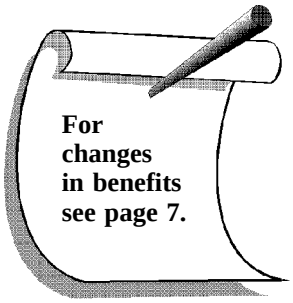
American Foreign Service Protective Association

Foreign Service Benefit Plan

http://www.afspa.org

2002

A fee-for-service plan with a preferred provider organization



Sponsored and administered by:
American Foreign Service Protective Association

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 automatically 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) the Foreign Agricultural Service; and to Executive Branch civilian employees assigned overseas or to U.S. possessions and territories; and the direct hire domestic employees assigned to support those activities.

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

URAC ACCREDITED

Mutual of Omaha Insurance Company, the underwriter for the **Foreign Service Benefit Plan** has received accreditation from URAC (also known as the American Accreditation Healthcare Commission), for Health Utilization Management Standards. See the 2002 Guide for more information on accreditation.

Authorized for distribution by the:

United States
Office of Personnel Management
Retirement and Insurance Service
http://www.opm.gov/insure

FEHB
Federal Employees Health Benefits Program

RI 72-001

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Introduction

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

Phone: **202/833-4910**
Fax: **202/833-4918**
E-mail: **afspa@afspa.org**

This brochure describes the benefits of the **Foreign Service Benefit Plan** under our contract (CS 1062) with the Office of Personnel Management (OPM), as authorized by the Federal Employees Health Benefits law. This brochure is the official statement of benefits. No oral statement can modify or otherwise affect the benefits, limitations, and exclusions of this brochure.

If you are enrolled in this Plan, you are entitled to the benefits described in this brochure. If you are enrolled for Self and Family coverage, each eligible family member is also entitled to these benefits. You do not have a right to benefits that were available before January 1, 2002, unless those benefits are also shown in this brochure.

OPM negotiates benefits and rates with each plan annually. Benefit changes are effective January 1, 2002, and changes are summarized on page 7. Rates are shown at the end of this brochure.

Plain Language

Teams of Government and health plans' staff worked on all FEHB brochures to make them responsive, accessible, and understandable to the public. For instance,

- 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 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.

If you have comments or suggestions about how to improve the structure of this brochure, let us know. Visit OPM's "Rate Us" feedback area at www.opm.gov/insure or e-mail OPM at fehbwebcomments@opm.gov. You may also write to OPM at the Office of Personnel Management, Office of Insurance Planning and Evaluation Division, 1900 E Street, NW, Washington, DC 20415-3650.

Inspector General Advisory

Stop health care fraud!

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

- Call the provider and ask for an explanation. There may be an error.
- If the provider does not resolve the matter, call us at 202/833-4910 and explain the situation.
- If we do not resolve the issue, call or write

THE HEALTH CARE FRAUD HOTLINE
202/418-3300
The United States Office of Personnel Management
Office of the Inspector General Fraud Hotline
1900 E Street, NW, Room 6400
Washington, DC 20415

Penalties for Fraud

Anyone who falsifies a claim to obtain FEHB Program benefits can be prosecuted for fraud. Also, the Inspector General may investigate anyone who uses an ID card if the person tries to obtain services for someone who is not an eligible family member, or is no longer enrolled in the Plan and tries to obtain benefits. Your agency may also take administrative action against you.

Section 1. Facts about this fee-for-service plan

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.

We also have Preferred Provider Organizations (PPO):

Our fee-for-service Plan offers services through a PPO. When you use our PPO providers, you will receive covered services at reduced cost. Contact us for the names of PPO providers and to verify their continued participation. Access our PPO directory either through Mutual of Omaha's web site, www.mutualofomaha.com, or as a link through our web site www.afspa.org or call 202/833-4910 for information concerning the PPO. You can also go to our web page, which you can reach through the FEHB web site, www.opm.gov/insure. Do not call OPM or your agency for our provider directory.

The non-PPO benefits are the standard benefits of this Plan. PPO benefits apply only when you use a PPO provider and reside in a PPO Network Area. Provider networks may be more extensive in some areas than others. We cannot guarantee the availability of every specialty in all areas. The selection of PPO providers is solely the Plan's responsibility. We cannot guarantee the continued participation of any specific provider. In the PPO Network Areas, 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 with us that your address of record is in a PPO area. Our records must reflect that you reside in a PPO area;**
- **Verify that the provider is in the PPO network when you make your appointment;**
- **Present your PPO Identification Card at the time you visit your healthcare provider, confirming your PPO participation to be eligible for PPO benefits. If you do not present your PPO ID Card, the provider may not accept our PPO discount;**
- **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.**

This Plan offers its members in certain areas the opportunity to reduce out-of-pocket expenses by choosing facilities and providers that participate in the Plan's Preferred Provider Organization (PPO). The following are considered PPO Network Areas:

- the Washington, D.C. metropolitan and Greater Baltimore areas, and certain areas of the following States

- Alabama
- Arizona
- Arkansas
- California
- Colorado
- Connecticut
- Delaware
- Florida
- Georgia
- Illinois
- Indiana
- Iowa
- Louisiana
- Maine
- Maryland
- Massachusetts
- Michigan
- Minnesota
- Missouri
- Nevada
- New Hampshire
- New Jersey
- New Mexico
- New York
- North Carolina
- Ohio
- Oklahoma
- Oregon
- Pennsylvania
- Rhode Island
- South Carolina
- Tennessee
- Texas
- Utah
- Virginia
- Washington
- West Virginia
- Wisconsin

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

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.

Your Rights

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

- **Years in existence and profit status -** The American Foreign Service Protective Association was established in 1929 and was incorporated in 1941 as a 501(c)(9) not-for-profit organization. The Foreign Service Benefit Plan is provided in conjunction with the Mutual of Omaha Insurance Company. The Mutual of Omaha Insurance Company was organized in 1909 as a mutual legal reserve system (private).

- **Licensing and certification -** The Mutual of Omaha Insurance Company meets all State and Federal licensing and certification requirements.

- **Fiscal solvency, confidentiality and transfer of medical records -** The Mutual of Omaha Insurance Company meets 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 may also contact us by fax at 202/833-4918, by e-mail at afspa@afspa.org or visit our website at www.afspa.org.

Section 2. How we change for 2002

Do not rely on these change descriptions; this page 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

- We changed the address for sending disputed claims to OPM. (Section 8)
- The following four states have been added to the list of medically underserved states for 2002: Georgia, Montana, North Dakota and Texas. Louisiana has been removed from the list of medically underserved states for 2002.

Changes to this Plan

- Your share of the premium will increase by 7.7% for Self Only and 6.4% for Self and Family.
- We clarified the brochure to better explain that the non-PPO benefits are the standard benefits of this Plan, that PPO benefits apply only when you use a PPO provider and that when no PPO provider is available, non-PPO benefits apply.
- We have added to your PPO service area. In addition to the states that had PPO providers last year, portions of the following states are now also considered within the PPO service area: Alabama, Arkansas, Louisiana, Maine, Michigan, Minnesota, Missouri, Nevada, New Mexico, Ohio, Oklahoma, Oregon, Utah, West Virginia and Wisconsin. We have also increased areas in Indiana and Tennessee. (Section 1)
- We have increased your routine physical exam benefit from a maximum of $500 per person per calendar year to a maximum of $750 per person per calendar year, subject to the calendar year deductible and appropriate coinsurance. (Section 5(a))
- We have changed the current mammogram schedule to allow one mammogram per calendar year, starting at age 35 subject to the calendar year deductible and appropriate coinsurance. (Section 5(a))
- We no longer limit total blood cholesterol tests to certain age groups. (Section 5(a))
- We now cover routine screening for chlamydial infection. (Section 5(a))
- We have added Chiropractor benefits, subject to the calendar year deductible and appropriate coinsurance. The Plan limits benefits to a maximum payable of $20 per visit with a 30-visit maximum per person per calendar year. (Section 5(a))
- We have expanded covered providers of acupuncture to include Oriental Medical Doctors (O.M.D.'s) and Licensed Acupuncturists (L.Ac.'s). We have limited the benefit to a maximum payable of $20 per visit with a 30-visit maximum per person per calendar year subject to the calendar year deductible and appropriate coinsurance. (Section 5(a))
- We changed speech therapy benefits by removing the requirement that services must be required to restore functional speech and have added a 90-visit combined maximum per person per calendar year for physical, speech and occupational therapies subject to the calendar year deductible and appropriate coinsurance. (Section 5(a))
- We have increased your Smoking cessation benefit from a maximum payable of $100 for one smoking cessation program per member per lifetime to a maximum payable of $100 for one program per person per 12 months subject to the calendar year deductible and appropriate coinsurance. Over the counter smoking cessation drugs and supplies are included in the $100 maximum payable per person per 12 months. (Section 5(a)) Prescription drugs for smoking cessation are now covered under your Prescription drug benefit. (Section 5(f))
- We now cover certain intestinal transplants. (Section 5(b))

Section 3. How you get care

Identification cards

We will send you a combined Foreign Service Benefit Plan/PAID Prescription Drug Identification Card (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 Employee Express confirmation letter. Call us if you need to purchase prescriptions and have not received your card.

If you do not receive your ID card within 60 days after the effective date of your enrollment, or if you need replacement cards, call us at 202/833-4910.

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:

- **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.)

Other covered providers include:

- **Qualified Clinical Psychologist** — An individual who has earned either a Doctoral or Masters 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).
- **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 1) has an active R.N. license in the United States, 2) has a baccalaureate or higher degree in nursing, and 3) 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 1) has a Masters or Doctoral degree in social work, 2) has at least two years of clinical social work practice, and 3) in states requiring licensure, certification, or registration, is licensed, certified, or registered as a social worker where the services are rendered.
- **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, Section 5(a)).
- **Nursing School Administered Clinic** — A clinic that is 1) licensed or certified in the state where the services are performed, and 2) 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.
- **Audiologist** — A person who is licensed, registered or certified in the state where services are performed.

Medically underserved areas. Note: We cover any licensed medical practitioner for any covered service performed within the scope of that license in states OPM determines are "medically underserved." For 2002, the states are: Alabama, Georgia, Idaho, Kentucky, Mississippi, Missouri, Montana, New Mexico, North Dakota, South Carolina, South Dakota, Texas, Utah, and Wyoming.

- **Covered facilities**

Covered facilities include:

- **Birthing 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.
- **Day Care Center** — A facility licensed as a day care center and that provides a planned program of psychiatric services for patients with mental conditions who must spend their days, but not nights, under psychiatric supervision, and that are not for schooling, custodial, recreational, or training services.
- **Hospice** — A public or private agency or organization that:

  1) primarily provides inpatient hospice care to terminally ill persons;

  2) is certified by Medicare as such, or is licensed or accredited as such by the jurisdiction it is in;

  3) is supervised by a staff of M.D.'s or D.O.'s at least one of whom must be on call at all times;

  4) provides 24-hour-a-day nursing services under the direction of an R.N. and has a full-time administrator; and

  5) provides an ongoing quality assurance program.

- **Hospital** —

  1) An institution that is accredited as a hospital under the hospital accreditation program of the Joint Commission on Accreditation of Healthcare Organizations (JCAHO); or

  2) Any other institution that is operated pursuant to law, under the supervision of a staff of doctors and with 24-hour-a-day nursing services, and that is primarily engaged in providing:

     a) General inpatient care and treatment of sick and injured persons through medical, diagnostic and major surgical facilities, all of which facilities must be provided on its premises or under its control; or

     b) Specialized inpatient medical care and treatment of sick or injured persons through medical and diagnostic facilities (including X-ray and laboratory) on its premises, under its control, or through a written agreement with a hospital (as defined above) or with a specialized provider of those facilities.

  3) For inpatient and outpatient treatment of alcohol and drug abuse, the term hospital also includes a free-standing alcohol and drug abuse treatment facility approved by the JCAHO.

  In no event shall the term hospital include a convalescent nursing home or institution or part thereof that:

  1) is used principally as a convalescent facility, rest facility, nursing facility or facility for the aged;

  2) furnishes primarily domiciliary or custodial care, including training in the routines of daily living; or

  3) 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.

What you must do to get covered care

It depends on the kind of care you want to receive. You can go to any covered provider you want, but we must approve some care in advance.

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 (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 other than 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 any PPO benefits continue until the end of your postpartum care, even if it is beyond the 90 days.

Hospital care:

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 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; or
- 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.

How to Get Approval for…

- **Your hospital, skilled nursing facility or hospice stay, or home health care**
  (See Other services (page 12) for obtaining approval for Mental Health/Substance Abuse Treatment)

Precertification is the process by which – prior to your inpatient hospital, skilled nursing facility or hospice admission, or receiving home health care – we evaluate the medical necessity of your proposed stay or treatment 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, hospital, skilled nursing facility, hospice or home health agency will take care of precertification. Because you are still responsible for ensuring that we are asked to precertify your care, you should always ask them if they have contacted us.

Warning:

We will reduce our benefits for the inpatient hospital stay by $500 if no one contacts us for precertification. Also, we will reduce our benefits for skilled nursing facility, hospice or home health care if no one contacts us for precertification. See below and pages 11-12 for more information on skilled nursing facility, hospice and home health care. In addition, if the stay or care is not medically necessary, we will not pay any benefits.

