PPO providers (\$500 per family for PPO and Providers outside the 50 United States or \$600 per family for non-PPO providers). The calendar year deductible applies to some benefits in this Section. We added “(No deductible)” to show when the calendar year deductible does not apply.
- The non-PPO benefits are the standard benefits of this Plan. PPO benefits apply only when you use a PPO provider or when you use a provider outside the 50 United States. When no PPO provider is available in the PPO Network, non-PPO benefits apply.
- When you use a PPO facility, keep in mind that the healthcare professionals who provide services to you in the facility may not be preferred providers in our PPO network. We will pay up to the Plan allowance at the preferred provider percentage for services you receive from non-PPO anesthesiologists (including Certified Registered Nurse Anesthetists), radiologists, pathologists, emergency room physicians, neonatologists, and surgeons when immediate or emergency care is required. You will be responsible to pay the PPO coinsurance and any difference between the Plan allowance and billed amount for these 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.
- Preauthorization of High End Radiology procedures is not required in the case of an accident or a medical emergency. See Section 3, *Other services*.

What is an accidental injury?

An accidental injury is a bodily injury that requires immediate medical attention and is sustained solely through violent, external, and accidental means, such as broken bones, animal bites, insect bites and stings, and poisonings. We cover dental care required as a result of an accidental injury under Section 5(g), *Dental benefits*.

What is a medical emergency?

A medical emergency is the sudden and unexpected onset of a condition or an injury that you believe endangers your life or could result in serious injury or disability and requires immediate medical or surgical care. Medical emergencies include heart attacks, cardiovascular accidents, loss of consciousness or respiration, convulsions, and such other acute conditions that we determine to be medical emergencies.

Benefits Description	You pay After the calendar year deductible...
Note: The calendar year deductible applies to some benefits in this Section. We say “(No deductible)” when it does not apply.	
Accidental injury	
We pay 100% of the Plan allowance for the following care you receive as a result of an accidental injury: <ul style="list-style-type: none"> • Emergency Room (ER) and urgent care facility charges, ER and urgent care physician’s charges and ancillary services performed at the time of the ER or urgent care facility visit; or • Initial office visit and ancillary services performed at the time of the initial office visit for accidental injury. 	<p>PPO: Nothing (No deductible)</p> <p>Non-PPO: Only the difference between the Plan allowance and the billed amount (No deductible)</p> <p>Providers outside the 50 United States: Nothing (No deductible)</p>

Accidental injury - continued on next page

Benefits Description	You pay After the calendar year deductible...
Accidental injury (cont.)	
<p>Note: We pay for services performed outside the ER or urgent care facility under the appropriate Plan benefit.</p> <p>Note: We pay Hospital benefits as specified in Section 5(c), <i>Services provided by a hospital or other facility</i> if you are admitted to the hospital.</p> <p>Note: We pay medical supplies, medical equipment, prosthetic and orthopedic devices for use at home under Section 5(a), <i>Medical services and supplies</i>.</p> <p>Note: We pay prescription medications for use at home under Sections 5(a), 5(c) or 5(f) as appropriate.</p>	<p>PPO: Nothing (No deductible)</p> <p>Non-PPO: Only the difference between the Plan allowance and the billed amount (No deductible)</p> <p>Providers outside the 50 United States: Nothing (No deductible)</p>
Medical emergency	
<p>Regular Plan benefits apply to care you receive in the outpatient Emergency Room (ER) or physician's office because of a medical emergency (non-accident). Items covered include:</p> <ul style="list-style-type: none"> • Medical services and supplies • Physician services and supplies • X-ray, laboratory and pathology services and machine diagnostic tests • Professional services for anesthesia 	<p>PPO: 10% of the Plan allowance</p> <p>Non-PPO: 10% of the Plan allowance and any difference between our allowance and the billed amount</p> <p>Providers outside the 50 United States: 10% of the Plan allowance</p>
<ul style="list-style-type: none"> • Outpatient care in an urgent care facility because of a medical emergency 	<p>PPO: \$35 copayment per occurrence (No deductible)</p> <p>Non-PPO: \$35 copayment per occurrence and any difference between our allowance and the billed amount (No deductible)</p> <p>Providers outside the 50 United States: \$35 copayment per occurrence (No deductible)</p>
Ambulance	
<ul style="list-style-type: none"> • Professional ambulance service when medically necessary <p>Note: This benefit includes air ambulance service when medically necessary to transport you to the nearest facility equipped to handle your medical condition.</p>	<p>PPO: 10% of the Plan allowance (No deductible)</p> <p>Non-PPO: 10% of the Plan allowance and any difference between our allowance and the billed amount (No deductible)</p> <p>Providers outside the 50 United States: 10% of the Plan allowance (No deductible)</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • Ambulance transport for you or your family's convenience 	<p><i>All charges</i></p>

Section 5(e). Mental health and substance abuse benefits

You may choose to get care from a PPO or a non-PPO provider if you live in the United States. When you receive **any** care in the United States, you must get our approval for services and follow a treatment plan we approve. Cost-sharing and limitations for mental health and substance abuse benefits are no greater than for similar benefits for other illnesses and conditions.

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- The calendar year deductible or, for facility care, the inpatient copayment applies to almost all benefits in this Section. We added “(No deductible)” to show when the calendar year deductible does not apply.
- The non-PPO benefits are the standard benefits of this Plan. PPO benefits apply only when you use a PPO provider or when you use a provider outside the 50 United States. When no PPO provider is available in the PPO Network, 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.
- **YOU MUST GET PRECERTIFICATION/PREAUTHORIZATION/CONCURRENT REVIEW FOR THESE SERVICES.** If you fail to follow these procedures, the Plan may reduce your benefit. See the precertification and Other services information shown in Section 3, *How you get care*, and the instructions below.
 - To be eligible to receive mental health and substance abuse benefits you must obtain and follow a treatment plan and follow all of our authorization processes. This applies to all inpatient and outpatient hospital care, and all inpatient, outpatient or office care you receive from doctors and other covered providers. **See Section 3, *How you get care* for more details.**
 - **Precertification** establishes the medical necessity of your admission to a hospital, residential treatment center or other facility for you to receive full Plan benefits. **You must precertify any inpatient care before you receive it.** If you do not precertify, we will reduce the benefits payable by \$500. You must report emergency admissions within two business days following the day of admission even if you have been discharged.
 - **Preauthorization** establishes the medical necessity for all levels of outpatient or office care. **You must preauthorize any outpatient or office care before you receive it.** If you do not preauthorize, we will request information from your provider to review the services for medical necessity. This will delay your claim.
 - **Concurrent review (which means review of continuing treatment)** establishes the medical necessity for all levels of *continuing* outpatient or office care. **You must obtain concurrent review for any continuing outpatient or office care you receive before you receive continuing care.** If you do not obtain concurrent review or follow your treatment plan, we will request information from your provider to review the continued services for medical necessity. This will delay your claim.
 - **To precertify or preauthorize care and obtain concurrent review for continuing care,** you, your representative, your doctor or your hospital **must** call the Plan at 1-800-593-2354 prior to the admission or care.

Note: We do not require precertification, preauthorization or concurrent review for continuing care for services you receive outside the 50 United States. However, the Plan will review all services to establish medical necessity. We may request medical records in order to determine medical necessity.

Note: We do not require precertification, preauthorization or concurrent review when Medicare Part A and/or B, or another group health insurance policy is the primary payor. Precertification, preauthorization and concurrent review for continuing care is required, however, when Medicare or the other group health insurance policy stops paying benefits for any reason.

Benefits Description	You pay After the calendar year deductible...
Note: The calendar year deductible applies to almost all benefits in this Section. We say “(No deductible)” when it does not apply.	
Mental health and substance abuse benefits	
<p>All covered diagnostic and treatment services contained in a treatment plan that we approve. The treatment plan may include services, drugs, and supplies described elsewhere in this brochure.</p> <p>Note: Benefits are payable only when we determine the care is clinically appropriate to treat your condition and only when you receive the care as part of a treatment plan that we approve.</p> <p>Note: If you receive care outside the 50 United States, we do not require precertification, preauthorization or concurrent review for continuing care. However, the Plan will review all services to establish medical necessity. We may request medical records in order to determine medical necessity. See Section 3, <i>How you get care</i> for details.</p>	<p>Your cost-sharing responsibilities are no greater than for other illnesses or conditions.</p>
<p>Professional services including:</p> <ul style="list-style-type: none"> • Individual or group therapy when rendered by covered providers • Medication management – Note: We cover this under Section 5(a) pharmacological visits, no preauthorization required. • Diagnostic tests including psychological testing 	<p>PPO: 10% of the Plan allowance</p> <p>Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount</p> <p>Providers outside the 50 United States: 10% of the Plan allowance</p>
<ul style="list-style-type: none"> • Services provided by a hospital (including residential treatment center) or other facility 	<p>PPO inpatient facility: Nothing for room and board and other services (No deductible)</p> <p>Non-PPO inpatient facility: \$200 copayment per person, per hospital stay and 20% of covered charges for room and board and other services (No deductible)</p> <p>Providers outside the 50 United States: Nothing for room and board and other services (No deductible)</p>
<p>Services in approved alternative care settings such as:</p> <ul style="list-style-type: none"> • Intensive Outpatient Programs (IOP). Programs offer time-limited services that: <ul style="list-style-type: none"> - Are coordinated, structured, and intensively therapeutic; - Are designed to treat a variety of individuals with moderate to marked impairment in at least one area of daily life resulting from psychiatric or addictive disorders; and - Offer 3-4 hours of active treatment per day at least 2-3 days per week. • Partial Hospitalization. Partial hospitalization is a time-limited, ambulatory, active treatment program that: <ul style="list-style-type: none"> - Offers therapeutically intensive, coordinated and structured clinical services within a stable therapeutic milieu; and - Provides at least 20 hours of scheduled programming extended over a minimum of 5 days per week in either a licensed or JCAHO accredited facility. 	<p>PPO: 10% of the Plan allowance</p> <p>Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount</p> <p>Providers outside the 50 United States: 10% of the Plan allowance</p>

Mental health and substance abuse benefits - continued on next page

Benefits Description	You pay After the calendar year deductible...
Mental health and substance abuse benefits (cont.)	
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>See Section 6, General exclusions, for non-covered services</i> <p><i>Note: OPM will base its review of disputes about treatment plans on the treatment plan's clinical appropriateness. OPM will generally not order us to pay or provide one clinically appropriate treatment plan in favor of another.</i></p>	<i>All charges</i>

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 *Covered medications and supplies*, this Section.
- Please remember that all benefits are subject to the definitions, limitations and exclusions in this brochure and are payable only when we determine they are medically necessary.
- The calendar year deductible is: \$250 per person for PPO and Providers outside the 50 United States or \$300 for non-PPO providers (\$500 per family for PPO and Providers outside the 50 United States or \$600 per family for non-PPO providers). The calendar year deductible does not apply to any benefits in this Section. We added “(No deductible)” to show when the calendar year deductible does not apply.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost-sharing works. Also, read Section 9 for information about how we pay if you have other coverage, or if you are age 65 or over.
- **YOU MUST GET PRIOR AUTHORIZATION FOR CERTAIN DRUGS; AND PRIOR AUTHORIZATION MUST BE RENEWED PERIODICALLY.** Prior authorization uses Plan rules based on FDA-approved prescribing and safety information, clinical guidelines and uses that are considered reasonable, safe and effective. See the prior authorization information shown in Section 3, *Other Services* and in *Coverage management*, this Section for more information about this important program.

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

Who can write your prescription.

- A U.S. licensed physician or prescriber such as a nurse practitioner or physician assistant must write the prescription.

When you have to purchase a prescription.

- We will provide you with a Foreign Service Benefit Plan Identification (ID) Card.
- In most cases, you simply present the card together with the prescription to a network pharmacy. You do not file a prescription card claim with the Plan.

Where you can obtain your prescription.

- **Network Pharmacies within the 50 United States** - *Your prescriber must be licensed in the United States.*
 - You must fill your prescription at a network pharmacy participating with Express Scripts (ESI). You may obtain the names of network pharmacies by calling 1-800-818-6717 or on the Internet as a link through the Plan's Web site at www.AFSPA.org/FSBP (click on the “Prescription Coverage and Programs” tab on the right). **You must present your Foreign Service Benefit Plan ID Card when filling your prescription in order to receive this benefit. See dispensing limitations on next page. Prescriptions you purchase at network pharmacies without the use of your card are not covered.**
- **Non-Network Pharmacies in the 50 United States**
 - Prescriptions you purchase at non-network pharmacies in the 50 United States are not covered.
- **Mail Order (the Medco Pharmacy®) within the 50 United States** - *Your prescriber must be licensed in the United States.*
 - You will receive forms for refills and future prescription orders each time you receive drugs or supplies through the Medco Pharmacy. You also may order refills on the Internet by visiting the Plan's Web site at www.AFSPA.org/FSBP (click on the “Prescription Coverage and Programs” tab on the right). Using the Internet saves you time and effort for refills. If you have any questions about a particular drug or a prescription, or to request order forms, you may call 1-800-818-6717 in the United States. **Prescriptions you purchase by mail order from a source other than the Medco Pharmacy or Accredo Health Group (Accredo), the Plan's specialty pharmacy, are not covered.**
- To order by mail: 1) Complete the initial mail order form; 2) Enclose your prescription and copayment; 3) **Mail your order to the Medco Pharmacy** at Medco Health Solutions of Fort Worth, PO Box 650322, Dallas TX 75265-0322 (*do not mail your order to the Plan*); and 4) Allow approximately two weeks for delivery.

- **Retail Pharmacies outside the 50 United States**

- Fill your prescription as you normally do. **Mail claims for prescription drugs and supplies you purchased through a retail pharmacy outside the 50 United States to the Plan's address shown in Section 7, *Filing a claim for covered services* (do not mail foreign prescription claims to the Medco Pharmacy).** Claims must include receipts that show the name of the patient, prescription number, name of drug(s), name of the prescribing physician, name of the pharmacy, date, and the charge. You may obtain claim forms by calling 202-833-4910 or from our Web site at www.AFSPA.org/FSBP.

