Foreign Service Benefit Plan

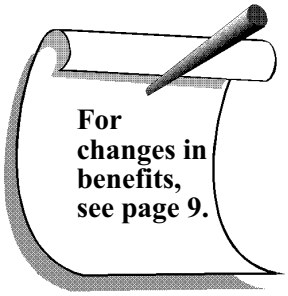
http://www.AFSPA.org/FSBP

AMERICAN FOREIGN SERVICE PROTECTIVE ASSOCIATION
FOREIGN SERVICE BENEFIT PLAN

2009

A fee-for-service plan (high option) 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 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
(6) Executive Branch civilian employees assigned overseas or to U.S. possessions and territories; and the direct hire domestic employees assigned to support those activities. Executive Branch includes all Federal civilian employees except those working for the Legislative (Congress) or Judicial (Courts) Branches of the Federal government.

Direct hire employees and Executive Branch civilian employees must enroll in the **FOREIGN SERVICE BENEFIT PLAN** when actively employed 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

The **FOREIGN SERVICE BENEFIT PLAN's** Health Utilization and Disease Management Programs have accreditation from the Utilization Review Accreditation Committee (URAC) and the National Committee for Quality Assurance (NCQA). The Coventry Health Care National Network (the Plan's PPO network) is credentialed and recredentialed to NCQA's, URAC's and CMS's (Center for Medicare and Medicaid Services) standards. See the 2009 Guide for more information on accreditation.

The **FOREIGN SERVICE BENEFIT PLAN's** Pharmacy Benefit Manager (PBM), Medco Health Solutions, Inc., has accreditation from the Joint Commission on Accreditation of Healthcare Organizations (JCAHO). See the 2009 Guide for more information on accreditation.

FEHB
Federal Employees
Health Benefits Program

Authorized for distribution by the:

United States
Office of Personnel Management

Center for
Retirement and Insurance Services
http://www.opm.gov/insure

Important Notice from the Foreign Service Benefit Plan About

Our Prescription Drug Coverage and Medicare

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

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

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

Please be advised

If you lose or drop your FEHB coverage and go 63 days or longer without prescription drug coverage that's at least as good as Medicare's prescription drug coverage, your monthly premium will go up at least 1% per month for every month that you did not have that coverage. For example, if you go 19 months without Medicare Part D prescription drug coverage, your premium will always be at least 19 percent higher than what many other people pay. You'll have to pay this higher premium as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the next Annual Coordinated Election Period (November 15th through December 31st) to enroll in Medicare Part D.

Medicare's Low Income Benefits

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

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

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

Table of Contents

Introduction

This brochure describes the benefits of the **Foreign Service Benefit Plan** under our contract (CS 1062) with the United States Office of Personnel Management, as authorized by the Federal Employees Health Benefits law. This Plan is underwritten by the First Health Life & Health Insurance Company/Cambridge Life Insurance Company, which are Coventry Health Care Companies. The address for the **Foreign Service Benefit Plan** administrative office is:

Foreign Service Benefit Plan

1716 N Street, NW

Washington, DC 20036-2902

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

Fax: 202-833-4918

E-mail:

- **Non-secure: health@AFSPA.org and enrollment@AFSPA.org; or**
- **Secure: Visit our Web site (www.AFSPA.org/FSBP) and click on the "Ask AFSPA" tab and then "FSBP" for a secure e-mail process.**

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

If you are enrolled in this Plan, you are entitled to the benefits described in this brochure. If you are enrolled in Self and Family coverage, each eligible family member is also entitled to these benefits. You do not have a right to benefits that were available before January 1, 2009, unless those benefits are also shown in this brochure.

OPM negotiates benefits and rates with each plan annually. Benefit changes are effective January 1, 2009, and changes are summarized on page 9. Rates are shown on the back cover of this brochure.

Plain Language

All FEHB brochures are written in plain language 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 United States Office of Personnel Management. If we use others, we tell you what they mean first.
- Our brochure and other FEHB plans' brochures have the same format and similar descriptions to help you compare plans.

If you have comments or suggestions about how to improve the structure of this brochure, let OPM 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 U.S. Office of Personnel Management, Insurance Services Programs, Program Planning & Evaluation Group, 1900 E Street, NW, Washington, DC 20415-3650.

Stop Health Care Fraud!

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

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

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

Do not give your plan identification (ID) number over the telephone or to people you do not know, except for your health care provider, authorized health benefits plan or OPM representative.

- Let only the appropriate medical professionals review your medical record or recommend services.
- Avoid using health care providers who say that an item or service is not usually covered, but they know how to bill us to get it paid.
- Carefully review explanations of benefits (EOBs) statements that you receive from us.
- Do not ask your doctor to make false entries on certificates, bills or records in order to get us to pay for an item or service.
- If you suspect that a provider has charged you for services you did not receive, billed you twice for the same service, or misrepresented any information, do the following:

  Call the provider and ask for an explanation. There may be an error.

  If the provider does not resolve the matter, call us at 202-833-4910 and explain the situation.