How to precertify a hospital, skilled nursing facility or hospice admission, or home health care

- You, your representative, your doctor, hospital, skilled nursing facility, hospice or home health agency must call Mutual of Omaha's Care Review Unit before the admission or care. The toll-free number is 1-800/228-0286.
- Provide the following information:
  - Enrollee's name and Plan identification number;
  - Patient's name, birth date, and phone number;
  - Reason for hospitalization or proposed treatment;
  - Name of hospital, facility or home health agency;
  - Name and phone number of admitting doctor; and
  - Number of planned days of confinement or care.

- 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, your doctor or your hospital must telephone us within two business days following the day of the emergency admission, even if you have been discharged from the hospital.
- For hospital confinements, when the preceding requirements are met, the Care Review Unit will tell the doctor and hospital the number of approved days of confinement for the care of the patient's condition.
- For home health care, hospice care or skilled nursing facility care, when the preceding requirements are met, the Care Review Unit will notify the patient, the doctor, and the facility or agency that the care is, or is not, certified as medically necessary.
- The Plan will send you, your doctor, and the hospital written confirmation of our certification decision. If the length of stay or care needs to be extended, follow the procedure below.

Maternity care

You do not need to precertify 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 within 2 business days 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.

What happens when you do not follow the precertification rules

- When we precertified the hospital admission but you remained 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 covered medical services and supplies otherwise payable on an outpatient basis and will not pay inpatient benefits.
- When we precertified the care in a skilled nursing facility, hospice or for home health care, you received treatment beyond the approved care and did not get the additional care precertified, then:
  - for the part of the admission or care that was medically necessary, we will provide full benefits as stated on pages 26 and 35, but
  - for the part of the admission to the skilled nursing facility that was not medically necessary, we will pay only covered medical services and supplies otherwise payable on an outpatient basis; and
  - for the part of the home health care that was not medically necessary, we will not pay benefits.
- If no one contacted us, we will decide if the hospital, skilled nursing facility or hospice stay, or home health care was medically necessary.
  - If we determine that the hospital stay was medically necessary, we will pay the inpatient hospital charges, less the $500 penalty.
  - If we determine that it was not medically necessary for you to be an inpatient, we will not pay inpatient hospital benefits. We will pay only covered medical supplies and services that are otherwise payable on an outpatient basis.
  - If we determine that the care you received in a skilled nursing facility or hospice was not medically necessary, we will pay only covered medical supplies and services that are otherwise payable on an outpatient basis.
  - If we determine that the home health care you received was not medically necessary, we will not pay benefits.

- If we denied the precertification request
  - for hospitalization, we will not pay inpatient hospital benefits, we will pay only covered medical supplies and services that are otherwise payable on an outpatient basis;
  - for skilled nursing facility or hospice admission, we will pay only covered medical supplies and services that are otherwise payable on an outpatient basis; and
  - for home health care, we will not pay benefits.

Exceptions:

You do not need precertification in these cases:

- You are admitted to a hospital outside the 50 United States.
- You have another group health insurance policy that is the primary payer for the hospital stay.
- Your Medicare Part A is the primary payer 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 payer and you **must** precertify.

• Other services

Some services require prior authorization.

- **Mental Health and Substance Abuse Benefits —**
  - You must precertify all inpatient admissions for mental health and substance abuse treatment. See sections on preceding pages for details and the penalty.
  - You must preauthorize outpatient mental health and substance abuse treatment for all levels of care whether in or out-of-network. You or your health care provider must call our preauthorization number at 1-800/228-0286 to preauthorize.
  - You must obtain concurrent review (which means review of continuing treatment) and follow your treatment plan for all levels of care whether in or out-of-network. You or your health care provider must call our preauthorization number at 1-800/228-0286 to obtain concurrent review.

    Note: We conduct concurrent review (which means review of continuing treatment) to determine the medical necessity and/or appropriateness of ongoing services. Review frequency is based on the severity and complexity of your condition. We may perform an on-site review of your medical records to ensure continuity of care.

    Note: A treatment plan is a detailed statement of the objectives and goals to be achieved within a clinical setting developed by your treating professional. The plan may also include the therapeutic modality to be used as well as the frequency of services and estimated length of treatment.

  - If you do not preauthorize your care, obtain concurrent review, or do not follow your treatment plan, we will reduce any available benefits by 50% of what we would have paid had you preauthorized, obtained concurrent review or followed your treatment plan. See pages 39-44 for details.

    Note: We do not require precertification, preauthorization or concurrent review if you receive treatment outside of the United States or when Medicare Part A and/or Part B, or another group health insurance policy is the primary payer. Precertification, preauthorization and concurrent review is required, however, when Medicare or the other group health insurance policy stops paying benefits for any reason.

Section 4. Your costs for covered services

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

- **Copayments**

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

Example:

- When you purchase prescriptions from a network pharmacy with the use of your combination Foreign Service Benefit Plan/PAID Prescription Drug Identification Card, you pay a copayment of $10 for generic or $20 for brand name prescriptions. When you purchase prescriptions from the Merck-Medco Home Delivery Pharmacy service by mail, you pay a copayment of $15 for generic or $25 for brand name prescriptions.
- When you are confined in a non-PPO hospital or an Out-of-Network hospital, you pay $200 per person per confinement.

We do not reimburse you for copayments.

- **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 the amount you pay after coinsurance does not count toward any deductible.

- The calendar year deductible is $300 per person. 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 $600. Expenses are "incurred" on the date on which the service or supply is received.

Note: If you change plans during open season, 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.

- **Coinsurance**

Coinsurance is the percentage of our allowance that you must pay for your care. We will base this percentage on either the billed charge or the Plan allowance, whichever is less.

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

Note: 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).

- **Differences between our allowance and the bill**

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

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

When you live in the Plan's PPO area, 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 live in one of our PPO areas and 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 bill. **Follow these procedures when you use a PPO provider in order to receive PPO benefits:**
  - **Verify with us that your address of record is in a PPO area;**
  - **When you phone for an appointment, verify that the physician or facility is still a PPO provider;**
  - **Present your PPO ID card confirming your PPO participation in order to receive PPO benefits; and**
  - **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. If you live in one of our PPO areas and 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, he can bill you for the $50 difference between our allowance and his bill.

When you live outside of the PPO Network Area in the United States or outside of the United States, and use Out-of-Network providers the following example explains how we will handle your bill:

- **Providers outside the PPO Network Area** also have no agreement to limit what they bill you. When you live overseas, for example, you will pay your deductible and coinsurance plus any difference between our allowance and charges on the bill. However, because you do not have a choice of PPO providers, the Plan does not penalize you and your coinsurance in this next example is less: You live overseas and see an Out-of-Network physician who charges $150. Our allowance in this case is $150. If you have met your deductible, you are responsible for your coinsurance, so you pay 20% of our $150 allowance ($30). You do not have any additional amount to pay. If you live in an area in the United States where we do not have PPO providers, your coinsurance is still only 20%, but the Plan allowance for the doctor's charge might be less. You might have an additional amount to pay, if his charge exceeds our allowance.

The following table 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 domestic Out-of-Network physician and vs. an overseas physician. 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	Domestic Out-of-Network Physician	Overseas Physician
Physician's charge	$150	$150	$150	$150
Our allowance	We set it at: 100	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	80% of our allowance: 80	80% of our allowance: 120
You pay: Coinsurance	10% of our allowance: 10	30% of our allowance: 30	20% of our allowance: 20	20% of our allowance: 30
+Difference up to charge?	No: 0	Yes: 50	Yes: 50	No: 0
TOTAL YOU PAY	10	80	70	30

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 copayment in that calendar year exceed

- $3,000 for Self Only and $3,500 for Self and Family enrollment (PPO providers)
- $4,000 for Self Only and $4,500 for Self and Family (non-PPO providers and out-of-network area).

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

The out-of-pocket expenses that apply to your out-of-pocket maximums described above include:

- The $200 per confinement copayment you pay for non-PPO and out-of-network area hospitals;
- The 20% you pay for room and board and other hospital charges in a non-PPO hospital for medical/surgical admissions;
- The 30% you pay for room and board and other hospital charges in a non-PPO hospital for mental conditions;
- The 10% you pay for PPO and out-of-network area surgery, the 30% you pay for non-PPO surgery, and the 20% you pay for assistant surgeons;
- The $300 (Self Only) or $600 (Self and Family) calendar year deductible you pay before the Plan begins paying benefits on certain services;
- The 10% you pay for PPO providers, the 30% you pay for non-PPO providers, and the 20% you pay for providers outside the network area;
- The 30% you pay for non-PPO doctors in-hospital and outpatient visits for mental conditions, subject to dollar and visit limitations;
- The 30% you pay for day care in a non-PPO facility subject to visit limitations;
- The 50% you pay for non-PPO outpatient group therapy subject to the dollar limitations; and
- The 20% you pay for purchasing prescriptions from pharmacies outside of the 50 United States or directly from doctors or other covered facilities.

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

- Expenses in excess of Plan allowances or maximum benefit or visit limitations;
- Expenses for dental care;
- Any amounts you pay because benefits have been reduced for non-compliance with cost containment, precertification or authorization requirements (see pages 10-12);
- Copayments you pay for prescription drugs; and
- Expenses for prescriptions purchased at pharmacies in the 50 United States without using the Plan's combined Foreign Service Benefit Plan/PAID Prescription Drug Identification Card or purchased from a source other than the Plan's Merck-Medco Home Delivery Pharmacy service.

Lifetime maximums

We have the following lifetime maximums:

- We limit the Hospice benefit to $7,500 per person when you precertify hospice care and to $4,500 when you do not precertify.
- We limit the Orthodontic benefit to $1,000 per person.
- We limit diagnosis and treatment of infertility to a maximum benefit of $5,000.

When government facilities bill us

Facilities of the Department of Veterans 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.

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

Under the FEHB law, we must limit our payments for those benefits you would be entitled to if you had Medicare. And, your physician and hospital must follow Medicare rules and cannot bill you for more than they could bill you if you had Medicare. 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 you owe 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; and
- the law prohibits a hospital from collecting more than the Medicare equivalent amount.

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

And, for your physician care, the law requires us to base our payment and your coinsurance 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 PPO provider,	your deductibles and coinsurance;
Participates with Medicare and is a **non**-PPO or **Out-of-Network** provider,	your deductibles, coinsurance, and any balance up to the Medicare approved amount;
Does not participate with Medicare (PPO, non-PPO or Out-of-Network providers),	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 your physician can collect from you. If your physician tries to collect more than allowed by law, ask your physician 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, or 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.

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 the difference between our payment combined with Medicare's payment and the charge.

Note: The 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 your Medicare carrier who sent you the MSN form. Call us if you need further assistance.

When you have a Medicare Private Contract with a physician

A physician may ask you to sign a private contract agreeing that you can be billed directly for services Medicare ordinarily covers. Should you sign an agreement, Medicare will not pay any portion of the charges, and we will not increase our payment. We will still limit our payment to the amount we would have paid after Medicare's payment.

Please see Section 9, *Coordinating benefits with other coverage*, for more information about how we coordinate benefits with Medicare.

Section 5. Benefits — OVERVIEW

(See page 7 for how our benefits changed this year and pages 70 - 71 for a benefits summary.)

NOTE: This benefits section is divided into subsections. Please read the important things you should keep in mind at the beginning of each subsection. Also read the General Exclusions in Section 6; they apply to the benefits in the following subsections. To obtain claims forms, claims filing advice, or more information about our benefits, contact us by phone at 202/833-4910 or e-mail at afspa@afspa.org or at our website at www.afspa.org.