- **Mail order (the Medco Pharmacy®) outside the 50 United States - *Your prescriber must be licensed in the United States.***

- Use the same forms as for mail order within the 50 United States referenced on the previous page. If you have any questions about a particular drug or a prescription or to request order forms, you may call 1-800-497-4641 (available in over 140 countries) from outside the 50 United States. Also, you can call the Medco Pharmacy collect at 412-829-5932 or 412-829-5933 if the toll-free number for outside the 50 United States does not work for you.
- **Note: Per Federal regulations, the Medco Pharmacy can mail only to addresses in the United States or to APO, FPO, DPO and Pouch Mail addresses. Allow appropriate mailing time to reach them, for them to fill your prescription and for the prescription to reach you.**
- If you are posted, living or traveling outside the 50 United States, you may request up to a 1-year supply of most medications. Ask your prescriber to write you a prescription for a 1-year supply with no refills. Contact the Plan or refer to our Web site if you need additional assistance. There are limitations to sending temperature sensitive medications outside the 50 United States. Please contact the Medco Pharmacy if you have been prescribed a temperature sensitive medication.
- **Use the Internet through the Plan's Web site at www.AFSPA.org/FSBP (click on the "Prescription Coverage and Programs" tab on the right) to refill mail order medications via the Internet. Using the Internet saves you considerable time for refills compared to APO/FPO/DPO and Pouch Mail.**

These are the dispensing limitations.

- The Plan follows Food and Drug Administration (FDA) guidelines.
- You may purchase up to a 30-day supply of medication at a network pharmacy. Refills cannot be obtained until 50% of the drug has been used. You may not obtain more than a 30-day supply through the network pharmacy arrangement except in the following situations. If you do not contact us prior to purchasing your prescription when either of the following applies, the Plan will not supply more than a 30-day supply of medication and we will not reimburse you if you purchase more than a 30-day supply without the use of your Foreign Service Benefit Plan ID Card:
 - You are traveling to a foreign country, do not have time to use the Medco Pharmacy (mail order) and need to purchase more than a 30-day supply of prescriptions to take with you.
 - You are visiting the United States for a short time period, do not have time to use the Medco Pharmacy and need to purchase more than a 30-day supply of prescriptions to take with you.
- You may purchase long-term (up to a 90-day supply) prescription needs through the Medco Pharmacy (mail order) to receive higher benefits. Per the mail order reference above, if you are posted, living or traveling outside the 50 United states, you may request up to a 1-year supply of most medications.
 - We cover all drugs and supplies referenced on the following pages except for those that require constant temperature control (temperature sensitive), are too heavy to mail, or that must be administered by a physician.
- **As stated above, per Federal regulations, the Medco Pharmacy (mail order) can mail only to addresses in the United States or to APO, FPO, DPO and Pouch Mail addresses.**
- You may not obtain hormone therapy treatment (for infertility) with your Foreign Service Benefit Plan ID Card or through the Medco Pharmacy (mail order).
- **Coverage Management**
 - The Plan utilizes coverage management programs to help ensure that you receive the prescription drugs you need at a reasonable cost. The information below and on the next page describes a feature of your prescription drug Plan known as coverage management. This program determines how the Plan will cover certain medications.
 - **Prior authorization review may be required: Some medications are not covered unless you receive approval through a coverage review (prior authorization).**

- **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. There are other medications that may be covered with limits (for example, only for a certain amount or for certain uses) unless you receive approval through a coverage review. Examples of drug categories requiring prior authorization include, but are not limited to, growth hormones, certain hormone therapies, interferons, erythroid stimulants, anti-narcoleptics, sleep aids, migraine medication, and oncologic agents. During this review, the Medco Pharmacy asks your doctor for more information than what is on the prescription before the medication may be covered under the Plan. If coverage is approved, you simply pay your normal copayment for the medication. *If coverage is not approved, you will be responsible for the full cost of the medication.*
- The Plan will participate in other approved managed care programs, as deemed necessary, to insure patient safety and appropriate quantities in accordance with the Plan rules based on FDA-approved guidelines referenced above.
- To find out if your prescription requires prior authorization or more about our coverage management program visit the Medco Pharmacy online at www.express-scripts.com. If you are a first-time visitor to the site, register with your member ID and a recent prescription number, or call their Member Services at 1-800-818-6717. Members outside the U.S. may call 1-800-497-4641.
- **“Specialty Drugs” means those covered drugs that typically are high in cost and have one or more of the following characteristics:** 1) complex therapy for complex disease; 2) specialized patient training and coordination of care (services, supplies, or devices) required prior to therapy initiation and/or during therapy; 3) unique patient compliance and safety monitoring requirements; 4) unique requirements for handling, shipping and storage; and 5) potential for significant waste due to the high cost of the drug. In addition, a follow-on-biologic or generic product will be considered a Specialty Drug if the innovator drug is a Specialty Drug.
 - Exceptions may exist based on certain characteristics of the drug or therapy which will still require the drug to be classified as a Specialty Drug.
 - Some examples of the disease categories currently in the Plan's specialty pharmacy programs include cancer, cystic fibrosis, Gaucher disease, growth hormone deficiency hemophilia, immune deficiency, Hepatitis C, infertility, multiple sclerosis, rheumatoid arthritis and RSV prophylaxis.
- **For drugs that are classified as Specialty Drugs, you may obtain only an initial 30-day supply and one refill of that medication at a Plan network retail pharmacy. All future refills of that medication must be purchased through the Plan's mail service benefit, Accredo Health Group, the Plan's specialty pharmacy.** The Plan will provide you instructions on purchasing future refills. Purchases of Specialty Drugs made after the first refill at a network pharmacy are not covered by the Plan. For inquiries about this special program, please call 1-800-803-2523 Monday – Friday 8 a.m. to 9 p.m. Eastern Time and Saturday 8 a.m. to 5 p.m. Eastern Time. Also, please note the following items:
 - Accredo provides patient support and instructions on administering the medication.
 - Most Specialty Drugs require special handling and cannot be shipped to APO/FPO/DPO and Pouch Mail addresses.
 - Not all network retail pharmacies carry Specialty Drugs. Contact Accredo at 1-800-803-2523 for more information.
 - Fertility drugs are covered only as specified under Section 5(a), *Infertility services*.

Four-level drug benefit - We divide prescription drugs into four levels. The four level drug benefit is not applicable to prescription drugs you purchase from a retail pharmacy outside the 50 United States and file as a claim.

- **Level I (generic drug):** Generic drugs are chemically and therapeutically equivalent to their corresponding brand name drugs, but cost less. The FDA must approve all generic versions of a drug and assure that they meet strict standards for quality, strength and purity. The FDA requires that generic equivalent medications contain the same active ingredients and be equivalent in strength and dosage to brand name drugs. The main difference between a generic and its brand name drug is the cost of the product.
- **Level II (single-source brand name drug):** Single-source brand name drugs are available from only one manufacturer and are patent-protected. No generic equivalent is available.
- **Level III (multi-source brand name drug):** Multi-source brand name drugs are brand name drugs for which the patent protection has expired. As a result, generic equivalent drugs are available. When an approved generic equivalent is available, that is the drug you will receive, unless you or your physician specifies that the prescription must be filled as written (“Dispense as Written – DAW”). When an approved generic equivalent is not available, you will pay the single-source brand name coinsurance/copayment. **If an approved generic equivalent is available, but you or your physician specifies that the prescription must be filled as written, you will pay the multi-source brand name coinsurance/copayment.**
- **Level IV (Specialty Drugs):** Specialty Drugs are described above.

Personalized Medicine Program

- Your prescription drug coverage includes the Personalized Medicine Program, a program that incorporates pharmacogenetic testing to optimize prescription drug therapies for certain conditions such as those prescribed to determine the tolerance of anticoagulant medications or prevent major adverse cardiovascular events. The conditions, drugs and testing covered by the program will change from time to time as new genetic tests become available that are recommended by the FDA and are included in the program. The most up-to-date information on the conditions and drugs covered by the program can be accessed online at the Plan's co-branded Web site at www.AFSPA.org/FSBP and clicking on the "Prescription Coverage and Programs" tab on the right or by calling a Medco Pharmacy customer service representative at 1-800-818-6717.
- If you are a qualified participant, services are available to you through the Personalized Medicine Program at no additional cost. The Personalized Medicine Program includes: (i) access to certain specified pharmacogenetic tests administered and analyzed by one of several designated clinical laboratories; and (ii) a clinical program that includes consultation with your prescriber of your test result by a representative of the Medco Pharmacy trained specifically in pharmacogenetic testing. The Pharmacy also will offer on-going outreach and education to physicians and patients when appropriate.
- When you qualify, the Medco Pharmacy will contact you and/or your physician to enroll you in the program. With approval from your physician, the clinical laboratory will facilitate the processing of a pharmacogenetic test and share the results of the test with your physician and the Pharmacy. The results of the pharmacogenetic test are for informational purposes only. Any dosing or medication changes remain in the sole discretion of your physician. Your participation is voluntary and, if you decide to participate, the Pharmacy will facilitate your coverage under the Program. **You pay nothing for this service.**

When you do have to file a claim.

- See **Where you can obtain your prescription** at the beginning of this Section for instructions when you purchase prescriptions from a pharmacy or Military Treatment Facility outside the 50 United States.
- Contact us for instructions on how to receive reimbursement if you purchase a prescription and any of the following apply such as:
 - You recently enrolled in the Plan and you do not have your Foreign Service Benefit Plan ID Card;
 - Your participating pharmacy does not accept your ID card (such as enrollment issues, compound prescription medication, etc.); or
 - You are in a nursing home that requires unit dosing or the purchase of medication from a non-network pharmacy.

Benefits Description	You Pay
<p align="center">Note: The calendar year deductible does not apply to benefits in this Section. We say "(No deductible)" when it does not apply.</p>	
Covered medications and supplies	
<p>We will send each new enrollee a Foreign Service Benefit Plan Identification Card that also serves as a prescription ID card, a Health, Allergy & Medication Questionnaire and mail order forms and envelopes.</p> <p>You must present your Foreign Service Benefit Plan ID Card when filling your prescription at a Plan network pharmacy.</p> <p>You may purchase the following medications and supplies prescribed for you by a U.S. licensed physician from either a Plan network pharmacy or by mail through the Medco Pharmacy®:</p> <ul style="list-style-type: none"> • Drugs that by Federal law of the United States require a physician's written prescription for their purchase except those listed as not covered • Insulin and diabetic supplies • Prescription drugs for weight management • FDA approved women's oral contraceptives (multi-source brand name drugs) that require a prescription • Tobacco cessation drugs and medications, see page 66. See also <i>Educational classes and programs</i> in Section 5(a), <i>Medical services and supplies</i> for information about the Plan's Tobacco Cessation Program. • Folic acid only when a physician's written prescription is required and only when medically necessary for women of childbearing age • Needles and syringes for the administration of covered medications <p>Prescription drugs you receive from a physician or facility are covered only as specified under Sections 5(a), <i>Medical services and supplies</i> and 5(c), <i>Services provided by a hospital and other facilities</i> and below.</p> <p>Note: The Plan requires a coverage review (prior authorization) of certain prescription drugs based on FDA-approved prescribing and safety information, clinical guidelines and uses that are considered reasonable, safe and effective. See <i>Coverage management</i> in this Section for more information. To find out if your prescription requires prior authorization or more about your prescription drug benefits, visit the Medco Pharmacy online at www.express-scripts.com. If you are a first-time visitor to the site register with your member ID and a recent prescription number, or call their Member Services at 1-800-818-6717. Members outside the United States may call the Pharmacy at 1-800-497-4641.</p> <p>Note: We do not require prior authorization for the purchase of certain prescription drugs when Medicare Part B or Part D is the primary payor or you are outside the 50 United States and purchase them from a retail pharmacy outside the 50 United States.</p>	<ul style="list-style-type: none"> • Network Retail (No deductible applies for all Levels): <ul style="list-style-type: none"> - Level I (generic drug): \$10 copay - Level II (single-source brand name drug): 25% (\$30 minimum) - Level III (multi-source brand name drug): 30% (\$50 minimum) - Level IV (Specialty Drugs): 25% (Note: After your first refill, you must use Accredo (see previous pages) if the Plan instructs you to do so. If you continue to use retail and the Plan has instructed you to use the Medco Pharmacy, you pay 100% of the cost.) • Network Retail (Medicare): <ul style="list-style-type: none"> - The Plan coordinates benefits with Medicare Part B and Part D coverage. - Be sure to present your Medicare ID card whenever using a retail pharmacy. If your medication or supplies are eligible for Medicare B or D, the retail pharmacy will submit your claim first to Medicare and then to the Plan for you. Most independent pharmacies and national chains are Medicare providers. To find a retail pharmacy near you that is a Medicare B- or D-participating pharmacy, please visit the Medicare website at www.medicare.gov/supplier/home.asp or call Medicare Customer Service at 1-800-633-4227. • Non-Network Retail (in the 50 United States, including Medicare): 100% of cost • Non-Network Retail (outside the 50 United States, including Medicare): 10% of cost (No deductible) <p>See next page for Mail Order (the Medco Pharmacy).</p>

Covered medications and supplies - continued on next page

Benefits Description	You Pay
Covered medications and supplies (cont.)	
<p>Note: Information in the left hand column of the previous page applies here.</p>	<ul style="list-style-type: none"> • Network Mail Order – the Medco Pharmacy® (No deductible applies for all Levels): <ul style="list-style-type: none"> - Level I (generic drug): \$10 - Level II (single-source brand name drug): \$55 - Level III (multi-source brand name drug): \$70 - Level IV (Specialty Drugs): 25% up to a maximum of \$150 • Network Mail Order – the Medco Pharmacy (Medicare): <ul style="list-style-type: none"> - The Plan coordinates benefits with Medicare Part B and Part D coverage. - To receive your Medicare Part B-eligible medications and supplies by mail, send your mail order prescriptions to the Medco Pharmacy. Medco will review the prescriptions to determine if they could be eligible for Medicare Part B coverage. - When Medicare Part B is primary, contact Medicare at www.medicare.gov/supplier/home.asp or call Medicare Customer Service at 1-800-633-4227 about your options for submitting claims for Medicare-covered medications and supplies, whether you use a Medicare-approved supplier or the Medco Pharmacy. Prescriptions typically covered by Medicare Part B include diabetes supplies (test strips and meters), specific medications used to aid tissue acceptance (such as with organ transplants), certain oral medications used to treat cancer, and ostomy supplies. - Once Medicare Part B pays the claim, it will submit the claim to the Plan for you. - To receive your Medicare Part D-eligible medications and supplies by mail, send your mail order prescriptions to your Medicare Part D Prescription Drug Plan (PDP). If your Medicare Part D PDP is the Medco Pharmacy, they will submit a claim first to Medicare and then to the Plan for you. If your Medicare Part D PDP is not the Medco Pharmacy, you will need to submit a paper claim to the Plan. <p>Note: If there is no generic equivalent available, you will still have to pay the single-source brand name drug coinsurance or copay.</p> <p>Note: A separate copay applies per prescription fill.</p>

Covered medications and supplies - continued on next page

Benefits Description	You Pay
Covered medications and supplies (cont.)	
<p>The following are covered:</p> <ul style="list-style-type: none"> • If you are outside the 50 United States and purchase prescriptions only from a retail pharmacy outside the 50 United States or a Military Treatment Facility outside the 50 United States • If you do not use your prescription card to purchase colostomy, ostomy or diabetic supplies 	<ul style="list-style-type: none"> • 10% of the cost (including Medicare) (No deductible)
<ul style="list-style-type: none"> • FDA-approved women's oral contraceptives (generic and single-source brand name drugs only) that require a prescription • Diaphragms • Cervical caps • Vaginal rings • Contraceptive hormonal patches • Injectable contraceptives 	<ul style="list-style-type: none"> • Network Retail, Mail Order and Non-Network Retail (outside the 50 United States): Nothing (No deductible) • Non-Network Retail (in the 50 United States): 100% of the cost <p>Note: If you are outside the 50 United States and purchase these prescriptions from a retail pharmacy on the economy or from a Military Treatment Facility you must include on your claim submission that the claim is for contraceptives and specify what contraceptive you purchased in order to receive benefits.</p>
<p>Tobacco cessation drugs and medications approved by the FDA to treat tobacco dependence for tobacco cessation purchased <u>in</u> the 50 United States</p> <p>Physician prescribed over-the-counter (OTC) medications and prescription drugs approved by the FDA to treat tobacco dependence for tobacco cessation are covered when you purchase them through:</p> <ul style="list-style-type: none"> • A Plan Network pharmacy (you must present your Foreign Service Benefit Plan ID card) • The Plan's mail order pharmacy (the Medco Pharmacy) <p>Note: A U.S. licensed physician's written prescription is required at a Plan Network pharmacy and the Medco Pharmacy for OTC medications.</p>	<p>Nothing (No deductible)</p>
<p>Tobacco cessation drugs and medications approved by the FDA to treat tobacco dependence for tobacco cessation purchased <u>outside</u> the 50 United States are covered when you purchase them through:</p> <ul style="list-style-type: none"> • A retail pharmacy outside the 50 United States • A Military Treatment Facility (MTF) outside the 50 United States (Note: A U.S. licensed physician's written prescription is required for prescription drugs purchased from an MTF.) <p>Note: You must file a claim for drugs and medications purchased at a retail pharmacy or MTF outside the 50 United States.</p> <ul style="list-style-type: none"> • The Plan's mail order pharmacy (the Medco Pharmacy) <p>Note: A U.S. licensed physician's written prescription is required for OTC medications and prescription drugs purchased from the Plan's mail order pharmacy.</p>	<p>Nothing (No deductible)</p>

Covered medications and supplies - continued on next page

Benefits Description	You Pay
Covered medications and supplies (cont.)	
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Drugs and supplies you purchase at a non-network pharmacy in the 50 United States except as covered under Sections 5(a) and 5(c) and except when Medicare Part B and Part D are primary</i> • <i>Specialty Drugs you purchase at a non-network pharmacy except when Medicare Part B and Part D are primary</i> • <i>Specialty Drugs you purchase at a network pharmacy after your first refill and/or you purchase from a source other than through Accredo Health Group, the Plan's specialty pharmacy, except when Medicare Part B and Part D are primary</i> • <i>Drugs and supplies you purchase without using your Foreign Service Benefit Plan ID Card at a network pharmacy except as covered under Section 5(a) and 5(c) and except when Medicare Part B and Part D are primary</i> • <i>Drugs and supplies (except colostomy, ostomy, or diabetic supplies) you purchase by mail order from a source other than the Medco Pharmacy, Accredo Health Group, the Plan's specialty pharmacy, or Liberty Medical, and except when Medicare Part B and Part D are primary</i> • <i>Medications for which you did not obtain prior authorization and which require prior authorization</i> • <i>Prescription drugs and over-the-counter (OTC) medications for tobacco cessation except those obtained with the use of your Foreign Service Benefit Plan ID Card at a Plan Retail Network Pharmacy, through the Medco Pharmacy (mail order) or when outside the 50 United States at a retail pharmacy or Military Treatment Facility</i> • <i>Non-prescription (OTC) medications</i> • <i>Prescription drug coinsurance</i> • <i>The Medco Pharmacy (mail order) copays</i> • <i>Drugs and supplies for cosmetic purposes</i> • <i>Nutritional supplements and vitamins except for folic acid when a physician's written prescription is required and when medically necessary for women of childbearing age</i> • <i>Medication that under Federal law does not require a prescription, even if your physician prescribes it or State law requires it or for which there is a non-prescription equivalent available</i> • <i>You may not obtain hormone therapy treatment with your Foreign Service Benefit Plan ID Card or through the Medco Pharmacy (mail order).</i> • <i>Drugs and supplies related to impotency, gender reassignment, sex transformations, sexual dysfunction, or sexual inadequacy</i> 	<p><i>All charges</i></p>

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 other coverage*.
- The calendar year deductible is: \$250 per person for PPO and Providers outside the 50 United States or \$300 for non-PPO providers (\$500 per family for PPO and Providers outside the 50 United States or \$600 per family for non-PPO providers). The calendar year deductible does not apply to most benefits in this Section. We added “(calendar year deductible applies)” to show when the calendar year deductible does 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.
- Note: We cover hospital services and supplies related to dental procedures when necessitated by a non-dental physical impairment to safeguard the health of the patient, even though we may not pay benefits for services of dentists or physicians in connection with the dental treatment. See Section 5 (c) for inpatient hospital benefits.

Accidental injury benefit	You pay
Accidental injury benefit	
<p>We cover dental work (including dental X-rays) to repair or initially replace sound natural teeth under the following condition:</p> <ul style="list-style-type: none"> • You must receive these services as a result of an accidental injury to the jaw or sound natural teeth. <p>Note: We cover dental care required as a result of accidental injury from an external force such as a blow or fall to sound natural teeth (not from biting or chewing) that requires immediate attention.</p> <p>Note: We define a sound natural tooth as a tooth which:</p> <ul style="list-style-type: none"> • Is whole or properly restored; • Is without impairment, periodontal or other conditions; and • Does not need treatment for any reason other than an accidental injury. <p>Note: The Plan will ask for information from your dentist that documents the teeth involved in the accident were sound natural teeth prior to the accident if such information is not submitted with the claim.</p>	<p>PPO: 20% of the Plan allowance (calendar year deductible applies)</p> <p>Non-PPO: 20% of the Plan allowance and any difference between our allowance and the billed amount (calendar year deductible applies)</p> <p>Providers outside the 50 United States: 20% of the Plan allowance (calendar year deductible applies)</p>

Dental benefits - continued on next page

Dental benefits		
Only those services listed below are covered		
<p>Preventive care, limited to two services per person, per calendar year</p> <ul style="list-style-type: none"> • Oral exam • Prophylaxis (cleaning), adult • Prophylaxis, child (thru age 14) • Prophylaxis with fluoride, child (thru age 14) 	<p>Only the following amounts are payable (scheduled allowance):</p> <ul style="list-style-type: none"> • \$13 per exam • \$23 per cleaning • \$16 per cleaning • \$26 per cleaning 	<p>All charges in excess of the scheduled amounts listed to the left</p>
<p>Surgery</p> <ul style="list-style-type: none"> • Apicoectomy (tooth root amputation) • Alveolectomy (excision of alveolar bone) • Alveolar abscess, incision and drainage • Gingivectomy (excision of gum tissue) <p>Note: Excision of impacted teeth and non-dental oral surgical procedures are covered under Section 5(b), <i>Oral and maxillofacial surgery</i>.</p>	<p>Only the following amounts are payable (scheduled allowance):</p> <ul style="list-style-type: none"> • \$50 per root • \$40 per quadrant • \$10 per abscess • \$50 per quadrant 	<p>All charges in excess of the scheduled amounts listed to the left</p>
Orthodontic services		
<p>We define orthodontics as the realignment of natural teeth or correction of malocclusion.</p>	<p>50% of the Plan allowance up to \$1,000 per course of treatment, per person</p> <p>Note: Courses of treatment are limited to one every five years.</p>	<p>50% of the Plan allowance until benefits stop at \$1,000 per course of treatment, per person and all charges after \$1,000</p> <p>Note: Courses of treatment are limited to one every five years.</p>

Section 5(h). Special features

Special feature	Description
Flexible benefits option	<p>Under the flexible benefits option, we determine the most effective way to provide services.</p> <ul style="list-style-type: none"> • 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 terms 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).
Electronic Funds Transfer (EFT) of claim reimbursements	<p>You can elect to receive your benefit reimbursement via Electronic Funds Transfer (EFT) and have payments deposited directly into your U.S. bank account.</p> <p>Some important things to know about signing up for EFT service:</p> <ul style="list-style-type: none"> • Only one bank account per family is permitted. • The Plan cannot retrieve funds from your bank account. The Electronic Funds Transfer (EFT)/Direct Deposit Authorization Form (Authorization Form) only allows the Plan to deposit funds into your bank account. • The Plan does not charge a fee for EFT service but your bank may charge a small transaction fee. We recommend that you verify with your bank if they will charge you any banking service fees. • Enrolling for EFT service is easy. Simply complete the Authorization Form in full and return it to the address on the form with a voided check or savings withdrawal slip attached to it. • The Authorization Form can be found on the Plan's <i>My Online Services</i> (MOS): <ul style="list-style-type: none"> - Visit www.AFSPA.org/FSBP - Select "My Online Services" - Log on to MOS - Select Member Info - Select Document Library (under Plan Information) - Select Electronic Funds Transfer(EFT)/Direct Deposit Authorization Form • When you receive benefit reimbursement via EFT, your Explanation of Benefits (EOB) will be available to you on MOS and will no longer be mailed to you. Visit the Plan's Web site (www.AFSPA.org/FSBP) and select "<i>My Online Services</i>" to view your EOB. Log on to MOS to view your EOB. • You may opt to have a paper copy of your EOB mailed to you by checking the box at the bottom of the enrollment form indicating your desire to continue to receive a paper EOB. • You have the option to receive benefit reimbursement via check. There is nothing you need to do if you choose this option. <p>See the next page for how to receive notification your EOB is ready for viewing.</p>

Special feature	Description
Electronic Funds Transfer (EFT) (cont.)	<ul style="list-style-type: none"> If you prefer to receive a notification when an EOB is available for viewing on MOS, please log on to MOS. Look for the 'Member Info' section, choose 'My Online Account and Preferences' and select the radial button for 'Online' under 'Communication Preferences'. Once this option is selected, a notification will be sent to the e-mail address that is linked to the MOS account to tell you that an EOB is available for you to view in MOS.
Scanned claim submission via secure Internet connection	<p>The Plan provides a secure method for you to submit claims to us via the Internet from overseas locations. Visit our Web site (www.AFSPA.org/FSBP) and click on the "Send a Secure FSBP E-mail" tab on the right. You can attach a scanned copy (as a PDF) of your claim to a message you send to us through this secure method. This tool also allows you to send secure claims to specific customer service representatives. We designed this secure process to eliminate the lengthy mail time from your post outside the United States to our office. Also, you may correspond with us via secure e-mail through this process. In addition, you may fax us your claims from overseas. Our special fax number is 202-464-4508.</p>
Electronic copies of Explanations of Benefits (EOBs)	<p>Call the Plan's customer service department at 202-833-4910 and request to stop receiving a paper copy of your EOB. Follow these easy steps to view and print your EOB on the Plan's <i>My Online Services</i> (MOS):</p> <ul style="list-style-type: none"> Visit www.AFSPA.org/FSBP Select "My Online Services" Log on to MOS Select Claims Select Explanation of Benefits <p>You will continue to receive your claim reimbursement checks unless you want to take advantage of our Electronic Funds Transfer (EFT) option (see previous page).</p> <p>If you would like to receive an e-mail notifying you that an EOB is available for viewing on MOS, please log on to MOS. Look for the 'Member Info' section, choose 'My Online Account and Preferences' and select the radial button for 'Online' under 'Communication Preferences'. Once this option is selected, a notification will be sent to the e-mail address that is linked to the MOS account to tell you that an EOB is available for you to view in MOS.</p>
FSBP 24-Hour Nurse Advice Line	<p>You have access to a registered nurse, 24 hours a day, 7 days a week to discuss any health concerns by calling the FSBP 24-Hour Nurse Advice Line. The registered nurse will provide advice and answer health-related questions and concerns.</p> <p>The registered nurses are available by phone at 1-855-482-5750 or 704-834-6782. Select option 1 to speak to a nurse. In addition, you may contact a registered nurse by secure e-mail and secure e-mail chat. Visit the Plan's Web site (www.AFSPA.org/FSBP) and click on "<i>My Online Services</i>". Once you log on to <i>My Online Services</i>, select "Wellness Tools" and then "Nurse Advice Line". Then you may register or log on to the site.</p>
FSBP 24-Hour Translation Line	<p>When you are overseas you have access to a translation service, 24 hours a day, 7 days a week to assist you in discussing your urgent health related conditions (such as accidents and medical emergencies that require immediate attention) with a foreign health care professional. You may call 1-855-482-5750 or 1-704-834-6782. Select option 2 to speak to an interpreter during an urgent or emergency visit to a foreign health care professional.</p>
Healthy Pregnancy Program	<p>You have access to the Plan's Healthy Pregnancy Program, which provides educational material and support to pregnant women during healthy and high risk pregnancies. Contact the Plan at 1-800-593-2354 for more information.</p>