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

IMPORTANT

Here are some 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: $300 per person ($600 per family). 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 and reside in a Network area. When no PPO provider is available in a Network area, non-PPO benefits apply. When you reside Out-of-Network, Out-of-Network benefits apply.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works, with special sections for members who are age 65 or over. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

IMPORTANT

Benefit Description	You pay After the calendar year deductible…
NOTE: The calendar year deductible applies to almost all benefits in this Section. We say "(No deductible)" when it does not apply.	
Diagnostic and treatment services	
• Professional services of physicians during a hospital stay, in the physician's office, at home, or consultations • Second opinion • Psychological tests and pharmacological visits • Medication provided in a physician's office • Drugs and medical supplies billed by a doctor or other covered facility (not including pharmacies) for use at home	PPO: 10% of the Plan allowance Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount Out-of-Network Area: 20% of the Plan allowance and any difference between our allowance and the billed amount
Not covered: • *Telephone consultations* • *Procedures, services, drugs, and supplies related to impotency, sex transformations, sexual dysfunction, or sexual inadequacy* • *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.*	*All charges.*
Lab, X-ray and other diagnostic tests	
X-ray, laboratory and pathology services and machine diagnostic tests – • not related to surgery or preadmission testing	PPO: 10% of the Plan allowance Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount Out-of-Network Area: 20% of the Plan allowance and any difference between our allowance and the billed amount

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

Lab, X-ray and other diagnostic tests *(continued)*	**You pay**
X-ray, laboratory and pathology services and machine diagnostic tests – • performed within 72 hours before admission to a hospital (preadmission testing)	PPO: Nothing (No deductible) Non-PPO: Only the difference between our allowance and the billed amount (No deductible) Out-of-Network Area: Only the difference between our allowance and the billed amount (No deductible)
X-ray, laboratory and pathology services and machine diagnostic tests – • performed within 72 hours of an outpatient surgical procedure	PPO: 10% of the Plan allowance (No deductible) Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount (No deductible) Out-of-Network Area: 10% of the Plan allowance and any difference between our allowance and the billed amount (No deductible)
Preventive care, adult	
Routine physical examination – limited to a maximum charge of $750 per person, per calendar year In addition Routine Cancer Screenings limited to: • Colorectal Cancer Screening, limited to – Fecal occult blood test – one annually for members age 40 and older – Sigmoidoscopy, screening – one every five years for members age 50 and older • Breast Cancer Screening (Mammogram) – one annually for women age 35 and older • Cervical Cancer Screening – Pap smear – one annually for women age 18 and older • Prostate Cancer Screening – Prostate Specific Antigen (PSA) – one annually for men age 40 and older Other Routine Services limited to: • Non-fasting total blood cholesterol test – once every three consecutive calendar years • Chlamydial screening	PPO: 10% of the Plan allowance Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount Out-of-Network Area: 20% of the Plan allowance and any difference between our allowance and the billed amount
Routine immunizations limited to • Tetanus-diphtheria (Td) booster – one every 10 consecutive calendar years from age 19 and over • Influenza vaccine and pneumococcal vaccine – one every calendar year, age 65 and over	PPO: 10% of the Plan allowance Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount Out-of-Network Area: 20% of the Plan allowance and any difference between our allowance and the billed amount

Preventive care, children	You pay
Preventive care for children is limited to: • Well-child visits through 18 months of age. Note: Well child visits after 18 months of age are covered the same as routine physical examinations. (See page 20, *Preventive care, adult.*)	PPO: 10% of the Plan allowance Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount Out-of-Network Area: 20% of the Plan allowance and any difference between our allowance and the billed amount
Immunizations for children are limited to: • Childhood immunizations recommended by the American Academy of Pediatrics are covered for members under age 22.	PPO: Nothing (No deductible) Non-PPO: Only the difference between our allowance and the billed amount (No deductible) Out-of-Network Area: Only the difference between our allowance and the billed amount (No deductible)
Maternity care	
Complete maternity (obstetrical) care, such as: • Prenatal care • Delivery • Postnatal care Note: Here are some things to keep in mind: • You do not need to precertify your normal delivery; see page 11 for other circumstances when you must precertify, such as extended stays for you or your baby. • 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, but you, your representative, your doctor or your hospital must precertify.	PPO: 10% of the Plan allowance (No Deductible) Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount (No Deductible) Out-of-Network Area: 10% of the Plan allowance and any difference between our allowance and the billed amount (No Deductible)
• 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. • We pay hospitalization and surgeon services (delivery) the same as for illness and injury.	See *Hospital benefits* (Section 5c) and *Surgery benefits* (Section 5b). 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 and Out-of-Network facilities. *If your child is not covered under a Self and Family enrollment you pay all of your child's charges after your discharge.*

Maternity care – *continued on next page*

Maternity care *(continued)*	**You pay**
Special Outpatient Care Benefit. When you receive services: • on an outpatient basis; • at a licensed birthing center; or • as an inpatient resulting in a hospital confinement of one day (overnight) or less and no more than one day's room and board charge the Plan pays 100% of our allowance for covered facility services at the time of delivery, not subject to the calendar year deductible or inpatient hospital copayment. Note: If you or your newborn child is transferred from a birthing center to a hospital due to medical complications, we will pay the birthing center expenses as shown above. If you or your child leave the hospital against medical advice before a one-day confinement (overnight) is completed, we will pay our regular benefits and not our special Outpatient Care Benefit.	PPO: Nothing (No deductible or hospital copayment) Non-PPO: Only the difference between our allowance and the billed amount (No deductible or hospital copayment) Out-of-Network Area: Only the difference between our allowance and the billed amount (No deductible or hospital copayment)
Not covered: • *Reversal of voluntary surgical sterilization* • *Procedures, services, drugs, and supplies related to impotency, sex transformations, sexual dysfunction or sexual inadequacy* • *Assisted Reproductive Technology (ART) procedures, such as artificial insemination, in vitro fertilization, embryo transfer, and gamete intrafallopian transfer (GIFT), and services and supplies related to ART procedures* • *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*	*All charges.*
Family planning	
A broad range of voluntary family planning services limited to surgery, medicine and IUD's Surgery limited to: • Voluntary sterilization • Surgery to implant contraceptives (such as Norplant)	PPO: 10% of the Plan allowance (No deductible) Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount (No deductible) Out-of-Network Area: 10% of the Plan allowance and any difference between our allowance and the billed amount (No deductible)
Medicine and IUDs limited to: • Injectable contraceptive drugs (such as Depo provera) • Intrauterine devices (IUDs) • Diaphragms Note: We cover FDA-approved drugs, prescriptions, and devices for birth control covered under the Prescription benefit in Section 5(f).	PPO: 10% of the Plan allowance (No deductible on surgery) Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount (No deductible on surgery) Out-of-Network: 20% of the Plan allowance and any difference between our allowance and the billed amount (No deductible on surgery)
Not covered: reversal of voluntary surgical sterilization, genetic counseling	*All charges.*

Infertility services	You pay
Diagnosis and treatment of infertility, except as shown in *Not covered.* The maximum payment the Plan can make is $5,000 per person per lifetime for the diagnosis and treatment of infertility as defined below. Diagnosis of infertility includes: • The initial diagnostic tests and procedures done solely to identify the cause or causes of the inability to conceive. The treatment of infertility includes: • Hormone therapy and related services; and • Medical or surgical services performed solely to create or enhance the ability to conceive. Hormone therapy to diagnose or treat infertility is not available under any other Plan provisions.	PPO: 10% of the Plan allowance until benefits stop at $5,000; All charges after the Plan's maximum payment of $5,000 Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount until benefits stop at $5,000; All charges after the Plan's maximum payment of $5,000 Out-of-Network Area: 20% of the Plan allowance and any difference between our allowance and the billed amount until benefits stop at $5,000; All charges after the Plan's maximum payment of $5,000
Not covered: • *Infertility services after voluntary sterilization* • *Assisted reproductive technology (ART) procedures, such as:* – *artificial insemination* – *in vitro fertilization* – *embryo transfer and gamete intrafallopian transfer (GIFT)* – *intravaginal insemination (IVI)* – *intracervical insemination (ICI)* – *intrauterine insemination (IUI)* • *Services and supplies related to ART procedures* • *Cost of donor sperm* • *Cost of donor egg*	*All charges.*
Allergy care	
• Testing, treatment, and injections including materials (such as allergy serum)	PPO: 10% of the Plan allowance Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount Out-of-Network Area: 20% of the Plan allowance and any difference between our allowance and the billed amount
Not covered: provocative food testing, end point titration techniques and sublingual allergy desensitization	*All charges.*

Treatment therapies	You pay
• Chemotherapy and radiation therapy (includes radium and radioactive isotopes) Note: High dose chemotherapy in association with autologous bone marrow transplants is limited to those transplants listed on page 31. • Intravenous (IV)/Infusion Therapy (supplies) – Home IV and antibiotic therapy (supplies) Note: See page 26 for home health services • Growth hormone therapy • Respiratory and inhalation therapies (includes oxygen and equipment for its administration)	PPO: 10% of the Plan allowance Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount Out-of-Network Area: 20% of the Plan allowance and any difference between our allowance and the billed amount
Renal dialysis Note: This benefit includes only the actual charge for the dialysis treatment. Other covered charges associated with the dialysis treatment are payable under section 5(a) Lab, X-ray and other diagnostic tests not related to surgery or preadmission testing.	PPO: Nothing (No deductible) Non-PPO: Only the difference between our allowance and the billed amount (No deductible) Out-of-Network Area: Only the difference between our allowance and the billed amount (No deductible)
Not covered: • *Chelation therapy, except for acute arsenic, gold, mercury, or lead poisoning*	*All charges.*
Physical, occupational and speech therapies	
Physical therapy, occupational therapy, and speech therapy when rendered by a registered physical or occupational therapist or licensed speech therapist for up to a total combined visit maximum of 90 visits per person per calendar year for the three listed therapies Note: We only cover therapy when a physician: 1) orders the care; 2) identifies the specific professional skills the patient requires and the medical necessity for skilled services; and 3) indicates the frequency and length of time the services are needed. 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. You must submit the above information from your doctor, along with the therapist's initial evaluation and treatment plan and therapist's progress (therapy) notes for each date of service.	PPO: 10% of the Plan allowance Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount Out-of-Network Area: 20% of the Plan allowance and any difference between our allowance and the billed amount
Not covered: • *Custodial care (see definition page 62)* • *Exercise programs*	*All charges.*

Hearing services (testing, treatment, and supplies)	You pay
Limited to: • Initial hearing exam	PPO: 10% of the Plan allowance Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount Out-of-Network Area: 20% of the Plan allowance and any difference between our allowance and the billed amount
Not covered: • *Hearing aids and examinations for them, except for the initial exam*	*All charges.*
Vision services (testing, treatment, and supplies)	
One pair of eyeglasses or contact lenses per incident if required to correct an impairment directly caused by • accidental ocular injury or • specifically ordered by the doctor in connection with a diagnosis of – cataract – keratoconus or – glaucoma	PPO: 10% of the Plan allowance Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount Out-of-Network Area: 20% of the Plan allowance and any difference between our allowance and the billed amount
Not covered • *Routine eye examinations* • *Eyeglasses and contact lenses, except as shown above* • *Eye exercises and visual training (orthoptics)* • *Refractions* • *All refractive surgeries*	*All charges.*
Foot care	
We do not provide benefits for routine foot care. Routine foot care would include such items as • treatment or removal of corns and calluses, or trimming of toenails • orthopedic shoes, orthotics and other supportive devices for the feet.	*All charges.*
Orthopedic and prosthetic devices	
• Artificial eyes or limbs required to replace natural eyes and limbs • External breast prostheses, including surgical bras and replacements, following a mastectomy • Internal prosthetic devices such as pacemakers, artificial hips, intraocular lenses and surgically implanted breast implant following mastectomy. Note: See 5(b) for coverage of the surgery to insert the device. 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.	PPO: 10% of the Plan allowance Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount Out-of-Network Area: 20% of the Plan allowance and any difference between our allowance and the billed amount
Not covered: • *Orthopedic shoes, orthotics and other supportive devices for the feet*	*All charges.*

Durable medical equipment (DME)	You pay
Rental, up to the purchase price, or purchase (at our option), including necessary repair and adjustment, of durable medical equipment such as: • Wheelchairs • Hospital-type beds • Oxygen and equipment for its administration • Crutches • Braces • Casts, splints, and trusses Durable medical equipment (DME) is equipment and supplies that: • 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; and • Serve a specific therapeutic purpose in the treatment of an illness or injury.	PPO: 10% of the Plan allowance Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount Out-of-Network Area: 20% of the Plan allowance and any difference between our allowance and the billed amount
Not covered: • *Other items that do not meet the definition of durable medical equipment such as sun or heat lamps, whirlpool baths, heating pads, air purifiers, humidifiers, air conditioners, and exercise devices*	*All charges.*
Home health services	
You must precertify home health care (see Section 3 "How to get approval for…" on pages 10-12) in order to get maximum benefits. • If you precertify your home health care, we pay **100%** of our allowance up to $80 per visit for a maximum of 90 visits per calendar year, limited to one visit per day, if such care is an alternative to hospitalization. • If you do not precertify your home health care, we pay **100%** of our allowance up to $40 per visit for a maximum of 40 visits per calendar year, limited to one visit per day, if such care is an alternative to hospitalization. Note: A home health care visit consists of one of the following: • Less than an 8 hour shift of nursing care provided on a part-time basis by a registered nurse (R.N.) or a licensed practical nurse (L.P.N.); • One session of physical, occupational or speech therapy provided by a licensed therapist; • One visit from a licensed social worker (limited to two visits per calendar year); or • Less than an 8 hour shift of a home health aide's services that are performed under the supervision of a registered nurse (R.N.) and that consists mainly of medical care and therapy provided solely for the care of the insured person. 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 doctor and furnished in your home. Note: We define a home health care plan as a plan of continued medical care and treatment ordered by a doctor who certifies that without home health care, you would need to be confined in a hospital or skilled nursing care facility. A public agency or private organization that is licensed as a home health agency by the State and is certified as such under Medicare must provide the care.	For precertified home health care, nothing (No deductible) up to $80 per visit up to 90 visits per calendar year; All charges above $80 per visit and/or 90 visits per calendar year and all charges above one visit per day. For non-precertified home health care, nothing (No deductible) up to $40 per visit up to 40 visits per calendar year; All charges above $40 per visit and/or 40 visits per calendar year and all charges above one visit per day

Home health services – *continued on next page*

Home health services *(continued)*	**You pay**
Private Duty Nursing at home: When you receive care by a registered nurse (R.N.) or licensed practical nurse (L.P.N.) in your home, we will cover up to 500 units of nursing care per calendar year. One unit equals up to one hour of private duty nursing care. We pay $12 per unit.	Nothing (No deductible) up to $12 per unit; All charges after $12 per unit and all charges after 500 units per calendar year
Not covered: • *Nursing care requested by, or for the convenience of, the patient or the patient's family* • *Custodial care (see definition page 62)* • *Home care primarily for personal assistance that does not include a medical component and is not diagnostic, therapeutic, or rehabilitative*	*All charges.*
Chiropractic	
Covered services are limited to: • Manipulation of the spine and extremities • Adjunctive procedures such as ultrasound, electrical muscle stimulation, vibratory therapy and cold pack application Benefits are limited to a maximum payable of $20 per visit up to 30 visits per person per calendar year. Note: The Plan defines Chiropractic as a system of therapeutics that attributes disease to dysfunction of the nervous system and attempts to restore normal function by manipulation and treatment of the body structures, especially those of the vertebral column.	PPO: 10% of Plan allowance and all charges above $20 per visit and/or 30 visits per person per calendar year Non-PPO: 30% of Plan allowance and all charges above $20 per visit and/or 30 visits per person per calendar year Out-of-network: 20% of Plan allowance and all charges above $20 per visit and/or 30 visits per person per calendar year
Alternative treatments	
Acupuncture only when performed by an M.D, D.O., O.M.D., or L.Ac. The benefit is limited to a maximum payable of $20 per visit and a maximum of 30 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.	PPO: 10% of Plan allowance and all charges above $20 per visit and/or 30 visits per person per calendar year Non-PPO: 30% of Plan allowance and all charges above $20 per visit and/or 30 visits per person per calendar year Out-of-network: 20% of Plan allowance and all charges above $20 per visit and/or 30 visits per person per calendar year
Not covered: • *Naturopathic services and medicines* • *Homeopathic services and medicines* *(Note: Benefits of certain alternative treatment providers may be covered in medically underserved areas; see page 8)*	*All charges.*
Educational classes and programs	
Coverage is limited to: • Smoking Cessation – Office visits, individual and group counseling and purchase of over-the-counter smoking cessation drugs and supplies up to a maximum payable of $100 for one program per person per 12 months. Note: Prescription drugs are covered only under the Prescription benefit not subject to the $100 limitation (see Section 5(f)). Note: Over-the-counter smoking cessation drugs and supplies you receive in conjunction with a smoking cessation program **cannot** be purchased with your drug card. You must file a claim for them.	PPO: 10% of the Plan allowance Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount Out-of-Network Area: 20% of the Plan allowance and any difference between our allowance and the billed amount

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

IMPORTANT

Here are some 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: $300 per person ($600 per family). The calendar year deductible does not apply to any benefits in this Section. We added "(No deductible)" to show that 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 and reside in a Network area. When no PPO provider is available in a Network area, non-PPO benefits apply. When you reside Out-of-Network, Out-of-Network benefits apply.
- Be sure to read Section 4, *Your costs for covered services,* for valuable information about how cost sharing works, with special sections for members who are age 65 or over. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- 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.).

IMPORTANT

Benefit Description	You pay After the calendar year deductible…
NOTE: The calendar year deductible does not apply to benefits in this Section. We say "(No deductible)" when it does not apply.	
Surgical procedures	
A comprehensive range of services, such as: • 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 — a condition in which an individual: 1) weighs 100 pounds or 100% over the standard weight as determined by us and has complicating medical condition(s); and 2) has been so for at least five years, despite documented unsuccessful attempts to reduce under a doctor-monitored diet and exercise program. Eligible members must be age 18 or over. • Insertion of internal prosthetic devices. See Section 5(a) – Orthopedic and prosthetic devices for device coverage information. • Voluntary sterilization • Surgical implantation of Norplant (a contraceptive) and intrauterine devices (IUDs) • Treatment of burns • Amniocentesis • Routine circumcision of a newborn child (only when the child is covered under a Self and Family enrollment) Note: Drugs, medical supplies, medical equipment, prosthetic and orthopedic devices and any covered items billed by a provider for use at home are covered only under Section 5(a) and the calendar year deductible and coinsurance apply. Note: Second opinion is covered under Section 5(a) – Diagnostic and treatment services	PPO: 10% of the Plan allowance (No deductible) Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount (No deductible) Out-of-Network Area: 10% of the Plan allowance and any difference between our allowance and the billed amount (No deductible)

Surgical procedures — *continued on next page*

Surgical procedures *(continued)*	**You pay**
Assistant Surgeon (inpatient/outpatient)	PPO: 20% of the Plan allowance (based on 20% of the Plan allowance allocated to the surgery charge) (No deductible) Non-PPO and Out-of-Network Area: 20% of the Plan allowance (based on 20% of the Plan allowance allocated to the surgery charge) and any difference between our allowance and the billed amount (No deductible)
When multiple or bilateral surgical procedures performed during the same operative session add time or complexity to patient care, we pay: • For the primary procedure: – PPO: 90% of the Plan allowance – Non-PPO: 70% of the Plan allowance – Out-of-Network: 90% of the Plan allowance • For the secondary procedure(s): – PPO: 90% of 50% of the Plan allowance – Non-PPO: 70% of 50% of the Plan allowance – Out-of-Network: 90% of 50% of the Plan allowance. Note: For certain surgical procedures, we may apply a value of less than 50% for subsequent procedures. 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.	PPO: 10% of the Plan allowance for the primary procedure and 10% of 50% of the Plan allowance for the secondary procedure(s) (No deductible) Non-PPO: 30% of the Plan allowance for the primary procedure and 30% of 50% of the Plan allowance for the secondary procedure(s); and any difference between our payment and the billed amount (No deductible) Out-of-Network Area: 10% of the Plan allowance for the primary procedure and 10% of 50% of the Plan allowance for the secondary procedure(s); and any difference between our allowance and the billed amount (No deductible)
Not covered: • *Cosmetic surgery except for the repair of accidental injuries sustained while covered under the FEHB Program; to correct a congenital anomaly; or for the reconstruction of a breast following a mastectomy* *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.* • *All refractive surgeries* • *Routine surgical treatment of conditions of the foot (see Section 5(a) – Foot care)* • *Services of a standby surgeon* • *Reversal of voluntary sterilization* • *Surgeries related to impotency, sex transformation, sexual dysfunction or sexual inadequacy*	*All charges.*

Reconstructive surgery	You pay
• Surgery to correct a functional defect • Surgery to correct a condition caused by injury or illness if: – the condition produced a major effect on the member's appearance and – the condition can reasonably be expected to be corrected by such surgery • Surgery to correct a condition that existed at or from birth and is a significant deviation from the common form or norm (Congenital anomaly). Examples of congenital anomalies are: protruding ear deformities; cleft lip; cleft palate; birth marks; and 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: – surgery to produce a symmetrical appearance on the other breast; – surgical treatment of any physical complications, such as lymphedemas; – breast prostheses; and surgical bras and replacements (see Prosthetic devices for coverage) 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.	PPO: 10% of the Plan allowance (No deductible) Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount (No deductible) Out-of-Network Area: 10% of the Plan allowance and any difference between our allowance and the billed amount (No deductible)
Not covered: • *Cosmetic surgery except for the repair of accidental injuries sustained while covered under the FEHB Program; to correct a congenital anomaly; or for the reconstruction of a breast following a mastectomy* *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.* • *Surgeries related to impotency, sex transformation, sexual dysfunction or sexual inadequacy*	*All charges.*
Oral and maxillofacial surgery	
Oral surgical procedures, limited to: • Reduction of fractures of the jaws or facial bones • Surgical correction of cleft lip, cleft palate or severe functional malocclusion (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 • Excision of impacted teeth only • Other surgical procedures that do not involve the teeth or their supporting structures	PPO: 10% of the Plan allowance (No deductible) Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount (No deductible) Out-of-Network Area: 10% of the Plan allowance and any difference between our allowance and the billed amount (No deductible)
Not covered: • *Oral implants and transplants* • *Procedures that involve any tooth or tooth structure, alveolar process, abscess, periodontal disease or disease of gingival tissue except as provided under Dental Benefits (see page 50)* • *Non-surgical treatment of Temporomandibular joint (TMJ) disorders including dental appliances, study models, splints and other devices* • *Excision of non-impacted teeth*	*All charges.*

Organ/tissue transplants	You pay
Limited to the following transplants: • Cornea • Heart • Kidney • Liver • Pancreas • Heart/lung • Single and double lung • Intestinal transplants (small intestine) and the small intestine with the liver or small intestine with multiple organs such as the liver, stomach, and pancreas for irreversible intestinal failure • Bone marrow and stem cell support as follows: – Allogeneic bone marrow transplants – Autologous bone marrow transplants (autologous stem cell support) and autologous peripheral stem cell support for 1) Acute lymphocytic or non-lymphocytic leukemia; 2) Advanced Hodgkin's and non-Hodgkin's lymphoma; 3) Advanced neuroblastoma; 4) Testicular, mediastinal, retroperitoneal and ovarian germ cell tumors; 5) Breast cancer; 6) Multiple myeloma; and 7) Epithelial ovarian cancer 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.	PPO: 10% of the Plan allowance (No deductible) Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount (No deductible) Out-of-Network Area: 10% of the Plan allowance and any difference between our allowance and the billed amount (No deductible) Note: Mutual of Omaha has special arrangements with facilities to provide services for tissue and organ transplants – its Medical Specialty Network. The network was designed to give you an opportunity to access providers that demonstrate high quality medical care for transplant patients. Your physician can coordinate arrangements by calling a case manager in Mutual of Omaha's Medical Management Department at 1-800/228-0286. For additional information regarding the transplant network, please call this number.
Not covered: • *Donor screening tests and donor search expenses, except those performed for the actual donor* • *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*	*All charges.*
Anesthesia	
Professional services provided in: • Hospital (inpatient) • Hospital outpatient department • Skilled nursing facility • Ambulatory surgical center • Office Note: Anesthesia rendered by a dentist only in relation to covered oral and maxillofacial surgery is also covered (see page 30)	PPO: 10% of the Plan allowance (No deductible) Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount (No deductible) Out-of-Network Area: 10% of the Plan allowance and any difference between our allowance and the billed amount (No deductible)

Section 5 (c). Services provided by a hospital or other facility, and ambulance services

IMPORTANT

Here are some 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.
- **Unlike the other subsections in Section 5, in this section, the calendar year deductible applies to only a few benefits. In that case, we added "(calendar year deductible applies)".** The calendar year deductible is: $300 per person ($600 per family).
- The non-PPO benefits are the standard benefits of this Plan. PPO benefits apply only when you use a PPO provider and reside in a Network area. When no PPO provider is available in a Network area, non-PPO benefits apply. When you reside Out-of-Network, Out-of-Network benefits apply.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works, with special sections for members who are age 65 or over. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- 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 OF 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 MUST ALSO GET PRECERTIFICATION OF CARE YOU RECEIVE IN SKILLED NURSING FACILITIES and HOSPICE and also HOME HEALTH CARE.** Please refer to this section (Skilled Nursing Facilities and Hospice) and section 5(a) (Home Health Care) for details on how your benefits are affected if you do not precertify. Also, please refer to the precertification information shown in Section 3 for additional details on precertification.