Special feature	Description
Mediterranean Wellness Program and Incentive	<p>Mediterranean Wellness Program</p> <p>You can receive up to 100% reimbursement for the Mediterranean Wellness Program once you complete at least 80% of the Program (see Section 5(a), <i>Medical services and supplies, Educational classes and programs, Nutritional counseling</i>). Once you complete at least 80% of the Program, you will receive a Certificate of Completion to submit to the Plan for reimbursement under the Plan's Nutritional counseling benefit.</p> <p>The Mediterranean Wellness Program assists you in maintaining a desirable weight and keeping healthy by eating nutritious, appealing and hearty food. The interactive, on-line, 8-week program provides you with the flexibility to enroll at any time. You will have access to an 80-page support manual and access to your own Registered Dietician.</p> <p>Mediterranean Wellness Program Incentive</p> <p>Once you complete 100% of the Program, you will earn \$50 to be deposited in a Wellness Incentive Coventry Fund Account to reimburse you for certain unreimbursed medical expenses ("Eligible Medical Expenses"). Eligible Medical Expenses, as defined by Internal Revenue Code Section 213(d), include your deductible, coinsurance and copayments (e.g. prescription drug copayments) incurred by you or your covered dependents. You and your dependents medical and prescription claims will automatically transfer to the Wellness Incentive Coventry Fund after processing. Reimbursement of your deductible, coinsurance and copayments will be sent to you if there are funds available. Other expenses, like dental and vision expenses will not be automatically reimbursed. You will need to submit appropriate documentation (receipts, etc.) with a claim form that can be found on My Online Services (MOS).</p> <ul style="list-style-type: none"> • Visit www.AFSPA.org/FSBP • Select "My Online Services" (MOS) • Log on to MOS • Select "Benefits" • Select "Manage My HRA/FSA or Coventry Fund" <p>Any unused funds in the Wellness Incentive Coventry Fund at the end of the calendar year will remain in the Wellness Incentive Coventry Fund Account for Eligible Medical Expenses in the next Plan year as long as you remain enrolled in the Plan.</p> <p>To monitor the availability of funds in your Wellness Incentive Coventry Fund Account, visit the Plan's Web site (www.AFSPA.org/FSBP) and click on "My Online Services" (MOS). Once you log on to MOS, select "Benefits" and then "Manage My HRA/FSA or Coventry Fund". If you would like to contact the Plan for more information about this Program, please call 202-833-4910.</p> <p>To learn more the Mediterranean Wellness Program, visit www.AFSPA.org/FSBP and click on "My Online Services" (MOS). After you log on to MOS, select the following: "Wellness Tools", then "WellBeing Solutions", then "Resources" and then select "Mediterranean Wellness Program". If you would like to contact the Plan for more information about this Program, please call 202-833-4910.</p>

Special feature	Description
Health Risk Assessment and Wellness Incentive	<p>Health Risk Assessment</p> <p>A free Health Risk Assessment (HRA) is available on My Online Services(MOS).</p> <ul style="list-style-type: none"> • Visit www.AFSPA.org/FSBP • Select “My Online Services” • Log on to MOS • Select “Wellness Tools” • Select “Health Risk Assessment” <p>The HRA will help you take an important first step toward improving your awareness of lifestyle behaviors and their effects on overall health risks. You will be provided a Personal Health Report that is generated automatically when the Assessment is completed.</p> <p>Health Risk Assessment Wellness Incentive</p> <p>Once you complete the HRA and meet the criteria listed below, you will earn a \$50 incentive to be deposited in a Wellness Incentive Coventry Fund Account to reimburse you for certain unreimbursed medical expenses (“Eligible Medical Expenses”). Eligible Medical Expenses, as defined by Internal Revenue Code Section 213(d), include your deductible, coinsurance and copayments (e.g. prescription drug copayments) incurred by you or your covered dependents. You and your dependents medical and prescription claims will automatically transfer to the Wellness Incentive Coventry Fund after processing. Reimbursement of your deductible, coinsurance and copayments will be sent to you if there are funds available. Other expenses, like dental and vision expenses will not be automatically reimbursed. You will need to submit appropriate documentation (receipts, etc.) with a claim form that can be found on My Online Services (MOS).</p> <ul style="list-style-type: none"> • Visit www.AFSPA.org/FSBP • Select “My Online Services” (MOS) • Log on to MOS • Select “Benefits” • Select “Manage My HRA/FSA or Coventry Fund” <p>Any unused funds in the Wellness Incentive Coventry Fund at the end of the calendar year will remain in the Wellness Incentive Coventry Fund Account for Eligible Medical Expenses in the next Plan year as long as you remain enrolled in the Plan.</p> <p>To monitor the availability of funds in your Wellness Incentive Coventry Fund Account, visit the Plan's Web site (www.AFSPA.org/FSBP) and click on “My Online Services” (MOS). Once you log on to MOS, select “Benefits” and then “Manage My HRA/FSA or Coventry Fund”. If you would like to contact the Plan for more information about this Program, please call 202-833-4910.</p> <p>The criteria to earn the \$50 Wellness Incentive Coventry Fund are completing the Health Risk Assessment once in a calendar year and obtaining the following services:</p> <ul style="list-style-type: none"> • Routine Physical examination • One online digital coaching program (as described in this Section, <i>My Online Services (Web based customer service)</i>) <p>Note: Limited to one HRA Wellness Incentive per calendar year, per member age 14 and older.</p>

Special feature	Description
Wellness incentives	<p>The Plan offers Wellness Incentives to help you maintain good health when you are diagnosed with Diabetes, Coronary Artery Disease or Asthma. Through this program, you can earn \$50 per condition to be deposited in a Wellness Incentive Coventry Fund Account to reimburse you for certain unreimbursed medical expenses (“Eligible Medical Expenses”). Eligible Medical Expenses, as defined by Internal Revenue Code Section 213(d), include your deductible, coinsurance and copayments (e.g. prescription drug copayments) incurred by you or your covered dependents. You and your dependents medical and prescription claims will automatically transfer to the Wellness Incentive Coventry Fund after processing. Reimbursement of your deductible, coinsurance and copayments will be sent to you if there are funds available. Other expenses, like dental and vision expenses will not be automatically reimbursed. You will need to submit appropriate documentation (receipts, etc.) with a claim form that can be found on My Online Services (MOS).</p> <ul style="list-style-type: none"> • Visit www.AFSPA.org/FSBP • Select “My Online Services” (MOS) • Log on to MOS • Select “Benefits” • Select “Manage My HRA/FSA or Coventry Fund” <p>Any unused funds in the Wellness Incentive Coventry Fund at the end of the calendar year will remain in the Wellness Incentive Coventry Fund Account for Eligible Medical Expenses in the next Plan year as long as you remain enrolled in the Plan.</p> <p>To monitor the availability of funds in your Wellness Incentive Coventry Fund Account, visit the Plan's Web site (www.AFSPA.org/FSBP) and click on “My Online Services” (MOS). Once you log on to MOS, select “Benefits” and then “Manage My HRA/FSA or Coventry Fund”. If you would like to contact the Plan for more information about this Program, please call 202-833-4910.</p> <p>Asthma Wellness Incentive - The criteria to earn the \$50 Wellness Incentive Coventry Fund Account for Asthma are participating in the Asthma Disease Management Program (see next page) and obtaining the following services:</p> <ul style="list-style-type: none"> • Annual physician visit • Using appropriate medication (or submit a letter from your physician stating no medication is required) • Spirometry test within the past 24 months <p>Coronary Artery Disease Wellness Incentive - The criteria to earn the \$50 Wellness Incentive Coventry Fund Account for Coronary Artery Disease are participating in the Coronary Artery Disease Management Program (see next page) and obtaining the following services:</p> <ul style="list-style-type: none"> • Annual Physician visit • Prescription for ACE Inhibitor or ARB per your physician’s orders • Prescription for Beta Blocker per your physician’s orders • LDL test <p>Diabetes Wellness Incentive - The criteria to earn the \$50 Wellness Incentive Coventry Fund Account for Diabetes are participating in the Diabetes Disease Management Program (see next page) and obtaining the following services:</p> <ul style="list-style-type: none"> • Annual Physician visit • LDL and Micro albumin tests • Hemoglobin A1C blood test • Dilated Retinal Eye Exam

Special feature	Description
Case Management Program	<p>We administer several components of your medical health plan. One of these components is case management. This program is a voluntary program provided to you and your dependents at no additional cost. Case management services are designed to assist and support you, your family and your physicians to address acute, complex and/or long term medical needs. If you feel you would benefit from case management services or would like more information, please call us at 1-800-593-2354. We are available to assist you Monday-Friday from 6:00 am to 5:00 pm MST.</p>
Disease Management Programs	<p>Disease Management Programs for members and covered dependents with asthma, chronic obstructive pulmonary disease (COPD), coronary artery disease (CAD), diabetes, congestive heart failure (CHF) or chronic kidney disease (CKD). Disease Management Programs are provided at no additional cost to participants.</p> <p>Domestic Disease Management Program - The Program provides:</p> <ul style="list-style-type: none"> • Nurse support; • Education about the disease and how it affects the body; and • Proper medical management that can help lead to a healthier lifestyle. <p>Members are automatically enrolled in the Program. However, participation is voluntary. If you are enrolled in the Program and do not want to participate, please call 1-800-579-5755. The participant and his/her physician remain in charge of the participant's treatment plan.</p> <p>If you would like to contact the Plan for more information about this Program, please call 1-800-579-5755. We are available to assist you Monday-Friday from 10:00 AM to 8:00 PM ET.</p> <p>Overseas Disease Management Program - The Program is tailored specifically to meet the needs of members who reside in a foreign country. This is an exclusive arrangement that the Plan has with Coventry. The Program provides:</p> <ul style="list-style-type: none"> • Information and nurse support to you via secure e-mail; and • Educational materials and notifications about your condition. <p>While overseas, members have the option of personal interaction with their case management nurse through the use of Skype audio and video.</p> <p>Members are automatically enrolled in the Program. However, participation is voluntary. If you are enrolled in the Program and do not want to participate, please e-mail us at FSBPhealth@cvtv.com or call us at 1-800-593-2354 (if available from your overseas location).</p> <p>If you would like to contact the Plan for more information about this program, please e-mail us at FSBPhealth@cvtv.com or call the number listed above. We are available to assist you Monday-Friday from 6:00 am to 5:00 pm MST.</p>
Pre-Diabetic Alert Program	<p>The Pre-Diabetic Alert Program is focused to provide education and support for members "at risk" for developing diabetes.</p> <p>We will contact those individuals identified at risk and offer them the opportunity to participate in the Program. Participation is voluntary. The participant and his/her physician remain in charge of the participant's treatment plan.</p> <p>Refer to Section 5(a), <i>Medical services and supplies</i> for the Plan's Diabetic Education or training benefit.</p> <p>If you would like to contact the Plan for more information about this Program, please call 1-800-593-2354.</p>

Special feature	Description
Cancer Management Program	<p>Cancer Management Program is designed to provide education and support to members.</p> <p>We will contact candidates and ask them to participate in the Program. Participation is voluntary. The participant and his/her physician remain in charge of the treatment plan.</p> <p>If you would like to contact the Plan for more information about this Program, please call 1-800-593-2354. We are available to assist you Monday-Friday from 6:00 am to 5:00 pm MST.</p> <p>See Section 5(a), <i>Treatment therapies</i> for our benefits for chemotherapy and radiation therapy. See below for information on TherapEase Cuisine, the Plan's cancer nutrition benefit.</p>
TherapEase Cuisine	<p>TherapEase Cuisine, a nutritional program through the Medco Pharmacy, the Plan's mail order pharmacy, offers an easy-to-use online program providing cancer patients access to nutritional information that follows the American Dietetic Association guidelines for cancer nutrition. TherapEase Cuisine helps answer the question, "What should I be eating?" for those diagnosed with cancer.</p> <p>Simply visit www.therapeasecuisine.com/medcomembers.aspx, complete the registration form and an access code will be sent to you via e-mail. You may use this code to access and use the system.</p> <p>Note: See Section 5(a), <i>Medical services and supplies, Educational classes and programs</i> for more information on how you can take advantage of the Plan's Cancer Management Program that provides education and nursing support for cancer patients.</p>
My Online Services (Web based customer service)	<p>Access the Plan's Web site tool My Online Services (MOS) through our link at www.AFSPA.org/FSBP. Click on "My Online Services". This provides you secure access to a broad range of your personal health information after you register.</p> <p>My Online Services provides tools to become an optimal health care consumer. Services such as the following are available:</p> <ul style="list-style-type: none"> • Interactive Personal Health Record — The Plan will build your health record with information from your claims. You also can add other personal health information such as blood pressure, weight, vital statistics, immunization records and more. • Robust claims information — You can view and organize your claims the way you want: sort by date of service, health care provider, procedure, etc. • Explanation of Benefits (EOBs) — You can access and print your EOBs. • Authorization notices — You can view and print your certification for medical services, such as a precertification of a planned hospital admission. • Decision support tools — You can check the average cost of medical procedures or view hospital quality information before you receive care. • Health information — You can obtain health information and news that is relevant to you. • Interactive health tools — Assess, understand, and manage conditions and health risks. Easy to use content helps members navigate common, but sometimes complex conditions. • Digital coaching programs — Includes nine base programs for weight management, smoking cessation, stress management, nutrition, physical activity, cholesterol management, blood pressure, depression management and sleep improvement. Programs are prioritized based on a member's health risk assessment to help create a personalized plan for successful behavior change. Members can engage and participate through personalized messaging with tools and resources to help track their progress and stay on the path to wellness. • KidsHealth Library — Nemours, one of the nation's largest nonprofit pediatric health systems, offers KidsHealth, an online resource that educates families and helps them make informed decisions about children's health. KidsHealth is an engaging way to encourage preventive behaviors and motivate kids and teens to become more involved in their health. KidsHealth has doctor-approved content for parents, kids, teens and families.

Special feature	Description
Express Scripts (ESI) - Prescription benefits (Web based customer service)	<p>Access the Plan's Web site tool for managing your Prescription benefits (See Section 5(f), <i>Prescription drug benefits</i>) through our link at www.AFSPA.org/FSBP. Click on the “Prescription Coverage and Programs” tab on the right. This provides you secure access to Express Scripts' Medco Pharmacy® and a broad range of prescription management and tools. Services such as the following are available:</p> <ul style="list-style-type: none"> • Refill and renew mail order prescriptions; • Verify mail order prescription status; • View retail and mail order prescription claim histories, expenses, and balances; • Locate participating network pharmacies; • Compare plan-specific pricing and drug coverage information with all lower cost, clinically appropriate alternatives identified; • Review drug information (interactions, side effects, precautions, guidelines for use, etc.); • Review benefit highlights, including days supply and copayments; • Prepare for a doctor visit; • Transfer retail prescriptions to mail; and • Receive automated e-mail refill and renewal reminders to help ensure continuous therapy and late-to-fill messages that indicate when you are late to fill an important medication.
Centers of Excellence for tissue and organ transplants	<p>The Plan has special arrangements with facilities to provide services for tissue and organ transplants. The network was designed to give you an opportunity to access providers that demonstrate high quality medical care for transplant patients.</p> <p>Note: If a qualified tissue/organ transplant is medically necessary and performed at a transplant network facility, you may be eligible for benefits related to expenses for travel, lodging and meals for the transplant recipient and one family member or caregiver. We also may assist you and one family member or caregiver with travel and lodging arrangements.</p> <p>See Section 5(b), <i>Organ/tissue transplants</i> for the Plan's Organ/Tissue transplants benefit.</p> <p>Contact the Plan at 1-800-593-2354 for more information. We are available to assist you Monday-Friday from 6:00 am to 5:00 pm MST.</p>
Overseas Second Opinion	<p>The Plan has a special arrangement with the Cleveland Clinic to provide patients who receive treatment in foreign countries a second opinion for certain diagnoses through the e-Cleveland Clinic. Patients who receive treatment in foreign countries and with qualifying diagnoses as determined by the Plan will have convenient access to the Cleveland Clinic's nationally-recognized specialists for a second opinion. This second opinion program is available in most locations throughout the world.</p> <p>To determine if you are an appropriate candidate for this second opinion benefit, e-mail the Plan at secondopinion@cvtv.com. If your diagnosis qualifies for this program, they will ask you to submit medical history information and answer questions specific to the diagnosis. You also may need to gather information from your local doctor or hospital, such as pathology (biopsy) slides or x-rays and mail them to the Plan as instructed.</p> <p>The appropriate physician will review the medical history and original tests before rendering a second opinion. You will be notified by e-mail within three to five days that the opinion is ready and can be viewed online at a secure Web site. Once a second opinion is obtained, you may proceed with the treatment that was originally recommended by your own physician or you may decide you want to seek another opinion or arrange care with another physician.</p>

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, copayments or catastrophic protection out-of-pocket maximums. These programs and materials are the responsibility of the American Foreign Service Protective Association (AFSPA) and all appeals must follow their guidelines.

Dental Insurance

We offer four Dental plans that cover you whether you are in the U.S. or overseas. The following is a brief description of each plan.

DentaQuest Access ePPO: A PPO plan where you must receive services from an Access ePPO network dentist (available in the Mid-Atlantic region only).

- \$25 calendar year deductible per person (\$75 maximum for family)
- Calendar year maximum of \$2,000 per person; however, a portion of the unused benefit dollars may be rolled over to the following year
- No waiting periods or claim forms to file
- Implant coverage
- Optional Orthodontia benefit is available
- Dependent child coverage to age 19; if a full-time student, then coverage is to age 24

CIGNA HMO: A dental HMO with nationwide coverage. Choose a dentist from the expansive CIGNA Dental network.

- No calendar year deductible, annual maximum, or waiting periods
- No claim forms to file
- Covers orthodontia for dependents up to age 19 with a lifetime benefit of \$1,500
- Dependent child coverage to age 26

CIGNA PPO: A dental PPO with nationwide coverage. Choose a dentist in the network (for reduced out-of-pocket expenses) or go to your own dentist.

- No calendar year deductible for preventive and diagnostic care services
- In-network benefits are 100%/80%/50%
- Calendar year maximum is \$3,000 per person, per year for in-network services
- Dependent child coverage to age 26

CIGNA International: A fee-for-service plan exclusively for our overseas members. Go to the overseas dentist of your choice. Services rendered overseas are not subject to a fee schedule or out-of-network penalties.

- Calendar year maximum is \$3,000 per person for services rendered outside the U.S.
- No calendar year deductible for services rendered outside the U.S.
- Coinsurance amount is 100%/80%/50% for services rendered outside the U.S.
- Coverage is available in the U.S. at reduced coinsurance amounts and calendar year maximums
- Multilingual customer service available 24/7
- Direct payment to foreign providers
- Direct deposit/EFT is available
- Dependent child coverage to age 26

Term Life Insurance You can obtain up to \$600,000 of term life coverage with this plan. Family coverage is also available.

- Includes Living Care and Dependent Education benefits
- Includes acts of terrorism or war
- Keep policy after leaving government service

Accidental Death & Dismemberment Insurance This plan helps to protect against accidents anywhere in the world. You can obtain up to \$600,000 of coverage, which includes:

- Spousal Education, Home Alteration and Vehicle Modification, Day Care Expense and Loss Due to Coma Benefits
- Acts of terrorism

Members of Household Health Insurance Worldwide medical insurance plans for eligible family members, i.e. domestic partners, parents and dependent children who do not qualify for coverage under the FEHB Program.

- **Reside** offers basic coverage at an affordable premium. Benefits are paid up to the amounts listed in the fee schedule for each service. Separate coverage applies for treatment received inside the U.S. and Canada.
- **Reside Prime** offers more extensive medical coverage. Benefits are based upon Reasonable and Customary charges up to a Policy Maximum. Separate coverage applies for treatment received inside the U.S. and Canada.
- **Liaison Majestic** is a comprehensive major medical plan that offers a choice of deductibles and plan maximums. Coverage applies when the family member is traveling outside his/her home country. This plan also offers a unique home country benefit.

These plans are individually underwritten. You will be subject to medical underwriting and pre-existing conditions are taken into consideration.

Long Term Care Insurance Our Long Term Care plan, underwritten by Prudential Insurance Company of America, provides excellent benefits that include nursing home, home health care, adult day care, assisted living facility and respite care.

- Lifetime maximum benefit pool of \$109,500 to \$328,500
- 90-day Elimination Period per lifetime
- Cash Alternative Benefit to reimburse for informal care, received anywhere in the world, provided by family or friends
- Home Support Services covers assistive devices or technology, caregiver training, medical alert systems and transportation expenses
- Respite Care and Bed Reservation covered
- Inflation Protection Option available
- Limited international coverage

Total Disability Insurance This plan fills a particular gap in coverage when you are unable to work for a long period of time due to an illness or injury, but are not permanently disabled. Consider buying this plan if you are a newly hired employee, do not have a substantial sick leave balance, or just want some extra protection.

- Benefit Amount of 60% of your salary, up to a monthly maximum of \$3,000 (less any in-force disability benefits)
- Optional Lump Sum Benefit of \$250,000 or 5 times your annual salary, whichever is less
- 24-month Benefit Period
- 45-day Elimination Period
- Worldwide coverage

Immediate Benefit Plan

A term life insurance plan available to employees of selected agencies to cover immediate expenses, such as mortgage payments, funeral expenses and final medical costs upon the death of a loved one.

- Benefit amount of \$15,000 (\$7,500 at age 70)
- Paid to the beneficiary generally within **two** business days upon **AFSPA's** receipt of notification of enrollee's death
- No medical questions to answer when enrolling during a qualifying event (new hire, open enrollment period, or first overseas assignment)

Travel Assistance Services

This plan offers emergency medical evacuation, on-the-spot medical payments, worldwide medical referrals and medical monitoring, prescriptions replacement assistance and repatriation of remains benefits. Annual and per trip coverage is available. As a member of **AFSPA**, you will receive a 10% discount.

Discount on Non-Covered Prescription Drugs

You may purchase non-covered (off-plan) prescription drugs at a discount directly from Express Scripts' Medco Pharmacy® such as:

- Dermatologicals (Renova), anorexiant
- Rx vitamins, erectile dysfunction agents
- Drugs labeled for cosmetic indications (Propecia)

You pay 100% of the discounted price. You cannot file a claim for off-plan prescriptions.

- Call the Pharmacy first at 1-800-818-6717 to find out the price of off-plan prescriptions.
- Obtain a prescription from your doctor, complete a mail order form and enclose the prescription with your check or credit card number. Include full payment with your order.

Note: This program is available only to members of the **Foreign Service Benefit Plan**.

Weight Watchers Online Discount Program

Plan members can receive \$10 off a 3-month subscription to Weight Watchers Online. Members will get Weight Watchers Online for only \$55.00 (less than \$5 per week).

To learn more, visit www.AFSPA.org/FSBP and select "My Online Services" (MOS). Once you log on to MOS, select "Wellness Tools" and then "Discount Programs" to locate the Weight Watchers Program information. Click on the link to sign up using the online form. Click "Enter Promotion Code" and enter code 8-334-791-17805 in the promotion code box and click "Apply Code". Follow the remaining steps for setting up your account.

Note: This program is available only to members of the **Foreign Service Benefit Plan**.

EyeMed Vision Care Program

Save up to 40% with your EyeMed Vision Care discount program on exams, glasses and contact lenses. Members have access to over 33,000 providers nationwide, including optometrists, ophthalmologists, opticians and leading optical retailers such as LensCrafters, participating Pearle Vision and Sears Optical locations, Target Optical, JCPenney Optical and many independents.

For more information concerning the program or to locate a participating provider, visit the Plan's Web site at www.AFSPA.org/FSBP and select "My Online Services" (MOS). Once you log on to MOS, select "Wellness Tools" and then "Discount Programs" or call us at 202-833-4910.

Note: For members who reside overseas, plan to take advantage of this program when you are in the United States.

Note: This program is available only to members of the **Foreign Service Benefit Plan**.

QualSight LASIK

QualSight LASIK brings members savings of 40% to 50% off the overall national average price for Traditional LASIK.

QualSight's network of the nation's most experienced LASIK surgeons has collectively performed over 2.5 million procedures. Choose from over 800 locations nationwide for your free LASIK consultation to find out if you are a candidate for this procedure. Flexible financing options and Lifetime Assurance plans are available. To locate a provider near you, call 1-877-213-3937 or visit www.QualSight.com/-Coventry.

To learn more, visit www.AFSPA.org/FSBP and select "My Online Services" (MOS). Once you log on to MOS, select "Wellness Tools" and then "Discount Programs" or call us at 202-833-4910.

Note: For members who reside overseas, plan to take advantage of this program when you are in the United States.

Note: This program is available only to members of the **Foreign Service Benefit Plan**.

International Fitness Club Network® (IFCN)

IFCN offers an opportunity for a healthier lifestyle through access to a network of high quality health and fitness clubs offered at affordable rates, as well as wellness programs and home fitness equipment at competitive prices.

Health Club Memberships

- Unlimited Free One-Week Fitness Certificates – Members are eligible to access an unlimited number of one-week introductory health club membership certificates, free of charge. Certificates are limited to one per health club.
- Lowest Membership Rates – No matter which participating health club or membership type is chosen, members are assured to be extended the club's IFCN rate.
- Passport Travel Program – Members who travel outside of a 50-mile radius from their home can continue to enjoy the health and fitness benefit at other Passport clubs for a small nominal fee.

Home Fitness Equipment

- IFCN provides a variety of home fitness equipment at preferred pricing.

For more information concerning the program or to locate a participating club, visit the Plan's web site at www.AFSPA.org/FSBP and select "My Online Services" (MOS). Once you log on to MOS, select "Wellness Tools" and then "Discount Programs" or call the IFCN 24-hr Customer Support Service Center at 1-800-866-8466.

Note: This program is available only to members of the Foreign Service Benefit Plan.

FSAFEDS Paperless Reimbursement Option

FSAFEDS, in partnership with the **Foreign Service Benefit Plan**, offers a Paperless Reimbursement option allowing you to be reimbursed from your FSAFEDS health care account without submitting a claim. When you receive benefits through the **Foreign Service Benefit Plan**, your out-of-pocket liability – the amount of money you paid to your provider – will be sent automatically to FSAFEDS for processing. FSAFEDS will review your claims and reimburse you for any eligible out-of-pocket expenses – no need for a claim form or receipt (in most cases – check with the Plan for exceptions). In many cases, you will receive your reimbursement before your provider's bill is due. Reimbursement will be made directly from your FSAFEDS account to you via Electronic Funds Transfer.

See Section 11 of this brochure, visit www.FSAFEDS.com, or call toll-free 1-877-FSAFEDS (372-3337) to learn more about how you can save money on your out-of-pocket health care expenses.

For more information or written material on any of our non-FEHB programs, please contact us at:

American Foreign Service **Protective Association**

Phone: 202-833-4910 Fax: 202-775-9082

1716 N Street, NW, Washington, DC 20036-2902

For the **Protective Association**

E-mail: AFSPA@AFSPA.org Web site: www.AFSPA.org

For the **FOREIGN SERVICE BENEFIT PLAN**

E-mail: Health@AFSPA.org Web site: www.AFSPA.org/FSBP

Section 6. General exclusions – services, drugs and supplies we do not 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 a covered provider 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 high end radiology procedures, chemotherapy/radiation therapies, home health care, transplants, skilled nursing facility admissions, mental health and substance abuse treatment, and certain prescription drugs see Section 3, *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 that are not medically necessary.
- Services, drugs, or supplies not required according to accepted standards of medical, dental, or psychiatric practice.
- Experimental or investigational procedures, treatments, drugs or devices.
- Services, drugs, or supplies related to clinical trials as follows: Extra care 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; and research 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.
- Services, drugs, or supplies related to abortions, except when the life of the mother would be endangered if the fetus were carried to term, or when the pregnancy is the result of an act of rape or incest.
- Services, drugs, or supplies related to impotency, gender reassignment, sex transformations, sexual dysfunction or sexual inadequacy.
- Services, drugs, or supplies you receive from a provider or facility barred from the FEHB Program.
- Any part of a provider's fee or charge ordinarily due from you that has been waived. If a provider routinely waives (does not require you to pay) a deductible, copayment or coinsurance, we will calculate the actual provider fee or charge by reducing the fee or charge by the amount waived.
- Charges which the enrollee or the Plan have no legal obligation to pay, such as excess charges for an annuitant 65 or older who is not covered by Medicare Parts A and/or B (see Section 9), doctor's charges exceeding the amount specified by the Department of Health and Human Services when benefits are payable under Medicare (limiting charge, see Section 9), preventable medical errors ("Never Events") as defined by Medicare that Medicare states you are not liable for, or State premium taxes however applied.
- Services, drugs, or supplies you receive without charge while in active military service.
- Services, drugs, or supplies for which no charge would be made if the covered individual had no health insurance coverage.
- Services and supplies not recommended or approved by a covered provider.
- Services for cosmetic purposes.
- Services, drugs, or supplies related to weight control or any treatment of obesity except as described in Sections 5(a), *Medical services and supplies* and 5(f), *Prescription drug benefits* and except surgery for morbid obesity as described in Section 5(b), *Surgical and anesthesia services*.
- Services, drugs, or supplies furnished or billed by a noncovered 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, drugs, or supplies furnished by immediate relatives or household members, such as spouse, parents, children, brothers or sisters by blood, marriage, or adoption.
- Services, drugs, or supplies not specifically listed as covered.
- Charges that we determine are over our Plan allowance.