IMPORTANT

Benefit Description	You pay
NOTE: The calendar year deductible applies ONLY when we say below: "(calendar year deductible applies)".	
Inpatient hospital	
Room and board, such as • ward, semiprivate, or intensive care accommodations; • general nursing care; and • meals and special diets. Note: We only cover a private room when you must be isolated to prevent contagion. Otherwise, we will pay the hospital's average charge for semiprivate accommodations. If the hospital only has private rooms, we base our payment on the average semiprivate rate of the most comparable hospital in the area.	PPO: Nothing Non-PPO: $200 copayment per confinement and 20% of charges. Out-of-Network Area: $200 copayment per confinement

Inpatient hospital — *continued on next page*

Inpatient hospital *(continued)*	**You pay**
Other services and supplies received while in a hospital, such as: • Use of operating, recovery, maternity and other treatment rooms • Surgical dressings • 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) 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. Note: We provide specified benefits for professional services of a doctor, 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. Note: See Section 5(a) for special preadmission testing benefit. 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 doctors in connection with the dental treatment.	See previous page.
Not covered: • *Confinement in 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, pages 8-9)* • *Cosmetic surgery except for the repair of accidental injuries sustained while covered under the FEHB Program; to correct a congenital anomaly; or for the reconstruction of a breast following a mastectomy* *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.* • *Custodial care (see definition page 62)* • *Any part of a hospital admission that is not medically necessary (see definition page 63), 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*	*All charges.*

Outpatient hospital or ambulatory surgical center	You pay
Services and supplies rendered within 72 hours of outpatient surgery such as: • 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) and the calendar year deductible and coinsurance apply.) 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 doctors in connection with the dental treatment. Note: See also Section 5(a) Lab, X-ray and other diagnostic tests for benefits for services received within 72 hours of outpatient surgery.	PPO: 10% of the Plan allowance Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount Out-of-Network Area: 10% of the Plan allowance and any difference between our allowance and the billed amount
Services and supplies not rendered within 72 hours of outpatient surgery or not related to surgery, such as: • Prescribed drugs and medicines for use in the facility • X-ray, laboratory and pathology services and machine diagnostic tests • Medical supplies and equipment, including oxygen • 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) and the calendar year deductible applies.)	PPO: 10% of the Plan allowance (calendar year deductible applies). Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount (calendar year deductible applies) Out-of-Network Area: 20% of the Plan allowance and any difference between our allowance and the billed amount (calendar year deductible applies)
Not covered: • *Cosmetic surgery except for the repair of accidental injuries sustained while covered under the FEHB Program; to correct a congenital anomaly; or for the reconstruction of a breast following a mastectomy* *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.* • *All refractive surgeries* • *Cutting, trimming, treatment or removal of corns, calluses or the free edge of toenails* • *Surgeries related to impotency, sex transformation, sexual dysfunction or sexual inadequacy*	*All charges.*

Extended care benefits/Skilled nursing care facility benefits	You pay

You must precertify your stay in a skilled nursing facility (see Section 3 "How to get approval for…" on pages 10-12) in order to receive maximum benefits.
• If you precertify your stay in a skilled nursing facility, we will pay **100%** of the Plan allowance for a maximum of 60 days per confinement, when your confinement:
  • is for the purpose of receiving medical care;
  • is under the supervision of a doctor; and
  • is an alternative to hospitalization.
• If you do not precertify your stay in a skilled nursing facility, we will pay **80%** of the Plan allowance for a maximum of 30 days per confinement, when the above conditions are met.
Note: We will restore skilled nursing facility benefits shown above for each new period of confinement. We define a new period of confinement when:
• the requirements listed above are met; and
• at least 60 days have elapsed since you were last confined in a skilled nursing facility.
	For precertified care: Nothing up to the Plan allowance for up to 60 days per confinement; All charges after 60 days
	For non-precertified care: 20% of the Plan allowance for up to 30 days per confinement; All charges after 30 days

Not covered: Custodial care (see definition page 62)	*All charges.*
Hospice care	
You must precertify your care in a hospice (see Section 3 "How to get approval for…" on pages 10-12 in order to receive maximum benefits. • If you precertify your care in a hospice, we will pay 100% of our allowance up to a lifetime maximum of $7,500 for hospice care provided by a hospice agency or organization. Your doctor must recommend the care and you must be terminally ill in the final stages of illness. • If you do not precertify your care in a hospice, we will pay 100% of our allowance up to a lifetime maximum of $4,500 for hospice care when you meet the above requirements. Note: We will pay for any services covered under our other benefits under those benefits as applicable before we use the Hospice benefit. Hospice is a coordinated program of home and inpatient pain control and supportive care for the terminally ill patient and the patient's family, provided by a medically supervised team under the direction of a Plan-approved independent hospice administration.	For precertified care: Nothing up to the Plan allowance until benefits stop at $7,500; All charges after $7,500 For non-precertified care: Nothing up to the Plan allowance until benefits stop at $4,500; All charges after $4,500
Not covered: Services shown as covered under any other provisions of this Plan	*All charges.*

Ambulance	You pay
Professional ambulance service to or from the hospital. Note: See Section 5(d) for Ambulance within 72 hours of an accident. Note: This benefit includes air ambulance service when medically necessary to transport you to the nearest facility equipped to handle your medical condition.	PPO: 10% of the Plan allowance (calendar year deductible applies) Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount (calendar year deductible applies) Out-of-Network Area: 20% of the Plan allowance and any difference between our allowance and the billed amount (calendar year deductible applies)
Not covered: Ambulance transport for you or your family's convenience	*All charges.*

Section 5 (d). Emergency services/accidents

IMPORTANT

Here are some important things to 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: $300 per person ($600 per family). 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 and reside in a Network area. When no PPO provider is available in a Network area, non-PPO benefits apply. When you reside Out-of-Network, Out-of-Network benefits apply.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works, with special sections for members who are age 65 or over. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

IMPORTANT

What is an accidental injury?

An accidental injury is a bodily injury caused by an external force such as a blow or a fall and which requires immediate medical attention. We also consider animal bites and poisonings to be accidental injuries. We cover dental care required as a result of an accidental injury to sound natural teeth. We do not consider an injury to the teeth while eating to be an accidental injury.

Benefit Description	You pay After the calendar year deductible…
NOTE: The calendar year deductible applies to almost all benefits in this Section. We say "(No deductible)" when it does not apply.	
Accidental injury	
We pay 100% of our allowance for outpatient emergency treatment (with or without surgery) for the following care you receive within 72 hours of an accidental injury: • Physician services and supplies • Related outpatient services Note: We pay Hospital benefits as specified in Section 5(c) if you are admitted.	PPO: Nothing (No deductible) Non-PPO: Only the difference between our allowance and the billed amount (No deductible) Out-of-Network Area: Only the difference between our allowance and the billed amount (No deductible)
For care you receive after 72 hours of your accidental injury, we cover: • Non-surgical physician services and supplies • Related outpatient services Note: We pay Hospital benefits as specified in Section 5(c) if you are admitted.	PPO: 10% of the Plan allowance Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount Out-of-Network Area: 20% of the Plan allowance and any difference between our allowance and the billed amount

Accidental injury — *continued on next page*

Accidental injury *(continued)*	**You pay**
If you receive surgical care for your accidental injury after 72 hours, we pay regular Surgical benefits. Note: We pay Hospital benefits as specified in Section 5(c) if you are admitted.	PPO: 10% of the Plan allowance (No deductible) Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount (No deductible) Out-of-Network Area: 10% of the Plan allowance and any difference between our allowance and the billed amount (No deductible)
Medical emergency	
Regular Plan benefits apply to care you receive because of a medical emergency (non-accident). Items covered include: • Outpatient medical services and supplies • Physician services and supplies • X-ray, laboratory and pathology services and machine diagnostic tests	PPO: 10% of the Plan allowance Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount Out-of-Network Area: 20% of the Plan allowance and any difference between our allowance and the billed amount
Ambulance	
If you use a professional ambulance service within 72 hours of an accident: • Plan pays the first $50 of charges in full. Note: See Section 5(c) for non-emergency service, for service after 72 hours and in excess of $50.	PPO: Nothing (No deductible) up to $50 Non-PPO: Nothing (No deductible) up to $50 Out-of-Network Area: Nothing (No deductible) up to $50
Not covered: Ambulance transport for you or your family's convenience	*All charges.*

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

IMPORTANT

You may choose to get care from a PPO or non-PPO provider if you live in the PPO area and from an Out-of-Network Area provider if you do not live in the PPO area. When you receive any care, you must get our approval for services and follow a treatment plan we approve. If you do, cost-sharing and limitations for PPO and Out-of-Network Area mental health and substance abuse benefits will be no greater than for similar benefits for other illnesses and conditions.

Here are some important things to keep in mind about these benefits:

- 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 apply 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 and reside in a Network area. When no PPO provider is available in a Network area, non-PPO benefits apply. When you reside Out-of-Network, Out-of-Network benefits apply.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works, with special sections for members who are age 65 or over. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- **YOU MUST GET PREAUTHORIZATION OF THESE SERVICES.** See the instructions after the benefits descriptions below.
- PPO mental health and substance abuse benefits are below and on the next page, non-PPO benefits begin on page 41 and Out-of-Network benefits begin on page 43.

IMPORTANT

Benefit Description	You pay After the calendar year deductible…
NOTE: The calendar year deductible applies to almost all benefits in this Section. We say "(No deductible)" when it does not apply.	
IN-NETWORK AREA BENEFITS — PPO mental health and substance abuse benefits (if you live in the PPO area and use a PPO provider)	
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. 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. We will reduce your benefits if you do not precertify, preauthorize, obtain concurrent review (which means review of continuing treatment) or follow your treatment plan for all levels of care.	Your cost sharing responsibilities are no greater than for other illnesses or conditions. Note: See pages 40-41 for penalties for not precertifying, preauthorizing, obtaining concurrent review (which means review of continuing treatment) or following your treatment plan.
Professional services including: • Individual and group therapy rendered by providers such as psychiatrists, psychologists, or clinical social workers • Medication management – Note: We cover this under Section 5(a) pharmacological visits, no preauthorization required.	PPO: 10% of Plan allowance

PPO mental health and substance abuse benefits — *continued on next page*

PPO mental health and substance abuse benefits *(continued)*	**You pay**
• Diagnostic tests including psychological testing	PPO: 10% of Plan allowance
• Services provided by a hospital or other facility	PPO Inpatient Facility: nothing for room and board and other services (No deductible)
• Services in approved outpatient care settings such as: • Intensive Outpatient Programs (IOP). These programs offer time-limited services that: – 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: – 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.	PPO IOP Intensive Outpatient Program and PPO Partial Hospitalization facility: 10% of Plan allowance
• Day Care in a day care facility (see definition, page 9)	PPO Day Care Facility: 10% of Plan allowance
Not covered: • *Services we have not approved* • *Counseling or therapy for marital, educational, sexual, or behavioral problems* • *Treatment of mental retardation and learning disabilities* • *Telephone consultations* *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.*	*All charges*

Precertification/Preauthorization

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 and your treatment plan. 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 pages 10-12 for more detail.** These include:

- **Precertification** to establish the medical necessity of your admission to a hospital or other facility for you to receive full Plan benefits. 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** to establish the medical necessity for all levels of outpatient or office care whether in or out-of-network. If you do not preauthorize, we will reduce any available benefits by 50% of what we would have paid had you preauthorized your care.
- **Concurrent review (which means review of continuing treatment)** to establish the medical necessity for all levels of continuing outpatient or office care whether in or out-of-network. If you do not obtain concurrent review or follow your treatment plan, we will reduce any available benefits by 50% of what we would have paid had you obtained concurrent review or followed your treatment plan.

Precertification/Preauthorization — *continued on next page*

PPO mental health and substance abuse benefits *(continued)*	
	• **To precertify or preauthorize care and obtain concurrent review for continuing care,** you, your representative, your doctor, or your hospital must call Mutual of Omaha's Care Review Unit at 1-800/228-0286 prior to the admission or care. Note: We do not require precertification, preauthorization or concurrent review for continuing care for services you receive outside of the United States or when Medicare Part A and/or B, or another group health insurance policy is the primary payer. 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.
PPO limitation	We will limit your benefits if you do not follow all of our preauthorization processes and your treatment plan.

IN-NETWORK AREA BENEFITS — Non-PPO mental health and substance abuse benefits (if you live in the PPO area and use a non-PPO provider	**You pay** **After the calendar year deductible**
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. 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. We will reduce your benefits if you do not precertify, preauthorize, obtain concurrent review (which means review of continuing treatment), or follow your treatment plan for all levels of care.	Your cost sharing responsibilities **are greater and limitations apply** when you use a **non-PPO** provider. Note: See pages 40-41 and 42 for penalties for not precertifying, preauthorizing, obtaining concurrent review (which means review of continuing treatment) or following your treatment plan.

Professional services including:
• Individual and group therapy rendered by providers such as psychiatrists, psychologists, or clinical social workers **with the following limitations:**
  • Non-PPO inpatient professional services limited to 50 visits per person per calendar year and a maximum payable of $60 per visit
  • Non-PPO inpatient group therapy limited to actual charges up to a maximum payable of $30 per session
  • Non-PPO outpatient individual therapy benefits limited to 60 visits per person per calendar year
  • Non-PPO outpatient group therapy benefits limited to $40 per session
	Non-PPO Professional fees:
	• Individual therapy inpatient: 30% of Plan allowance plus all charges above $60; and all visits above 50 per person per calendar year
	• Group therapy inpatient: Nothing up to $30 per session and all charges above $30
	• Individual therapy outpatient: 30% of Plan allowance and any difference between our allowance and the billed amount up to 60 visits per person per calendar year; and all visits after 60 per person per calendar year
	• Group therapy outpatient: 50% of Plan allowance plus and all charges above $40

• Medication management - Note: We cover this under Section 5(a) pharmacological visits, no preauthorization required and not subject to the Plan's maximum visit limitation.	Non-PPO medication management: 30% of Plan allowance and any difference between our allowance and the billed amount
• Diagnostic tests including psychological testing	Non-PPO: 30% of Plan allowance

Non-PPO mental health and substance abuse benefits — *continued on next page*

Non-PPO mental health and substance abuse benefits *(continued)*	**You pay**
• Services provided by a hospital or other facility	Non-PPO Inpatient Facility: $200 copayment per person per confinement and 30% of covered charges for room and board and other services (No deductible)
• Services in approved outpatient care settings such as: • Intensive Outpatient Programs (IOP). These programs offer time-limited services that: – 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: – 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.	Non-PPO IOP Intensive Outpatient Program and non-PPO partial hospitalization facility: 30% of Plan allowance and any differences between our allowance and the billed amount
• Day Care in a day care facility (see definition, page 9) **with the following limitation:** – Non-PPO day care facility services limited to 20 visits per person to a day care facility.	Non-PPO Day Care Facility: 30% of Plan allowance and any difference between our allowance and the billed amount for up to 20 days. After 20 days you pay all charges.
Not covered: • *Services we have not approved* • *Counseling or therapy for marital, educational, sexual, or behavioral problems* • *Treatment of mental retardation and learning disabilities* • *Telephone consultations* *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.*	*All charges.*

Precertification/Preauthorization	We have the same precertification, preauthorization and concurrent review (which means review of continuing treatment) requirements for non-PPO (within Network Area) services and Out-of-Network Area in the United States as we do for PPO (within Network Area). See pages 40-41 for details.
Non-PPO limitation	We will limit your benefits if you do not follow all of our authorization processes and your treatment plan.