Listed below are examples of some of our exclusions:

- Applied behavior analysis (ABA)
- All charges for chemical aversion therapy, conditioned reflex treatments, narcotherapy or any similar aversion treatments and all related charges (including room and board).
- Any provider not specifically listed as covered.
- Counseling or therapy for marital, educational, sexual, or behavioral problems; or related to intellectual/developmental disabilities or learning disabilities.
- Community-based programs such as self-help groups or 12 step programs.
- Services by pastoral, marital, or drug/alcohol counselors.
- Biofeedback (except for treatment of incontinence), conjoint therapy, hypnotherapy or milieu therapy.
- Charges for completion of reports or forms, interest, and missed or canceled appointments.
- Charges related to medical records submission if the medical records are needed to process a claim. If the Plan requests medical records inappropriately, the expenses may be covered.
- Bank fees including those associated with currency exchange.
- Custodial care.
- Mutually exclusive procedures. These are procedures that typically are not provided to the same patient on the same date of service.
- Non-medical services such as social services, recreational, educational, visual and nutritional counseling except as described in Section 5(a), *Medical services and supplies*.
- Services performed or billed by residential therapeutic camps such as wilderness camps and similar programs.
- Non-surgical treatment of temporomandibular joint (TMJ) dysfunction including dental appliances, study models, splints and other devices.
- Telephone consultations, mailings, faxes, e-mails or any other communication to or from a physician, hospital or other medical provider except as provided for in Sections 5(a), *Medical services and supplies* and 5(h), *Special features*.
- Treatment for learning disabilities and intellectual/developmental disabilities.

Note: An exclusion that is primarily identified with a single benefit category is listed along with that benefit category, but may apply to other categories.

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 procedures (services, drugs or supplies requiring prior Plan approval), including urgent care claims procedures.

How to claim benefits

To obtain claim forms, visit our Web site at www.AFSPA.org/FSBP. To obtain claims filing advice or answers about our benefits, contact us by secure e-mail through our Web site at www.AFSPA.org/FSBP (click on the “Send a Secure FSBP E-mail” tab on the right), by phone at 202-833-4910 (members) or 202-833-5751 (health care providers), fax at 202-833-4918, or by mail at the **Foreign Service Benefit Plan**, 1716 N Street, NW, Washington, DC 20036-2902.

In most cases, providers and facilities file claims for you. Your physician must file on the form CMS-1500, Health Insurance Claim Form. Your facility will file on the UB-04 form.

When you must file a claim – such as for non-PPO providers or when another group health plan is primary – submit it on the CMS-1500 or a claim form that includes the information shown below. Claims from foreign providers do not need to be filed on a CMS-1500 (see *Overseas Claims* on next page). 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. The Plan cannot accept a claim from you as an e-mail attachment, except as described above through our secure e-mail method (and also in detail on the next page under *Overseas Claims*).

In addition:

- Generally, you need to fill out only one claim form per year. You should fill out a claim form if you submit a claim due to accidental injury, you have changed your address, or if the member’s other insurance/Medicare status has changed.
- 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 private duty nursing care must show that the nurse is a Registered Nurse (R.N.) or Licensed Practical Nurse (L.P.N.). You also should include the initial history and physical, treatment plan indicating expected duration and frequency from your attending physician and the nurse’s notes from the nurse.
- Claims for rental or purchase of durable medical equipment must include the purchase price, a prescription and a statement of medical necessity including the diagnosis and estimated length of time needed.
- Claims for physical, occupational, and speech therapy must include an initial evaluation and treatment plan indicating length of time needed for therapy and progress (therapy) notes for each date of service from the therapist.
- Claims for dental services must include a copy of the dentist’s itemized bill (including the information required above) and the dentist’s Federal Tax ID Number. We do not have separate dental claim forms.

- Claims for alternative treatment services must include a copy of the provider's itemized bill (including the information required on the previous page) and the provider's Federal Tax ID Number (only if a United States provider).
- We will provide translation and currency conversion services for claims for overseas (foreign) services. See *Overseas Claims* below.

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 provide you with a record of expenses you submit and benefits we paid for each claim that you file (explanation of benefits (EOB)). You are responsible for keeping these. We will not provide duplicate or year-end statements. If you need duplicate copies, please refer to Section 5(h), *Special features* under *My Online Services (Web based customer service)*.

Deadline for filing your claim

Send us all of the documents for your claim as soon as possible. You must submit the claim within 2 years from the date you incur the expense. 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. Once we pay benefits, there is a three-year limitation on the reissuance of uncashed checks.

Overseas Claims

The **Foreign Service Benefit Plan** pays claims for providers outside the 50 United States at the same PPO coinsurance rate as PPO providers in the 50 United States.

If you are posted outside the 50 United States and both the Medical and Health Program of the Department of State – Office of Medical Services (OMS) and we cover you, submit claims to us as described on the previous page or as directed by OMS, through your Management Office.

If the Medical and Health Program of the Department of State does not cover you, you should submit claims directly to us as described on the previous page.

You do not need to file overseas claims on CMS-1500 or UB-04 forms.

We use the following methods to process your foreign claims:

- We will translate your claim, if you do not provide a translation.
- We will use the U.S. dollar exchange rate applicable on the date the claim was processed, if you do not supply us with a currency exchange rate. There are exceptions, such as:
 - If you provide us with only one currency exchange rate and your claim covers multiple dates of service, the currency exchange rate you provided will be applied for all dates of service.
 - If you receive services from a provider who is part of our Direct Billing Arrangements, we will use the exchange rate on the date the claim is processed or pay according to our Direct Billing Arrangements.
 - If you have paid a direct billing provider prior to your claim submission, we request that you provide us with a copy of your receipt along with the exchange rate you used to convert the currency.

We have **special direct billing arrangements** with hospitals in several countries, including China, Colombia, France, Germany, Great Britain, Italy, Korea, Panama, Russia, Switzerland and Turkey. In addition, overseas Seventh-day Adventist Hospitals and Clinics participate in our special billing arrangement. Please contact us for more information on these arrangements if you are in these locations.

The Plan provides a secure electronic method for you to submit claims to us via the Internet from overseas locations. Visit our Web site (www.AFSPA.org/FSBP) and click on the “Send a Secure FSBP E-mail” tab on the right. You can attach a scanned copy of your claim (as a PDF) to a message you send to us through this secure method. This tool also allows you to send secure claims to specific customer service representatives. We designed this secure process to eliminate the lengthy mail time from your post to our office and to protect your private health information (PHI). Also, you may correspond with us via secure e-mail through this process. In addition, you may fax us your claims from overseas. Our special fax number is 202-464-4508.

If you prefer, you may send your claim with proper documentation via mail to:

**Foreign Service Benefit Plan
1716 N Street, NW
Washington, DC 20036-2902**

Do not send your claims in care of Department of State (Pouch Mail). It will delay your claim substantially.

Plan telephone numbers: 202-833-4910 (members); 202-833-5751 (health care providers)

**When we need
more information**

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

**Authorized
Representative**

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

**Notice
Requirements**

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

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

Section 8. The disputed claims process

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

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 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 Foreign Service Benefit Plan, 1716 N Street, NW, Washington, DC 20036 or calling (202) 833-4910.

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

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

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

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

- 1** Ask us in writing to reconsider our initial decision. You must:
 - a) Write to us within 6 months from the date of our decision; and
 - b) Send your request to us at: **Foreign Service Benefit Plan**, 1716 N Street, NW, Washington, DC 20036-2902; 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 member), if you would like to receive our decision via email. Please note that by giving us your email, we may be able to provide our decision more quickly.

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

- 2** In the case of a post-service claim, we have 30 days from the date we receive your request to:
 - a) Pay the claim; or
 - b) Write to you and maintain our denial; or
 - c) Ask you or your provider for more information.

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

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

3

If you do not agree with our decision, you may ask OPM to review it.

You must write to OPM within:

- 90 days after the date of our letter upholding our initial decision; or
- 120 days after you first wrote to us – if we did not answer that request in some way within 30 days; or
- 120 days after we asked for additional information.

Write to OPM at: United States Office of Personnel Management, Healthcare and Insurance, Federal Employee Insurance Operations, Health Insurance II, 1900 E Street, NW, Washington, DC 20415-3620.

Send OPM the following information:

- A statement about why you believe our decision was wrong, based on specific benefit provisions in this brochure;
- Copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms;
- Copies of all letters you sent to us about the claim;
- Copies of all letters we sent to you about the claim;
- Your daytime phone number and the best time to call; and
- Your email address, if you would like to receive OPM's decision via email. Please note that by providing your email address, you may receive OPM's decision more quickly.

Note: If you want OPM to review more than one claim, you must clearly identify which documents apply to which claim.

Note: You are the only person who has a right to file a disputed claim with OPM. Parties acting as your representative, such as medical providers, must include a copy of your specific written consent with the review request. However, for urgent care claims, a health care professional with knowledge of your medical condition may act as your authorized representative without your 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 within 60 days. There are no other administrative appeals.

If you do not agree with OPM's decision, your only recourse is to sue. If you decide to sue, you must file the suit against OPM in Federal court by December 31 of the third year after the year in which you received the disputed services, drugs, or supplies or from the year in which you were denied precertification or prior approval. This is the only deadline that 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 sue until you have completed the disputed claims process. Further, Federal law governs your lawsuit, benefits, and payment of benefits. The Federal court will base its review on the record that was before OPM when OPM decided to uphold or overturn our decision. You may recover only the amount of benefits in dispute.

Note: **If you have a serious or life threatening condition** (one that may cause permanent loss of bodily functions or death if not treated as soon as possible), and you did not indicate that your claim was a claim for urgent care, then call us at 202-833-4910. We will hasten our review (if we have not yet responded to your claim); or we will inform OPM so they can quickly review your claim on appeal. You may call OPM's Health Insurance II at 202-606-3818 between 8 a.m. and 5 p.m. eastern time.

Please remember that we do not make decisions about plan eligibility issues. For example, we do not determine whether you or a dependent is covered under this plan. You must raise eligibility issues with your Agency personnel/payroll office if you are an employee, your retirement system if you are an annuitant or the Office of Worker's Compensation programs if you are receiving Worker's 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 group health plan or has automobile insurance that pays health care expenses without regard to fault. This is called “double coverage”.

When you have double coverage, one plan normally pays its benefits in full as the primary payor and the other plan pays a reduced benefit as the secondary payor. We, like other insurers, determine which coverage is primary according to the National Association of Insurance Commissioners’ (NAIC) guidelines. For more information on NAIC rules regarding the coordinating of benefits, visit the NAIC web site at <http://www.NAIC.org>.

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

When we are the secondary payor, we will determine our allowance. You must send us your primary plan’s explanations of benefits (EOBs) if we ask for them. After the primary plan pays, we will pay what is left of our allowance, up to the lesser of:

- Our benefits in full; or
- A reduced amount that, when added to the benefits payable by the primary plan, does not exceed 100% of covered expenses.

We will not pay more than our allowance. The combined payments from both plans might not equal the entire amount billed by the provider.

Please see Section 4, *Your costs for covered services*, for more information about how we pay claims.

• TRICARE and CHAMPVA

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

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

• Workers’ Compensation

We do not cover services that:

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

Once OWCP or a similar agency pays its maximum benefits for your treatment, we will cover your care.

• Medicaid

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

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

**When other
Government agencies
are responsible for
your care**

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

**When others are
responsible for injuries**

We have the right to recover payment we have made to you or on your behalf from any recovery you receive because of illness or injury caused by the act or omission of a third party (another person or organization). In these circumstances, any payments that we make are conditional in nature, and are subject to the following requirements:

If you do not seek damages you must agree to let us try. This is called subrogation. We also are subrogated to your present and future claims against the third party.

Furthermore, if you suffer an injury or illness through the act or omission of a third party, you agree:

- To reimburse us for benefits paid up to the recovery amount from any and all recoveries that you receive; and
- That we are subrogated to your rights to the extent of benefits paid, including the right to bring suit.

All recoveries you receive for your damages, from whatever source and however characterized, must be used to reimburse us for benefits paid. Unless we agree in writing to a reduction, you cannot reduce our share of the recovery because you do not receive the full amount of damages claimed (for example, you were not “made whole”), or some other reason (such as the “common fund” doctrine).

If we invoke this provision:

- We will pay benefits for the injury or illness as long as you:
 - Take no action to prejudice our ability to recover benefits; and
 - Reasonably assist us in recovery.
- Our reimbursement right extends only to the amount we paid or would pay because of the injury or illness.
- We may insist on a proceeds assignment and may withhold payment of benefits otherwise due until the assignment is provided. Failure to request or obtain assignment prior to us paying benefits will in no way diminish our rights of reimbursement and subrogation.

We will have a lien on the proceeds of your claim to the third party to reimburse ourselves the full amount of benefits we have paid or may pay. Our lien will apply to any and all recoveries for the claim and will be satisfied in full out of the proceeds before the satisfaction of any individual's claim.

You are required to notify us promptly of any claim that you may have for damages as a result of the act or omission of a third party, for which we have paid or may pay benefits. In addition, you are required to notify us promptly of any recovery that you obtain, and you are required to reimburse us from that recovery in full for the benefits paid or to be paid. Any reduction in our lien for costs including attorney's fees or any other costs associated with obtaining that recovery must be approved by us prior to payment.

**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 health/dental plan, Federal law permits your insurers to follow a procedure called “coordination of benefits” to determine how much each should pay when you have a claim. The goal is to make sure that the combined payments of all plans do not add up to more than your covered expenses.

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.com, you will be asked to provide information on your FEHB plan so that your plans can coordinate benefits. Providing your FEHB information may reduce your out-of-pocket cost.

Clinical trials

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

When you have Medicare

- **What is Medicare?** Medicare is a health insurance program for:

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

Medicare has four parts:

- Part A (Hospital Insurance). Most people do not have to pay for Part A. If you or your spouse worked for at least 10 years in Medicare-covered employment, you should be able to qualify for premium-free Part A insurance. (If you were a Federal employee at any time both before and during January 1983, you will receive credit for your Federal employment before January 1983.) Otherwise, if you are age 65 or older, you may be able to buy it. Contact 1-800-MEDICARE (1-800-633-4227), (TTY 1-877-486-2048) for more information.
- Part B (Medical Insurance). Most people pay monthly for Part B. Generally, Part B premiums are withheld from your monthly Social Security check or your retirement check.
- Part C (Medicare Advantage). You can enroll in a Medicare Advantage plan to get your Medicare benefits. Please review the information on coordinating benefits with Medicare Advantage plans on page 96.
- Part D (Medicare prescription drug coverage). There is a monthly premium for Part D coverage. If you have limited savings and a low income, you may be eligible for Medicare's Low-Income Benefits. For people with limited income and resources, extra help in paying for a Medicare prescription drug plan is available. Information regarding this program is available through the Social Security Administration (SSA). For more information about this extra help, visit SSA online at www.socialsecurity.gov, or call them at 1-800-772-1213, (TTY 1-800-325-0778). Before enrolling in Medicare Part D, please review the important disclosure notice from us about the FEHB prescription drug coverage and Medicare. The notice is on the first inside page of this brochure. The notice will give you guidance on enrolling in Medicare Part D.

- **Should I enroll in Medicare?**

The decision to enroll in Medicare is yours. We encourage you to apply for Medicare benefits 3 months before you turn age 65. It's easy. Just call the Social Security Administration toll-free number 1-800-772-1213, (TTY 1-800-325-0778) to set up an appointment to apply. If you do not apply for one or more Parts of Medicare, you can still be covered under the FEHB Program.

If you can get premium-free Part A coverage, we advise you to enroll in it. Most Federal employees and annuitants are entitled to Medicare Part A at age 65 **without cost**.

When you don't have to pay premiums for Medicare Part A, it makes good sense to obtain the coverage. It can reduce your out-of-pocket expenses as well as costs to the FEHB, which can help keep FEHB premiums down.

Everyone is charged a premium for Medicare Part B coverage. The Social Security Administration can provide you with premium and benefit information. Review the information and decide if it makes sense for you to buy the Medicare Part B coverage. If you do not sign up for Medicare Part B when you are first eligible, you may be charged a Medicare Part B late enrollment penalty of a 10% increase in premium for every 12 months you are not enrolled. If you didn't take Part B at age 65 because you were covered under FEHB as an active employee (or you were covered under your spouse's group health insurance plan and he/she was an active employee), you may sign up for Part B (generally without an increased premium) within 8 months from the time you or your spouse stop working or are no longer covered by the group plan. You also can sign up at any time while you are covered by the group plan.

If you are eligible for Medicare, you may have choices in how you get your health care. Medicare Advantage is the term used to describe the various private health plan choices available to Medicare beneficiaries. The information in the next few pages shows how we coordinate benefits with Medicare, depending on whether you are in the Original Medicare Plan or a private Medicare Advantage plan.

Please refer to *When you are age 65 or over and do not have Medicare* in this section for information about how we provide benefits when you are age 65 or older and do not have Medicare.

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

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

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

When you are enrolled in Original Medicare along with this Plan, you still need to follow the rules in this brochure for us to cover your care. We do not require precertification, preauthorization, or concurrent review when Medicare Part A and/or Part B is the primary payor. Precertification, preauthorization and concurrent review are required, however, when Medicare stops paying benefits for any reason. We do not require prior authorization for the purchase of certain prescription drugs when Medicare Part B or Part D is the primary payor for the drugs or you are outside the 50 United States and purchase them from a retail pharmacy outside the 50 United States. However, when Medicare stops paying benefits for any reason, you must follow our precertification, preauthorization, prior authorization, and concurrent review procedures.

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.

Claims process when you have the Original Medicare Plan – Send us a copy of your Medicare Card when we are secondary to Medicare. We need this information in order to start electronic crossover of your claims. Electronic crossover is a process that assures, in most cases, you do not have to file a claim when Medicare is primary. Call us at 202-833-4910 or contact us through our secure e-mail process from the Plan's Web site at www.AFSPA.org/FSBP (click on the “Send a Secure FSBP E-mail” tab on the right) to find out if your claims are being electronically filed or you have questions about the process described below. You probably will 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, we will coordinate your claim automatically and provide secondary benefits for covered charges. There are exceptions:

- If you have not sent us a copy of your Medicare Card as stated above, you will need to send us your claims and Medicare Summary Notices (MSNs) until you have sent us a copy of your Medicare Card and we have had time to set up electronic crossover.
- If Medicare rejects your claim completely, send us your claim and your MSN. You must send them in order for us to begin processing your claim.
- If Medicare rejects a part of your claim or pays a reduced amount, you may need to send us your claim and MSN. In that case, we will ask you for a copy of them. You must send them to us in order for us to continue processing your claim.

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

- **Medical services and supplies provided by physicians and other health care professionals in Section 5(a).**
 - If you are enrolled in Medicare Part B, we will waive your calendar year deductible and coinsurance.
- **Surgical and anesthesia services provided by physicians and other health care professionals in Section 5(b).**
 - If you are enrolled in Medicare Part B, we will waive your coinsurance.
- **Services provided by a hospital or other facility, and ambulance services in Section 5(c).**
 - If you are enrolled in Medicare Part A, we will waive your inpatient hospital copayment and coinsurance for inpatient stays.
 - If you are enrolled in Medicare Part B, we will waive the deductible and coinsurance for outpatient hospital, ambulatory surgical center and ambulance.
- **Services provided by facilities and providers covered under Emergency services/accidents in Section 5(d).**
 - If you are enrolled in Medicare Part B, we will waive the deductible, coinsurance and copay.
- **Services provided by mental health and substance abuse facilities and providers in Section 5(e).**
 - If you are enrolled in Medicare Part A, we will waive the inpatient hospital copayment and coinsurance for inpatient stays.
 - If you are enrolled in Medicare Part B, we will waive the deductible and coinsurance.
- **Services provided under Prescription benefits in Section 5(f).**
 - If you are enrolled in Medicare Part B and Medicare Part B is primary, the Plan will coordinate benefits and waive the deductible, coinsurance and/or copayment for prescription drugs you purchase only at Network pharmacies, which are covered under Medicare Part B.

- If you are enrolled in Medicare Part B and Medicare Part B is primary, the Plan will coordinate benefits and waive the deductible, coinsurance and/or copayment for colostomy, ostomy and diabetic supplies you purchase from any Medicare Part B provider, which are covered under Medicare Part B.
 - **Services provided under Dental benefits in Section 5(h).**
 - We do **not** waive the coinsurance under Dental benefits.
- **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 also must 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**

A physician may ask you to sign a private contract agreeing that you can be billed directly for services ordinarily covered by Original Medicare, that is, the physician may have opted out of the entire Medicare Program. Should you sign an agreement, neither you nor the physician may bill Medicare. Medicare will not pay any portion of the charges and we will not increase our payment. We will limit our payment to the coordinated 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.

If the physician did not inform you of his/her "Opt Out" status or did not ask you to sign a private contract, we will process your initial claim for that physician using our regular PPO/non-PPO benefit coinsurance. We will inform you and your physician in a letter that future claims will be processed per the above paragraph. If you continue receiving services from the physician, you will be responsible for paying the difference between the billed amount and the amount we paid as described above.
- **Medicare Advantage (Part C)**

If you are eligible for Medicare, you may choose to enroll in and get your Medicare benefits from a Medicare Advantage plan. These are private health care choices (like HMOs and regional PPOs) in some areas of the country. To learn more about Medicare Advantage plans, contact Medicare at 1-800-MEDICARE (1-800-633-4227), (TTY 1-877-486-2048) or at their website, www.medicare.gov.

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

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

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

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

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

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

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

Also, this Plan is primary if you receive services or incur charges:

- Outside the 50 United States; or
- On board a ship not in a U.S. port or more than six hours before arrival at, or after departure from a U.S. port, even if the ship is of U.S. registry.

Note: Medicare remains primary in certain bordering areas of Canada and Mexico.

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

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

If you:

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

Then, for your inpatient hospital care:

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

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

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

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

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

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

When you have the Original Medicare Plan (Part A, Part B, or both)

We limit our payment to an amount that supplements the benefits that Medicare would pay under Medicare Part A (Hospital insurance) and Medicare Part B (Medical insurance), regardless of whether Medicare pays. Note: We pay our regular benefits for emergency services to an institutional provider, such as a hospital, that does not participate with Medicare and is not reimbursed by Medicare.

We use the Department of Veterans Affairs (VA) Medicare-equivalent Remittance Advice (MRA) when the statement is submitted to determine our payment for covered services provided to you if Medicare is primary, when Medicare does not pay the VA facility.

If you are covered by Medicare Part B and it is primary, your out-of-pocket costs for services that both Medicare Part B and we cover depend on whether your physician accepts Medicare assignment for the claim.

If your physician accepts Medicare assignment, then you pay nothing for covered charges.

If your physician does not accept Medicare assignment, then you pay nothing because we supplement Medicare's payment up to the "limiting charge".

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.

Please see this section, *The Original Medicare Plan (Part A or Part B)*, for more information about how we coordinate benefits with Medicare.

Section 10. Definitions of terms we use in this brochure

Admission	The period from entry (admission) into a hospital or other covered facility until discharge. In counting days of inpatient care, we count the date of entry and the date of discharge as the same day.
Assignment	You authorize us to issue payment of benefits directly to the provider of services. The Plan reserves the right to pay the member directly for all covered services.
Calendar year	January 1 through December 31 of the same year. For new enrollees, the calendar year begins on the effective date of their enrollment and ends on December 31 of the same year.
Cardiac rehabilitation	A comprehensive exercise, education, and behavioral modification program designed to improve the physical and emotional condition of patients with heart disease. Heart attack survivors, bypass and angioplasty patients, cardiac valvular surgery patients and individuals with angina, congestive heart failure, and heart transplants are all candidates for a cardiac rehabilitation program. Cardiac rehabilitation is prescribed to control symptoms, improve exercise tolerance, and improve the overall quality of life in these patients.
Clinical trials cost categories	<ul style="list-style-type: none">• Routine care costs – costs for routine services such as doctor visits, lab tests, x-rays and scans, and hospitalizations related to treating the patient’s condition whether the patient is in a clinical trial or is receiving standard therapy• Extra care costs – costs related to taking part in a clinical trial such as additional tests that a patient may need as part of the trial, but not as part of the patient’s routine care• Research costs – costs related to conducting the clinical trial such as research physician and nurse time, analysis of results, and clinical tests performed only for research purposes
Coinsurance	The percentage of our allowance that you must pay for your care. You also may be responsible for additional amounts. See Section 4, <i>Coinsurance</i> .
Copayment	A fixed amount of money you pay to the provider when you receive covered services. See Section 4, <i>Copayment</i> .
Cost-Sharing	Cost-sharing is the general term used to refer to your out-of-pocket costs (e.g., deductible, coinsurance, and copayments) for the covered care you receive.
Covered services	Services we provide benefits for, as described in this brochure.
Custodial care	<p>Treatment or services, regardless of who recommends them or where they are provided, that a person not medically skilled could render safely and reasonably, or that help you mainly with daily living activities. These activities include but are not limited to:</p> <ol style="list-style-type: none">1. Personal care, such as help in: walking; getting in and out of bed; bathing; eating by spoon, tube or gastrostomy; exercising; dressing;2. Homemaking, such as preparing meals or special diets;3. Moving you;4. Acting as companion or sitter;5. Supervising medication that you can usually take yourself; or6. Treatment or services that you may be able to perform with minimal instruction including, but not limited to, recording temperature, pulse, respirations, or administration and monitoring of feeding systems. <p>We determine which services are custodial care.</p>
Deductible	A fixed amount of covered expenses you must incur for certain covered services and supplies before we start paying benefits for those services. See Section 4, <i>Deductible</i> .

Effective date	<p>The date the benefits described in this brochure become effective:</p> <ol style="list-style-type: none"> 1. January 1 for all continuing enrollments; 2. The first day of the first full pay period of the new year if you change plans or options or elect FEHB coverage during the Open Season for the first time; or 3. The date determined by your employing or retirement system if you enroll during the calendar year, but not during the Open Season.
Expense	<p>The cost incurred for a covered service or supply ordered or prescribed by a covered provider. You incur an expense on the date the service or supply is received. Expense does not include any charge:</p> <ol style="list-style-type: none"> 1. For a service or supply that is not medically necessary; or 2. That is in excess of the Plan's allowance for the service or supply.
Experimental or investigational service	<p>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.</p> <p>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.</p> <p>Reliable evidence means only: the 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.</p> <p>If you need additional information regarding the determination of experimental and investigational, please contact us.</p>
Group health coverage	<p>Health care coverage that you are eligible for because of employment, membership in, or connection with, a particular organization or group that provides payment for any health care services or supplies, or that pays a specific amount for each day or period of hospitalization if the specified amount exceeds \$200 per day, including extension of any of these benefits through COBRA.</p>
Health care professional	<p>A physician or other health care professional licensed, accredited, or certified to perform specified health services consistent with state law.</p>
Hospital stay	<p>An admission (or series of admissions separated by less than 60 days) to a hospital as an inpatient for any illness or injury. You start a new hospital stay when:</p> <ol style="list-style-type: none"> 1. The admission is for a cause unrelated to the previous admission; 2. An employee returns to work for at least one day before the next admission; or 3. The hospital stays are separated by at least 60 days for a dependent or retiree.
Intensive day treatment	<p>Outpatient treatment of mental conditions or substance abuse rendered at and billed by a facility that meets the definition of a hospital. Treatment program must be established which consists of individual or group psychotherapy and/or psychological testing.</p>

Medically necessary	<p>Services, drugs, supplies or equipment provided by a hospital or covered provider of the health care services that we determine:</p> <ol style="list-style-type: none"> 1. Are appropriate to diagnose or treat your condition, illness or injury; 2. Are consistent with standards of good medical practice in the United States; 3. Are not primarily for your, a family member's or a provider's personal comfort or convenience; 4. Are not a part of or associated with your scholastic education or vocational training; and 5. In the case of inpatient care, cannot be provided safely on an outpatient basis. <p>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.</p>
Mental conditions/ substance abuse	<p>Conditions and diseases listed in the most recent edition of the International Classification of Diseases (ICD) as psychoses, neurotic disorders, or personality disorders; other nonpsychotic mental disorders listed in the ICD, to be determined by us; or disorders listed in the ICD requiring treatment for abuse of or dependence upon substances such as alcohol, narcotics, or hallucinogens.</p>
Plan allowance	<p>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:</p> <p>PPO Providers – Our Plan allowance is a negotiated amount between the Plan and the provider. We base our coinsurance on this negotiated amount, and the provider has agreed to accept the negotiated amount as full payment for any covered services rendered. This applies to all benefits in Section 5 of this brochure.</p> <p>Non-PPO Providers – Our Plan allowance is the lesser of: (1) the provider's billed charge; or (2) the Plan's out-of-network (OON) fee schedule amount. The Plan's OON fee schedule amount is equal to the 90th percentile amount for the charges listed in the Prevailing Healthcare Charges System, administered by Fair Health, Inc. The OON fee schedule amounts vary by geographic area in which services are furnished. We base our coinsurance of this OON fee schedule amount. This applies to all benefits in Section 5 of this brochure.</p> <p>For certain services, exceptions may exist to the use of the OON fee schedule to determine the Plan's allowance for non-PPO providers, including, but not limited to, the use of Medicare fee schedule amounts. For claims governed by the Omnibus Budget Reconciliation Act (OBRA) of 1990 and 1993, the Plan allowance will be based on Medicare allowable amounts as is required by law. For claims where the Plan is the secondary payer to Medicare (Medicare COB situations), the Plan allowance is the Medicare allowable charge.</p> <p>Other Participating Providers – 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 non-PPO benefit levels, subject to any applicable deductibles, coinsurance and copayments. This applies to all benefits in Section 5 of this Brochure.</p> <p>Providers outside the 50 United States – We generally do not reduce claims from providers outside the 50 United States to a Plan allowance, that is, our Plan allowance is the amount billed by the provider or as part of our Direct Billing Arrangements. However, we reserve the right to request information from you or your provider that will enable us to determine medical necessity or an allowance on charges that we deem to be excessive.</p> <p>For more information, see Section 4, <i>Differences between our allowance and the bill</i>.</p>

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, preauthorization, concurrent review, or prior approval and (2) where failure to obtain precertification, preauthorization, concurrent review, or prior approval results in a reduction of benefits.
Routine testing/ screening	Health care services provided to an individual without apparent signs and symptoms of an illness, injury or disease for the purpose of identifying or excluding an undiagnosed illness, disease or condition.
Urgent care claims	<p>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:</p> <ul style="list-style-type: none"> • 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. <p>Urgent care claims usually involve pre-service claims and not post-service Claims. We will judge whether a claim is an urgent care claim by applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine. If you believe your claim qualifies as an urgent care claim, please contact the Plan through our Customer Service Department at the Foreign Service Benefit Plan, 1716 N Street, NW, Washington, DC 20036-2902, by phone at 202-833-4910, fax at 202-833-4918, or secure e-mail through our our Web site at www.AFSPA.org/FSBP (click on the “Send a Secure FSBP E-mail” tab on the right). 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.</p>
Us/We	Us and We refer to the Foreign Service Benefit Plan .
You	You refers to the enrollee and each covered family member.