OUT-OF-NETWORK AREA BENEFITS — Mental health and substance abuse benefits	**You pay** **After the calendar year deductible**
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. 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. We will reduce your benefits if you do not precertify, preauthorize, obtain concurrent review (which means review of continuing treatment) or follow your treatment plan for all levels of care. Note: If you receive care outside of the United States, we do not require precertification, preauthorization or concurrent review for continuing care. See pages 10-12 for details.	Your cost sharing responsibilities are no greater than for other illness or conditions. Note: See pages 40-41 and 44 for penalties for not precertifying, preauthorizing or obtaining concurrent review (which means review of continuing treatment) or following your treatment plan.
Professional services including: • Individual and group therapy rendered by providers such as psychiatrists, psychologists, or clinical social workers	Out-of-Network Area Professional fees: • Individual therapy inpatient and outpatient: 20% of Plan allowance and any difference between our allowance and the billed amount • Group therapy inpatient and outpatient: 20% of Plan allowance and any difference between our allowance and the billed amount
• Medication management – Note: We cover this under Section 5(a) pharmacological visits, no preauthorization required.	Out-of-Network medication management: 20% of Plan allowance and any difference between our allowance and the billed amount
• Diagnostic tests including psychological testing	Out-of-Network Area: 20% of Plan allowance
• Services provided by a hospital or other facility	Out-of-Network Area Inpatient Facility: $200 copayment per person per confinement (No deductible)

Out-of-Network Area mental health and substance abuse benefits — *continued on next page*

OUT-OF-NETWORK AREA BENEFITS **Mental health and substance abuse benefits** *(continued)*	**You pay**
• Services in approved outpatient care settings such as: • Intensive Outpatient Programs (IOP). These programs offer time-limited services that: – 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: – 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.	Out-of-Network Area: IOP Intensive Outpatient Program and partial hospitalization facility: 20% of Plan allowance and any difference between our allowance and the billed amount
• Day Care in a day care facility (see definition, page 9)	Out-of-Network Area Day Care Facility: 20% of Plan allowance and any difference between our allowance and the billed amount for up to 20 days. After 20 days you pay all charges.
Not covered: • *Services we have not approved* • *Counseling or therapy for marital, educational, sexual, or behavioral problems* • *Treatment of mental retardation and learning disabilities* • *Telephone consultations* *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.*	*All charges.*

Precertification/Preauthorization	We have the same precertification, preauthorization and concurrent review (which means review of continuing treatment) requirements for non-PPO (within Network Area) services and Out-of-Network Area in the United States as we do for PPO (within Network Area). We waive these requirements for treatment you receive outside of the United States. See pages 40-41 for details.
Out-of-Network Area Limitation	We will limit your benefits if you do not follow all of our authorization processes and your treatment plan except for care received outside of the U.S.

See these sections of the brochure for more valuable information about these benefits:

- Section 4, *Your cost for covered services,* for information about catastrophic protection for these benefits.
- Section 7, *Filing a claim for covered services,* for information about submitting non-PPO and Out-of-Network claims

Section 5 (f). Prescription drug benefits

IMPORTANT

Here are some important things to keep in mind about these benefits:

- We cover prescribed drugs and medications, as described in the chart beginning on page 47.
- 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: $300 per person ($600 per family). The calendar year deductible applies only to prescriptions purchased outside of the 50 United States 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, with special sections for members who are age 65 or over. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

IMPORTANT

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

- **Who can write your prescription.** A licensed physician must write the prescription.
- **When you have to purchase a prescription.**
  - We will provide you with a combination Foreign Service Benefit Plan/PAID Prescription Drug Identification Card. The PAID Prescription LOGO will appear on the front of the card. The Plan's RX Group Number of FSBP000 and PAID PRESCRIPTIONS, L.L.C. appear with the logo as follows:

    FSBP000
    PAID PRESCRIPTIONS, LLC

    In most cases, you simply present the card together with the prescription to a network pharmacy. You do not file a PAID prescription card claim with the Plan.

- **Where you can obtain your prescription.**
  - **Network Pharmacies within the 50 United States**
    You must fill your prescription at a network pharmacy participating in the PAID TelePAID system. You may obtain the names of network pharmacies by calling 1-800/818-6717, on the internet at www.merckmedco.com, or as a link through our web page at www.afspa.org. **You must present your combined Foreign Service Benefit Plan/PAID Prescription Drug Identification Card when filling your prescription in order to receive this benefit.** ***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**
    You will receive forms for refills and future prescription orders each time you receive drugs or supplies under the Merck-Medco Mail Service Pharmacy (Home Delivery Pharmacy service). You may also order refills over the internet directly from Home Delivery Pharmacy service by visiting www.merckmedco.com. If you have any questions about a particular drug or a prescription, or to request your order forms, you may call 1-800/818-6717 in the United States or 1-800/497-4641 (available in over 140 countries) from overseas. You can also call Merck-Medco collect at 973/560-6100 if the overseas number does not work for you. Your doctor must be licensed in the United States. If you are posted, living or traveling overseas, you may request up to a 1 year supply of most medications. *Prescriptions you purchase by mail order from a source other than Merck-Medco Home Delivery Pharmacy service 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 Home Delivery Pharmacy service; and 4) Allow approximately two weeks for delivery.
  - **Retail Pharmacies outside of the 50 United States**
    Fill your prescription as you normally do. Use the Plan's claim form to claim benefits for prescription drugs and supplies you purchased through a retail pharmacy **outside of the 50 United States**. Claims must include receipts that show the name of the patient, prescription number, name of drug(s), name of the prescribing doctor, name of the pharmacy, date, and the charge. You may obtain claim forms by calling 202/833-4910 or from our website at www.afspa.org. Mail claims to the Plan's address shown on page 53.

- **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.
  - You may purchase long-term (up to a 90-day supply) prescription needs through the Home Delivery Pharmacy service to receive higher benefits. Home Delivery Pharmacy service will fill your prescription. We cover all drugs and supplies listed except for those that require constant refrigeration, are too heavy to mail, or that must be administered by a physician.
  - **Per Federal regulations, Home Delivery Pharmacy service can only mail to addresses in the United States, APO and FPO addresses.**
  - You may not obtain hormone therapy treatment with your combined Foreign Service Benefit Plan/PAID Prescription ID Card or through the Home Delivery Pharmacy service.
- If a Federally-approved generic equivalent to the prescribed drug is available, the Home Delivery Pharmacy service will dispense the generic equivalent instead of the brand name unless your physician specifies that the brand name is required. Your physician must note "Dispense as Written" (DAW) for you to receive the name brand.

- **Why use generic drugs?**

  Generic drugs offer a safe and economic way to meet your prescription drug needs. The generic name of a drug is its chemical name; the brand name is the name under which the manufacturer advertises and sells a drug. Under Federal law, generic and brand name drugs must meet the same standards for safety, purity, strength, and effectiveness.

  You can save money by using generic drugs. However, you and your physician have the option to request a brand name drug if a generic is available. To do so, make sure your physician notes "Dispense as Written" (DAW) for you to receive the brand name.

When you have to file a claim.

- See the previous page for instructions when you purchase prescriptions from a pharmacy outside of the United States.
- Contact us for instructions on how to receive reimbursement if you purchase a prescription and any of the following apply:
  - You recently enrolled in the Plan and you do not have your combined Foreign Service Benefit Plan/PAID Prescription 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 purchase of medication from a non-network pharmacy.

Prescription drug benefits begin on next page.

Benefit Description	You pay
NOTE: The calendar year deductible applies only to prescriptions purchased outside of the 50 United States. We say "(No deductible)" when it does not apply.	
Covered medications and supplies	
You must present your combined Foreign Service Benefit Plan/PAID Prescription Drug Identification Card when filling your prescription at a network pharmacy. You may purchase the following medications and supplies prescribed by a physician from either a network pharmacy, retail pharmacy outside of the 50 United States, or by mail through the Home Delivery Pharmacy service: • Drugs that by Federal law of the United States require a doctor's prescription for their purchase except those listed as not covered • Insulin • FDA-approved drugs, prescriptions, and devices for birth control • Prescription drugs for smoking cessation You may also purchase the following supplies that do not require a prescription by using your card: • Needles and syringes for the administration of covered medications • Diabetic, colostomy, and ostomy supplies Prescription drugs you receive from a doctor or facility are covered only as specified under Section 5(a) and 5(c).	• Network Retail (including Medicare Part B): $10 generic/$20 brand name (No deductible) • Non-Network Retail (in the 50 United States, including Medicare Part B): 100% of cost • Non-Network Retail pharmacies (outside of the 50 United States, including Medicare Part B): 20% of cost • Network Mail Order –the Home Delivery Pharmacy service (including Medicare Part B): $15 generic/$25 brand (No deductible) Note: If there is no generic equivalent available, you will still have to pay the brand name copay. Note: When Medicare Part B is the primary payer, the Plan does not waive the copayment applicable to covered drugs and supplies purchased at a network pharmacy or through the Home Delivery Pharmacy service.
Not covered: • *Drugs and supplies you purchase at a non-network pharmacy in the United States except as covered under Section 5(a) and 5(c)* • *Drugs and supplies you purchase without using your combined Foreign Service Benefit Plan/PAID Prescription Drug ID Card at a network pharmacy except as covered under Section 5(a) and 5(c)* • *Drugs and supplies you purchase by mail order from a source other than the Plan's Merck-Medco Home Delivery Pharmacy service* • *Prescription Drug Card copays* • *Non-prescription medicines (over-the-counter medications)* • *Drugs and supplies for cosmetic purposes* • *Nutritional supplements and vitamins* • *Medication that under Federal law does not require a prescription, even if your doctor prescribes it or State law requires it or for which there is a non-prescription equivalent available* • *Hormone therapy to diagnose or treat infertility except that limited to the $5,000 lifetime maximum as part of the diagnosis and treatment of infertility (see page 23). You may not obtain hormone therapy treatment with your combined Foreign Service Benefit Plan/PAID Prescription ID Card or through the Home Delivery Pharmacy service.* • *Drugs and supplies related to impotency, sex transformations, sexual dysfunction, or sexual inadequacy*	*All charges.*

Section 5 (g). Special features

Special features	Description
Flexible benefits option	Under the flexible benefits option, we determine the most effective way to provide services. • We may identify medically appropriate alternatives to traditional care and coordinate other benefits as a less costly alternative benefit. • Alternative benefits are subject to our ongoing review. • By approving an alternative benefit, we cannot guarantee you will get it in the future. • The decision to offer an alternative benefit is solely ours, and we may withdraw it at any time and resume regular contract benefits. • Our decision to offer or withdraw alternative benefits is not subject to OPM review under the disputed claims process.
24 hour nurse line	Optum® NurseLine: You can reach a R.N. 24 hours every day by calling: • Toll-free 1-877/610-9809 (this number is also available in over 140 countries from overseas using the specific country's AT&T Access Number); or • A dedicated collect call number (from overseas) at 304/767-7374. You can also access health and well-being information through Optum's Internet application at www.healthforums.com. Optum NurseLine provides assistance with: • General health information • Deciding where to go for care • Choosing self-care measures • Guidance for difficult conditions • Medication questions • Communicating with your health care provider We mail new members information on Optum NurseLine that contains more details on the services Optum offers.
Centers of excellence for tissue and organ transplants	Mutual of Omaha has special arrangements with facilities to provide services for tissue and organ transplants – its Medical Specialty Network. The network was designed to give you an opportunity to access providers that demonstrate high quality medical care for transplant patients. Your physician can coordinate arrangements by calling a case manager in Mutual of Omaha's Medical Management Department at 1-800/228-0286. For additional information regarding the transplant network, please call this number.
Disease management programs	**Healthy*directions*[sm] , a disease management program for members and covered dependents with asthma, diabetes, or congestive heart failure (CHF).** **Healthy*directions*[sm]** is provided at no additional cost to participants. The program provides: • Nurse support; • Education about the disease and how it affects the body; and • Proper medical management that can help lead to a healthier lifestyle. We will contact candidates and ask them to participate voluntarily. The participant and his/her physician remain in charge of the participant's treatment plan. If you would like to contact Mutual of Omaha for more information about this program, please call 1-800/228-0286.

Section 5 (h). Dental benefits

IMPORTANT

Here are some important things to 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: $300 per person ($600 per family). 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, with special sections for members who are age 65 or over. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- 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 doctors in connection with the dental treatment.