Section 11. Other Federal Programs

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

Important information about three Federal programs that complement the FEHB Program

First, the **Federal Flexible Spending Account Program**, also known as FSAFEDS, lets you set aside pre-tax money from your salary to reimburse you for eligible dependent care and/or health care expenses. You pay less in taxes so you save money. The result can be a discount of 20% to more than 40% on services/products you routinely pay for out-of-pocket.

Second, the **Federal Employees Dental and Vision Insurance Program (FEDVIP)** provides comprehensive dental and vision insurance at competitive group rates. There are several plans from which to choose. Under FEDVIP you may choose self only, self plus one, or self and family coverage for yourself and any eligible dependents.

Third, the **Federal Long Term Care Insurance Program (FLTCIP)** can help cover long term care costs, which are not covered under the FEHB Program.

The Federal Flexible Spending Account Program – FSAFEDS

What is an FSA?

It is an account where you contribute money from your salary **BEFORE** taxes are withheld, then incur eligible expenses and get reimbursed. You pay less in taxes so you save money. **Annuitants are not eligible to enroll.**

There are three types of FSAs offered by FSAFEDS. Each type has a minimum annual election of \$250. The maximum annual election for a health care flexible spending account (HCFSAs) or a limited expense health care spending account (LEX HCFSAs) is \$2,500.

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

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

Limited Expense Health Care FSA (LEX HCFSAs) – Designed for employees enrolled in or covered by a High Deductible Health Plan with a Health Savings Account. Eligible expenses are limited to dental and vision care expenses for you and your tax dependents including adult children (through the end of the calendar year in which they turn 26) which are not covered or reimbursed by FEHBP or FEDVIP coverage or any other insurance.

Dependent Care FSA (DCFSA) – Reimburses you for eligible non-medical day care expenses for your child (ren) under age 13 and/or for any person you claim as a dependent on your Federal Income Tax return who is mentally or physically incapable of self-care. You (and your spouse if married) must be working, looking for work (income must be earned during the year), or attending school full-time to be eligible for a DCFSA.

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

Where can I get more information about FSAFEDS?

Visit www.FSAFEDS.com or call an FSAFEDS Benefits Counselor toll-free at 1-877-FSAFEDS (1-877-372-3337), Monday through Friday 9 a.m. until 9 p.m., Eastern time. TTY: 1-800-952-0450.

The Federal Employees Dental and Vision Insurance Program – *FEDVIP*

Important Information

The Federal Employees Dental and Vision Insurance Program (FEDVIP) is separate and different from the FEHB Program and was established by the Federal Employee Dental and Vision Benefits Enhancement Act of 2004. This Program provides comprehensive dental and vision insurance at competitive group rates with no pre-existing condition limitations for enrollment.

FEDVIP is available to eligible Federal and Postal Service employees, retirees, and their eligible family members on an enrollee-pay-all basis. Employee premiums are withheld from salary on a pre-tax basis.

Dental Insurance

All dental plans provide a comprehensive range of services, including:

- Class A (Basic) services, which include oral examinations, prophylaxis, diagnostic evaluations, sealants and x-rays.
- Class B (Intermediate) services, which include restorative procedures such as fillings, prefabricated stainless steel crowns, periodontal scaling, tooth extractions, and denture adjustments.
- Class C (Major) services, which include endodontic services such as root canals, periodontal services such as gingivectomy, major restorative services such as crowns, oral surgery, bridges and prosthodontic services such as complete dentures.
- Class D (Orthodontic) services with up to a 24-month waiting period for dependent children up to age 19.

Vision Insurance

All vision plans provide comprehensive eye examinations and coverage for lenses, frames and contact lenses. Other benefits such as discounts on LASIK surgery also may be available.

Additional information

You can find a comparison of the plans available and their premiums on the OPM Web site at www.opm.gov/insure/vision and www.opm.gov/insure/dental. These sites also provide links to each plan's Web site, where you can view detailed information about benefits and preferred providers.

How do I enroll?

You enroll on the Internet at www.BENEFEDS.com. For those without access to a computer, call 1-877-888-3337 (TTY 1-877-889-5680).

The Federal Long Term Care Insurance Program – *FLTCIP*

It's important protection

The Federal Long Term Care Insurance Program (FLTCIP) can help pay for the potentially high cost of long term care services, which are not covered by FEHB plans. Long term care is help you receive to perform activities of daily living – such as bathing or dressing yourself – or supervision you receive because of a severe cognitive impairment such as Alzheimer's disease. For example, long term care can be received in your home from a home health aide, in a nursing home, in an assisted living facility or in adult day care. To qualify for coverage under the FLTCIP, you must apply and pass a medical screening (called underwriting). Federal and U.S. Postal Service employees and annuitants, active and retired members of the uniformed services, and qualified relatives, are eligible to apply. Certain medical conditions, or combinations of conditions, will prevent some people from being approved for coverage. You must apply to know if you will be approved for enrollment. For more information, call 1-800-LTC-FEDS (1-800-582-3337) (TTY 1-800-843-3557) or visit www.ltcfeds.com.

Pre-existing Condition Insurance Program (PCIP)

Do you know someone who needs health insurance but can't get it? The Pre-Existing Condition Insurance Plan (PCIP) may help.

An individual is eligible to buy coverage in PCIP if:

- He or she has a pre-existing medical condition or has been denied coverage because of the health condition;
- He or she has been without health coverage for at least the last six months. (If the individual currently has insurance coverage that does not cover the pre-existing condition or is enrolled in a state high risk pool then that person is not eligible for PCIP.);
- He or she is a citizen or national of the United States or resides in the U.S. legally.

The Federal government administers PCIP in the following states: Alabama, Arizona, District of Columbia, Delaware, Florida, Georgia, Hawaii, Idaho, Indiana, Kentucky, Louisiana, Massachusetts, Minnesota, Mississippi, North Dakota, Nebraska, Nevada, South Carolina, Tennessee, Texas, Vermont, Virginia, West Virginia, and Wyoming. To find out about eligibility, visit www.pcip.gov and/or www.healthcare.gov or call 1-866-717-5826 (TTY): 1-866-561-1604.

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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. **This index references both covered and non-covered services and supplies.**

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Summary of benefits for the High Option of the Foreign Service Benefit Plan - 2013

Do not rely on this chart alone. All benefits are subject to the definitions, limitations, and exclusions in this brochure. On this page we summarize specific expenses we cover; for more detail, look inside.

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

Below, an asterisk (*) means the item is subject to the \$250 calendar year deductible for PPO and Providers outside the 50 United States or \$300 for non-PPO providers. And, after we pay, you generally pay any difference between our allowance and the billed amount if you use a non-PPO physician or other health care professional.

High Option Benefits	You pay	Page
Medical services provided by physicians:		
<ul style="list-style-type: none"> Diagnostic and treatment services provided in the hospital and office 	PPO: 10% of our allowance* Non-PPO: 30% of our allowance and any difference between our allowance and the billed amount* Providers outside the 50 United States: 10% of our allowance*	28
Surgical and Anesthesia Services provided by physicians:	PPO: 10% of the Plan allowance Non-PPO: 30% of the Plan allowance Providers outside the 50 United States: 10% of the Plan allowance	44
Services provided by a hospital:		
<ul style="list-style-type: none"> Inpatient 	PPO: Nothing Non-PPO: \$200 per hospital stay and 20% of charges Providers outside the 50 United States: Nothing	51
<ul style="list-style-type: none"> Outpatient 	Surgical: PPO: 10% of our allowance* Non-PPO: 30% of our allowance and any difference between our allowance and the billed amount* Providers outside the 50 United States: 10% of our allowance* Medical: PPO: 10% of our allowance* Non-PPO: 30% of our allowance and any difference between our allowance and the billed amount* Providers outside the 50 United States: 10% of our allowance*	53

High Option Benefits	You pay	Page
Emergency benefits:		
<ul style="list-style-type: none"> Accidental injury: emergency room charges (ER) and urgent care facility charges, ER and urgent care physicians' charges and ancillary services (performed at the time of the ER or urgent care facility visit) or initial office visit and ancillary services (performed at the time of the initial office visit) 	<p>PPO: Nothing</p> <p>Non-PPO: Only the difference between our allowance and the billed amount</p> <p>Providers outside the 50 United States: Nothing</p>	55
<ul style="list-style-type: none"> Medical emergency 	<p>PPO: 10% of our allowance*</p> <p>Non-PPO: 10% of our allowance and any difference between our allowance and the billed amount*</p> <p>Providers outside the 50 United States: 10% of our allowance*</p>	56
<ul style="list-style-type: none"> Outpatient care in an urgent care facility because of a medical emergency 	<p>PPO: \$35 copayment per occurrence</p> <p>Non-PPO: \$35 copayment per occurrence and any difference between our allowance and the billed amount</p> <p>Providers outside the 50 United States: \$35 copayment per occurrence</p>	56
Mental health and substance abuse treatment:	<p>PPO: Regular cost-sharing*</p> <p>Non-PPO: Regular cost-sharing*</p> <p>Providers outside the 50 United States: Regular cost-sharing*</p>	57
Prescription drugs:		
<ul style="list-style-type: none"> Retail pharmacy 	<p>Network Pharmacies in the 50 United States: Note – You must show your Plan ID card:</p> <ul style="list-style-type: none"> Level I (generic): \$10 copay for up to a 30-day supply Level II (single-source brand name): 25% (\$30 minimum) for up to a 30-day supply Level III (multi-source brand name): 30% (\$50 minimum) for up to a 30-day supply Level IV (Specialty Drugs): 25% for up to a 30-day supply (Note: Restrictions apply on refills.) <p>Non-Network Pharmacies in the 50 United States: 100% and cannot claim reimbursement from the Plan (no coverage)</p> <p>Retail Pharmacies outside of the 50 United States: 10% (claim reimbursement from the Plan)</p>	64

High Option Benefits	You pay	Page
<ul style="list-style-type: none"> • Mail order 	Mail Order (the Medco Pharmacy): <ul style="list-style-type: none"> • Level I (generic): \$10 for up to a 90-day supply • Level II (single-source brand name): \$55 for up to a 90-day supply • Level III (multi-source brand name): \$70 for up to a 90-day supply • Level IV (Specialty drugs): 25% up to maximum of \$150 for up to a 90-day supply 	65
Dental care:		
<ul style="list-style-type: none"> • Routine preventive care and surgical procedures 	The difference between our scheduled allowances and the actual billed amounts	69
<ul style="list-style-type: none"> • Orthodontics 	50% of our allowance up to \$1,000 per course of treatment, per person and 100% after our maximum payment of \$1,000	69
Special features:		
<ul style="list-style-type: none"> • The Plan offers the following Special Features: <ul style="list-style-type: none"> - Flexible benefits option - Electronic Funds Transfer (EFT) of claim reimbursements - Scanned claim submission via secure Internet connection - Electronic copies of Explanations of Benefits - 24-Hour Nurse Advice Line - 24 Hour Translation Line - Healthy Pregnancy Program - Mediterranean Wellness Program and Incentive - Health Risk Assessment and Wellness Incentive - Wellness Incentives - Case Management Program - Disease Management Programs - Pre-Diabetic Alert Program - Cancer Management Program - TherapEase Cuisine - My Online Services (Web based customer service) - Express Scripts (ESI) Prescription benefits (Web based customer service) - Centers of Excellence for tissue and organ transplants - Overseas Second Opinion 		70-78

High Option Benefits	You pay	Page
Protection against catastrophic costs (out-of-pocket maximum):	<p>PPO: Nothing after \$4,000/Self Only or \$4,500/Self and Family enrollment per year</p> <p>Non-PPO: Nothing after \$6,000/Self Only or \$6,500/Self and Family enrollment per year</p> <p>Providers outside the 50 United States: Nothing after \$4,000/Self Only or \$4,500/Self and Family enrollment per year</p> <p>Note: Benefit maximums still apply and some costs do not count toward this protection.</p>	24

Notes

Notes

2013 Rate Information for the Foreign Service Benefit Plan

2013 rates for this Plan follow. If you are in a special enrollment category, refer to the *Guide to Federal Benefits* for that category or contact the agency that maintains your health benefits enrollment.

Type of Enrollment	Enrollment Code	Non-Postal Premium			
		Biweekly		Monthly	
		Gov't Share	Your Share	Gov't Share	Your Share
High Option Self Only	401	\$171.84	\$ 57.28	\$372.32	\$124.11
High Option Self and Family	402	\$423.41	\$141.13	\$917.38	\$305.79