IMPORTANT

Accidental injury benefit	You pay
We cover dental work (including dental X-rays) to repair or initially replace sound natural teeth under the following conditions: • You must receive these services as a result of an accidental injury (see page 37) to the jaw or sound natural teeth. • You must be covered by this Plan when the accident occurred. • You must receive these services within 24 months of the accident. Note: We define a sound natural tooth as a tooth which • 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.	PPO: 20% of Plan allowance (calendar year deductible applies) Non-PPO and Out-of-Network Area: 20% of Plan allowance and any difference between our allowance and the billed amount (calendar year deductible applies)

Dental benefits – *continued on next page*

Dental benefits *(continued)* **(Only those services listed below are covered)**

Service	We pay (scheduled allowance)	You pay
Preventive care, limited to two services per person per calendar year		All charges in excess of the scheduled amounts listed to the left
• Oral exam	$13 per exam	
• Prophylaxis (cleaning), adult	$23 per cleaning	
• Prophylaxis, child (thru age 14)	$16 per cleaning	
• Prophylaxis with fluoride, child (thru age 14)	$26 per cleaning	
Surgery		
• Apicoectomy (tooth root amputation)	$50 per root	
• Alveolectomy (excision of alveolar bone)	$40 for 4 through 12 teeth $60 for 13 through 20 teeth $80 for 21 or more teeth	
• Alveolar abscess, incision and drainage	$10 per abscess	
• Gingivectomy (excision of gum tissue)	$50 per quadrant	
Note: Excision of impacted teeth and non-dental oral surgical procedures are covered under Surgery Section 5(b), page 30.		

Orthodontic Services	We pay	You pay
We define orthodontics as the realignment of natural teeth or correction of malocclusion.	50% of Plan allowance up to a lifetime maximum of $1,000 per person	50% of Plan allowance until benefits stop at $1,000. All charges after $1,000.

Section 5 (i). 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 out-of-pocket maximums.

Long Term Care	The importance of Long Term care insurance has never been clearer. The government will present its own offering in October of this year and you can read about it on page 67 of this brochure. AFSPA members are eligible for our plans **NOW**. We offer two excellent policies with group rates and deep discounts. Both plans provide benefits for all levels of nursing home care (skilled, intermediate, custodial), assisted living facility, home health care, adult day care and respite care. The underwriters, Mutual of Omaha and John Hancock, are highly respected pillars of the insurance industry. **Mutual of Omaha** • $100 daily benefit • 5% simple inflation • Benefit Increase Option • International coverage • Return-of-premium feature **John Hancock** • $50 to $300 daily benefit • 5% simple or compound inflation • 100% of benefit for home health care • 2-year to lifetime benefit period • Some International coverage
Discount on Non-Covered Prescription Drugs	You may purchase non-covered (off-plan) prescription drugs at a discount directly from Merck-Medco Rx (MMRx) Services such as: ➤ Dermatologicals (Retin-A) ➤ Anorexiants ➤ Rx Vitamins ➤ Erectile dysfunction agents (Viagra) ➤ Drugs labeled for cosmetic indications (Propecia) • You pay 100% of the discounted price. You cannot file a claim with us for off-plan prescriptions. • Call MMRx Services first at 1-800/818-6717 to find out the price of off-plan prescriptions. • Obtain the prescription from your doctor. • Complete the mail order envelope and enclose your prescription along with your check or credit card number. You must include full payment with your order for prescriptions.
Term Life Insurance	• Up to $200,000 of coverage • Includes acts of terrorism or war • Simple, inexpensive, straightforward protection
Expanded Dental Benefits	Two Plans offered: • CONSUMER DENTAL CARE (Available DC/MD/VA Only) No claim forms, deductibles, or waiting period for pre-existing conditions • DENTAL INDEMNITY PLAN (CIGNA International) International and domestic coverage; Based on coinsurance at 100%, 80% and 50%; Overseas dental referrals; Claims processed in any language and most currencies
Long Distance Telephone Services	• Calling Card and, for those overseas, Callback Service No sign-up fees, no monthly fees, excellent domestic and international rates, and no hidden costs
Senior Living Services	• At no cost to our members, we offer information on senior living facilities throughout the U.S.
Legal Services	• Three firms located in the Washington Metropolitan area serve our members at special rates
Travel Assistance Services	• Emergency medical evacuation; On-the-spot medical payments; Worldwide medical referrals and medical monitoring; Prescription replacement assistance; Repatriation of remains benefit

For information and written material on any of the above programs, please contact us at:

American Foreign Service Protective Association
1716 N Street, NW
Washington, D.C. 20036-2902

202/833-4910
202/833-4918 (fax)
E-mail: afspa@afspa.org

Web site: www.afspa.org

Section 6. General exclusions — things we don't cover

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

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;
- Procedures, 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;
- Procedures, services, drugs, or supplies related to impotency, sex transformations, sexual dysfunction or sexual inadequacy;
- Services, drugs, or supplies you receive from a provider or facility barred from the FEHB Program;
- Services and supplies for which you would not be charged if you had no health insurance coverage;
- Services and supplies you receive without charge; while in active military service; or required for illness or injury sustained on or after the effective date of enrollment (1) as a result of an act of war within the United States, its territories, or possessions or (2) during combat;
- Services and supplies you receive from immediate relatives or household members, such as spouse, parents, children, brothers or sisters by blood, marriage or adoption;
- Services and supplies you receive from a noncovered facility, except that medically necessary prescription drugs are covered;
- Services and supplies not recommended or approved by a covered provider;
- Services and supplies not specifically listed as covered;
- Services and supplies related to weight control or any treatment of obesity, except surgery for morbid obesity;
- Non-medical services such as recreational and educational therapy and nutritional counseling;
- Treatment of mental retardation and learning disabilities;
- Services for cosmetic purposes;
- Non-surgical treatment of temporomandibular joint (TMJ) dysfunction including dental appliances, study models, splints and other devices;
- Any portion 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 you or we have no legal obligation to pay, such as: excess charges for an annuitant age 65 or older who is not covered by Medicare Parts A and/or B (see page 16), doctor charges exceeding the amount specified by the Department of Health and Human Services when benefits are payable under Medicare (limiting charge) (see page 17), or State premium taxes however applied;
- Mutually exclusive procedures. These are procedures that are not typically provided to the same patient on the same date of service;
- Charges for completion of reports or forms;
- Exclusions primarily identified with a single benefit category, listed along with that benefit category and which may apply to other categories; or
- Charges that we determine are over our Plan allowance.

Section 7. Filing a claim for covered services

How to claim benefits

To obtain claim forms or other claims filing advice or answers about our benefits, contact us by mail at Foreign Service Benefit Plan, 1716 N Street, NW, Washington, DC 20036-2902, by phone at 202/833-4910, by fax at 202/833-4918, by e-mail at afspa@afspa.org or at our website at www.afspa.org.

In most cases, providers and facilities file claims for you. Your physician must file on the form HCFA-1500, Health Insurance Claim Form. Your facility will file on the UB-92 form.

When you must file a claim — such as for non-PPO or out-of-network providers, overseas claims or when another group health plan is primary — submit it on the HCFA-1500 or a claim form that includes the information shown below. Bills and receipts should be itemized and show:

- Name of patient and relationship to enrollee;
- Plan identification number of the enrollee;
- Name and address of person or firm providing the service or supply;
- Dates that services or supplies were furnished;
- Diagnosis;
- Type of each service or supply; and
- The 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 as an e-mail attachment.

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 or you have changed your address, or if the member's other insurance/Medicare status has changed.
- You must send a copy of the explanation of benefits (EOB) from any primary payer (such as the Medicare Summary Notice (MSN)) with your claim. See page 59 for Medicare claims.
- Bills for private duty nursing care must show that the nurse is a registered (R.N.) or licensed practical nurse (L.P.N.). You should also include the initial history and physical, treatment plan indicating expected duration and frequency from your attending physician and the nursing 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 I.D. number. We do not have separate dental claim forms.

Overseas (foreign) claims

- If you are posted overseas 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 Administrative 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 may include an English translation (not required) and a currency exchange rate (recommended). We will translate claims and will convert to U.S. Currency using the exchange rate applicable at the time the expense was incurred if you do not supply us with a translation or conversion.

- **We have direct billing arrangements with hospitals in several countries, including Brazil, Germany, Korea and Panama. We also have a fast track payment process if you are posted in Korea.** Please contact us for more information on these arrangements if you are in these locations.

After you complete a claim form and attach proper documentation, send your claims to:

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

If you are overseas and have access to the Department of State pouch mail, you may send your claims in care of Department of State, Washington, DC 20520. Note: Do not use this address if you are in the United States. It will delay your claim.

Plan telephone number: 202/833-4910

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.

Deadline for filing your claim

Send us all of the documents for your claim as soon as possible. You must submit the claim within 90 days after you incur the expense, but in no event later than 2 years from the date you incur the expense. We can extend this deadline if you were prevented from filing your claim timely by administrative operations of Government or legal incapacity, provided you file the claim as soon as reasonably possible. Once we pay benefits, there is a three-year limitation on the reissuance of uncashed checks.

When we need more information

Please reply promptly when we ask for additional information. We may delay processing or deny your claim if you do not respond.

Section 8. The disputed claims process

Follow this Federal Employees Health Benefits Program disputed claims process if you disagree with our decision on your claim or request for services, drugs, or supplies - including a request for preauthorization/prior approval:

Step	Description
1	Ask us in writing to reconsider our initial decision. You must: (a) Write to us within 6 months from the date of our decision; and (b) Send your request to us at: 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.
2	We have 30 days from the date we receive your request to: (a) Pay the claim (or, if applicable, arrange for the health care provider to give you the care); or (b) Write to you and maintain our denial — go to step 4; or (c) Ask you or your provider for more information. If we ask your provider, we will send you a copy of our request-go to step 3.
3	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.
4	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: Office of Personnel Management, Office of Insurance Programs, Contracts Division 2, 1900 E Street, NW, Washington, D.C. 20415-3620 **The Disputed Claims process** Send OPM the following information: • A statement about why you believe our decision was wrong, based on specific benefit provisions in this brochure; • Copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms; • Copies of all letters you sent to us about the claim; • Copies of all letters we sent to you about the claim; and • Your daytime phone number and the best time to call. Note: If you want OPM to review different claims, you must clearly identify which documents apply to which claim.

The Disputed Claims process (continued)

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.

Note: The above deadlines may be extended if you show that you were unable to meet the deadline because of reasons beyond your control.

5 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 based on the terms of the contract. OPM will send you a final decision within 60 days. There are no other administrative appeals.

6 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

(a) We haven't responded yet to your initial request for care or preauthorization/prior approval, then call us at 202/833-4910 and we will expedite our review; or

(b) We denied your initial request for care or preauthorization/prior approval, then:

- If we expedite our review and maintain our denial, we will inform OPM so that they can give your claim expedited treatment too, or
- You can call OPM's Health Benefits Contracts Division II at 202/606-3818 between 8 a.m. and 5 p.m. eastern time.

Section 9. Coordinating benefits with other coverage

When you have other health coverage

You must tell us if you are covered or a family member is covered under another group health plan or have 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 payer and the other plan pays a reduced benefit as the secondary payer. We, like most other insurers, determine which coverage is primary according to the National Association of Insurance Commissioners' guidelines.

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

When we are the secondary payer, 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.

• What is Medicare?

Medicare is a Health Insurance Program for:

- People 65 years of age and 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 two 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. (Someone who was a Federal employee on January 1, 1983 or since automatically qualifies.) Otherwise, if you are age 65 or older, you may be able to buy it. Contact 1-800-MEDICARE 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.

If you are eligible for Medicare, you may have choices in how you get your health care. Medicare+Choice is the term used to describe the various health plan choices available to Medicare beneficiaries. The information in the next few pages shows how we coordinate benefits with Medicare, depending on the type of Medicare+Choice plan you have.

• 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. Some things are not covered under Original Medicare, like prescription drugs.

When you are enrolled 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 of inpatient hospital confinements when Medicare Part A is primary. We do not require preauthorization and concurrent review of Mental Health Substance Abuse treatment when Medicare Part B is primary. However, when Medicare stops paying benefits for any reason, you must follow our precertification, preauthorization and concurrent review procedures.

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 at afspa@afspa.org to find out if your claims are being electronically filed or you have questions about the process described below.

- When we are the primary payer, we process the claim first.
- When Original Medicare is the primary payer, Medicare processes your claim first. In most cases, we will coordinate your claims automatically and we will pay the balance of 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 (MSN) until you have sent us 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 when you have the Original Medicare Plan — When Original Medicare is the primary payer, 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 confinement.
  - 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 and coinsurance.
- **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 confinement.
  - If you are enrolled in Medicare Part B, we will waive the deductible and coinsurance.
- **Services provided under Prescription benefits Section 5(f).**
  - We do **not** waive the prescription copay.
- **Services provided under Dental benefits in Section 5(h).**
  - We do not waive the coinsurance under Dental benefits.

– The following chart illustrates whether Original Medicare or this Plan should be the primary payer 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.

Primary Payer Chart

A. When either you — or your covered spouse — are age 65 or over and …	**Then the primary payer is…**	
	Original Medicare	**This Plan**
1) Are an active employee with the Federal government (including when you or a family member are eligible for Medicare solely because of a disability),		✓
2) Are an annuitant,	✓	
3) Are a reemployed annuitant with the Federal government when…		
a) The position is excluded from FEHB, or	✓	
b) The position is not excluded from FEHB		✓
(Ask your employing office which of these applies to you.)		
4) 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),	✓	
5) Are enrolled in Part B only, regardless of your employment status,	✓ (for Part B services)	✓ (for other services)
6) Are a former Federal employee receiving Workers' Compensation and the Office of Workers' Compensation Programs has determined that you are unable to return to duty,	✓ (except for claims related to Workers' Compensation.)	
B. When you — or a covered family member — have Medicare based on end stage renal disease (ESRD) and…		
1) Are within the first 30 months of eligibility to receive Part A benefits solely because of ESRD,		✓
2) Have completed the 30-month ESRD coordination period and are still eligible for Medicare due to ESRD,	✓	
3) Become eligible for Medicare due to ESRD after Medicare became primary for you under another provision,	✓	
C. When you or a covered family member have FEHB and…		
1) Are eligible for Medicare based on disability, and		
a) Are an annuitant, or	✓	
b) Are an active employee		✓
c) Are a former spouse of an annuitant	✓	
d) Are a former spouse of an active employee		✓

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

- At a VA Medical Center;
- Overseas; 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.

- **Medicare managed care plan**

If you are eligible for Medicare, you may choose to enroll in and get your Medicare benefits from another type of Medicare+Choice Plan — a Medicare managed care plan. These are health care choices (like HMOs) in some areas of the country. In most Medicare managed care plans, you can only go to doctors, specialists, or hospitals that are part of the plan. Medicare managed care plans provide all the benefits that original Medicare covers. Some cover extras, like prescription drugs. To learn more about enrolling in a Medicare managed plan, contact Medicare at 1-800-MEDICARE (1-800/633-4227) or at www.medicare.gov.

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

This Plan and another plan's Medicare managed care plan: You may enroll in another plan's Medicare managed care plan and also remain enrolled in our FEHB plan. We will still provide benefits when your Medicare managed care plan is primary, even out of the managed care 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 managed care plan, tell us. We will need to know whether you are in the Original Medicare Plan or in a Medicare managed care plan so we can correctly coordinate benefits with Medicare.

Suspended FEHB coverage to enroll in a Medicare managed care plan: If you are an annuitant or former spouse, you can suspend your FEHB coverage to enroll in a Medicare managed care plan, eliminating your FEHB premium. (OPM does not contribute to your Medicare managed care 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 managed care plan's service area.

- **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. Should you sign an agreement, Medicare will not pay any portion of the charges, and we will not increase our payment. We will still limit our payment to the amount we would have paid after Original Medicare's payment.

- **If you do not enroll in Medicare Part A or Part B**

If you do not have one or both Parts of Medicare, you can still be covered under the FEHB Program. We will not require you to enroll in Medicare Part B and, if you can't get premium-free Part A, we will not ask you to enroll in it.

TRICARE

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

Workers' Compensation

We do not cover services that:

- you need because of a workplace-related 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.

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 from any recovery you receive because of illness or injury caused by the act or omission of a third party (another person or organization).

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

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; and
- that we are subrogated to your rights to the extent of benefits paid, including the right to bring suit.

All recoveries 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.

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 of any recovery that you obtain, and you are required to reimburse us in full for the benefits paid or to be paid. Any reduction of our lien for payment of associated costs must be approved by us prior to payment.

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.

Coinsurance

The percentage of our allowance that you must pay for your care. You may also be responsible for additional amounts. See page 13.

Confinement

An admission (or series of admissions separated by less than 60 days) to a hospital as an inpatient for any one illness or injury. You start a new confinement when an admission is: (1) for a cause entirely unrelated to the cause for the previous admission; (2) for an enrolled employee who returns to work for at least one day before the next admission; or (3) for a dependent or annuitant when confinements are separated by at least 60 days.

Copayment

A fixed amount of money you pay to the provider when you receive covered services. See page 13.

Covered services

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

Custodial care

Treatment or services, regardless of who recommends them or where they are provided, that 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:

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; or
6) 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.

We determine which services are custodial care.

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 page 13.

Effective date

The date the benefits described in this brochure become effective:

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

The cost incurred for a covered service or supply ordered or prescribed by a doctor. You incur an expense on the date the service or supply is received. Expense does not include any charge:

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 Services

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

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

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

If you need additional information regarding the determination of experimental and investigational, please contact us.

Group health coverage

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.

Medical emergency

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 that you receive within 72 hours after the onset. Medical emergencies include deep cuts, broken bones, heart attacks, cardiovascular accidents, poisonings, loss of consciousness or respiration, convulsions, and such other acute conditions that we determine to be medical emergencies.

Medically necessary

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

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.

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

Mental Conditions/ Substance Abuse

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

Plan allowance

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

PPO Providers - Our Plan allowance is a negotiated amount between us and the provider. Neither you nor the provider can unilaterally change the negotiated amount. We base our coinsurance on this negotiated amount. This applies to all benefits in Section 5 of this Brochure.

Non-PPO and Out-of-Network Providers - We base our Plan allowance on reasonable and customary charges (R&C). We define R&C as charges that are:

- Comparable to those made by other providers for similar services and supplies under comparable circumstances in the same geographic area;
- Developed from actual claims we receive from each Zip Code area throughout the United States, as compiled by the Health Insurance Association of America;
- Updated twice a year; and
- Are within the 90th percentile of the charges. We chose the 90th percentile to assure that as broad a range of charges are considered to be within R&C as possible under the FEHB Program.

  We use this method for determining our allowance for all benefits in Section 5 of this Brochure. For certain specific services in Section 5, exceptions to this general method for determining the Plan's allowances may exist.

  We generally do not reduce overseas claims to a Plan allowance. However, we reserve the right to request information that will enable us to determine an allowance on charges that we deem to be excessive.

We determine what is a reasonable and customary charge and what is within our Plan allowance.

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

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. FEHB facts

No pre-existing condition limitation

We will not refuse to cover the treatment of a condition that 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. Also, your employing or retirement office can answer your questions, and give you a *Guide to Federal Employees Health Benefits Plans*, brochures for other plans, and other materials you need to make an informed decision about:

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

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 unmarried dependent children under age 22, including any foster children or stepchildren your employing or retirement office authorizes coverage for. Under certain circumstances, you may also continue coverage for a disabled child 22 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 health benefits, nor will we. Please tell us immediately when you add or remove family members from your coverage for any reason, including divorce, or when your child under age 22 marries or turns 22.

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.

When benefits and premiums start

The benefits in this brochure are effective on 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. 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.

Your medical and claims records are confidential

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

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

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.

You may be eligible for spouse equity coverage or TCC.

- **Spouse equity coverage**

If you are divorced from a Federal employee or annuitant, you may not continue to get benefits under your former spouse's enrollment. But, you may be eligible for your own FEHB coverage under the spouse equity law. If you are recently divorced or are anticipating a divorce, contact your ex-spouse's employing or retirement office to get RI 70-5, the *Guide to Federal Employees Health Benefits Plans for Temporary Continuation of Coverage and Former Spouse Enrollees*, or other information about your coverage choices.

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

If you leave Federal service, or if you lose coverage because you no longer qualify as a family member, you may be eligible for TCC. For example, you can receive TCC if you are not able to continue your FEHB enrollment after you retire, if you lose your Federal job, if you are a covered dependent child and you turn 22 or marry, 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 Employees Health Benefits Plans 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 (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 have information about Federal and State agencies you can contact for more information.

Long Term Care Insurance Is Coming Later in 2002!

- Many FEHB enrollees think that their health plan and/or Medicare covers long-term care. Unfortunately, they are *WRONG!*
- How are YOU planning to pay for the future custodial or chronic care you may need? Consider buying long-term care insurance.

The Office of Personnel Management (OPM) will sponsor a high-quality long term care insurance program effective in October 2002. As part of its educational effort, OPM asks you to consider these questions:

What is long term care (LTC) insurance?

- It's insurance to help pay for long term care services you may need if you can't take care of yourself because of an extended illness or injury, or an age-related disease such as Alzheimer's.
- LTC insurance can provide broad, flexible benefits for care in a nursing home, in an assisted living facility, in your home, adult day care, hospice care, and more. *Long term care insurance can supplement care provided by family members, reducing the burden you place on them.*

I'm healthy. I won't need long term care. Or, will I?

- 76% of Americans believe they will never need long term care, but the facts are that about half them will. And it's not just the old folks. About 40% of people needing long term care are under age 65. They may need chronic care due to a serious accident, a stroke, or developing multiple sclerosis, etc.
- We hope you will never need long term care, but you should have a plan just in case. *LTC insurance may be vital to your financial and retirement planning.*

Is long term care expensive?

- Yes. A year in a nursing home can exceed $50,000 and only three 8-hour shifts a week can exceed $20,000 a year, that's before inflation!
- LTC can easily exhaust your savings but LTC insurance can protect it.

But won't my FEHB plan, Medicare or Medicaid cover my long term care?

- Not FEHB. Look under *"Not covered"* in sections 5(a) and 5(c) of your FEHB brochure. Custodial care, assisted living, or continuing home health care for activities of daily living are not covered. Limited stays in skilled nursing facilities can be covered in some circumstances.
- Medicare only covers skilled nursing home care after a hospitalization with a 100 day limit.
- Medicaid covers LTC for those who meet their state's guidelines, but restricts covered services and where they can be received. LTC insurance can provide choices of care and preserve your independence.

When will I get more information?

- Employees will get more information from their agencies during the late summer/early fall of 2002.
- Retirees will receive information at home.

How can I find out more about the program NOW?

A toll-free telephone number will begin in mid-2002. You can learn more about the program now at www.opm.gov/insure/ltc.

Index

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.**

Notes

Summary of benefits for the Foreign Service Benefit Plan – 2002

- **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 $300 calendar year deductible. And, after we pay, you generally pay any difference between our allowance and the billed amount if you use a Non-PPO AND Out-of-Network Area physician or other health care professional.

Benefits	You Pay	Page
Medical services provided by physicians:	PPO: 10% of our allowance*	
• Diagnostic and treatment services provided in the hospital and office	Non-PPO: 30% of our allowance and any difference between our allowance and the billed amount*	19-27
	Out-of-Network Area: 20% of our allowance and any difference between our allowance and the billed amount*	
Services provided by a hospital:		
• Inpatient	PPO: Nothing	32-33
	Non-PPO: $200 per confinement and 20% of charges	
	Out-of-Network Area: $200 per confinement	
• Outpatient	Surgical:	34
	PPO: 10% of our allowance	
	Non-PPO: 30% of our allowance and any difference between our allowance and the billed amount	
	Out-of-Network Area: 10% of our allowance and any difference between our allowance and the billed amount	
	Medical:	34
	PPO: 10% of our allowance*	
	Non-PPO: 30% of our allowance and any difference between our allowance and the billed amount*	
	Out-of-Network Area: 20% of our allowance and any difference between our allowance and the billed amount*	

Benefits	You Pay	Page
Emergency benefits:		
• Accidental injury (for outpatient care received within 72 hours)	PPO: Nothing Non-PPO and Out-of-Network Area: Only the difference between our allowance and the billed amount	37-38
• Medical emergency	Regular benefits*	38
Mental health and substance abuse treatment	PPO and Out-of-Network Area: Regular cost sharing* Non-PPO: Benefits are limited*	39-44
Prescription drugs	Network Pharmacies in the 50 United States: Note — You must show your Plan ID card: • Generic: $10 for up to a 30-day supply • Brand name: $20 for up to a 30-day supply Non-Network Pharmacies in the 50 United States: You pay 100% and cannot claim reimbursement from the Plan (no coverage) Retail Pharmacies outside of the 50 United States: 20%* (claim reimbursement from the Plan) Mail Order (Home Delivery Pharmacy service): • Generic: $15 for up to a 90-day supply • Brand name: $25 for up to a 90-day supply	45-47
Dental Care • Routine preventive care and surgical procedures	The difference between our scheduled allowances and the actual billed amounts	49-50
• Orthodontics	50% of our allowance up to our maximum payment of $1,000; 100% after our maximum payment of $1,000	
Special features: • Flexible benefits option • 24 hour nurse line • Centers of excellence for tissue and organ transplants • Disease management		48
Protection against catastrophic costs (your out-of-pocket maximum)	PPO: Nothing after $3,000/Self Only or $3,500/Family enrollment per year Non-PPO and Out-of-Network Area: Nothing after $4,000/Self Only or $4,500/Family enrollment per year Note: Benefit maximums still apply and some costs do not count toward this protection.	15

2002 Rate Information for

Foreign Service Benefit Plan

2002 rates for this Plan follow. If you are in a special enrollment category, refer to an FEHB Guide for that category or contact the agency that maintains your health benefits enrollment.

		Premium			
		Biweekly		Monthly	
Type of Enrollment	Code	Gov't Share	Your Share	Gov't Share	Your Share
Self Only	401	$ 97.86	$ 37.44	$212.03	$ 81.12
Self & Family	402	$223.41	$105.19	$484.06	$227.91