  If we do not resolve the issue:

CALL -- THE HEALTH CARE FRAUD HOTLINE

202-418-3300

OR WRITE TO:

United States Office of Personnel Management

Office of the Inspector General Fraud Hotline

1900 E Street, NW, Room 6400

Washington, DC 20415-1100

- Do not maintain as a family member on your policy:

  Your former spouse after a divorce decree or annulment is final (even if a court order stipulates otherwise); or

  Your child over age 22 (unless he/she is disabled and incapable of self support).

- If you have any questions about the eligibility of a dependent, check with your personnel office if you are employed, with your retirement office (such as OPM) if you are retired, or with the National Finance Center if you are enrolled under Temporary Continuation of Coverage.
- You can be prosecuted for fraud and your agency may take action against you if you falsify a claim to obtain FEHB benefits or try to obtain services for someone who is not an eligible family member or who is no longer enrolled in the Plan.

Preventing medical mistakes

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

1. Ask questions if you have doubts or concerns.

- Ask questions and make sure you understand the answers.
- Choose a doctor with whom you feel comfortable talking.

- Take a relative or friend with you to help you ask questions and understand answers.

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

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

3. Get the results of any test or procedure.

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

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

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

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

- Make sure you, your doctor, and your surgeon all agree on exactly what will be done during the operation.
- Ask your doctor, "Who will manage my care when I am in the hospital?"
- Ask your surgeon:

  Exactly what will you be doing?

  About how long will it take?

  What will happen after surgery?

  How can I expect to feel during recovery?

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

Visit these Web sites for more information about patient safety.

- www.ahrq.gov/path/beactive.htm. The Agency for Healthcare Research and Quality makes available a wide-ranging list of topics not only to inform consumers about patient safety but also to help choose quality health care providers and improve the quality of care you receive.
- www.npsf.org. The National Patient Safety Foundation has information on how to ensure safer health care for you and your family.
- www.talkaboutrx.org. The National Council on Patient Information and Education is dedicated to improving communication about the safe, appropriate use of medicines.

- www.leapfroggroup.org. The Leapfrog Group is active in promoting safe practices in hospital care.
- www.ahqa.org. The American Health Quality Association represents organizations and health care professionals working to improve patient safety.
- www.quic.gov/report. Find out what federal agencies are doing to identify threats to patient safety and help prevent mistakes in the nation's health care delivery system.

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.

General features of our High Option

We have a Preferred Provider Organization (PPO):

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

The non-PPO benefits are the standard benefits of this Plan. PPO benefits apply only when you use a PPO provider. Provider networks may be more extensive in some areas than others. PPO benefit levels also apply to providers outside the 50 United States. We cannot guarantee the availability of every specialty in all areas. The selection of PPO providers is solely Coventry's responsibility. We cannot guarantee the continued participation of any specific provider. In the PPO Network 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 that the provider is in the PPO Network Area when you make your appointment;**
- **Present your Foreign Service Benefit Plan Identification (ID) Card at the time you visit your health care provider, confirming your PPO participation in order to receive PPO benefits and the provider's continued participation in our Network. If you do not present your ID Card, the provider may not give you the PPO discount; and**
- **Generally, you do not pay a PPO provider at the time of service. PPO providers must bill us directly. We must reimburse the provider directly. PPO providers will bill you for any balance after our payment to them.**

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

How we pay providers

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

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

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

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

Your Rights

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

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

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

Your medical and claims records are confidential

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

Section 2. How we change for 2009

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

Program-wide changes

- In Section 3, under **Covered providers**, Illinois has been added to the list of medically underserved areas for 2009.

Changes to this Plan

- Your share of the premium will **decrease** for Self Only or **decrease** for Self and Family. See back cover.
- The Plan now has a nationwide PPO network. We no longer offer Out-of-Network benefits.
- The Plan has increased the coinsurance from 90% to 100% of the Plan allowance and eliminated the maximum charge limitation for a routine physical examination for PPO providers and providers outside the 50 United States under the Preventive care, adult benefit (see page 25).
- The Plan has increased the coinsurance from 90% to 100% of the Plan allowance for routine cancer screenings and other routine services for PPO providers and providers outside the 50 United States under the Preventive care, adult benefit (see pages 25-26).
- The Plan has increased the coinsurance from 90% to 100% of the Plan allowance for PPO providers and providers outside the 50 United States under the Preventive care, children benefit (see page 26).
- The Plan has increased the coinsurance from 90% to 100% of the Plan allowance for PPO providers and providers outside the 50 United States under the Maternity care benefit (see page 26).
- The Plan has added coverage for one hearing aid exam and one hearing aid per ear for adults subject to a maximum payable of $1,200 once every 5 years (see page 30).
- The Plan has added coverage for wigs needed as a result of chemotherapy or radiation treatment for cancer, up to a $350 annual maximum (see page 31).
- The Plan has added coverage for augmentative and alternative communication (AAC) devices, up to a $1,000 annual maximum (see page 32).
- The Plan has added coverage for nutritional counseling, up to a $200 annual maximum (see page 35).
- The Plan has increased the list of covered Blood or Marrow Stem Cell Transplants (Allogeneic, Autologous and Autologous tandem) for certain specified conditions (see pages 39-40).
- The Plan has changed the benefit level for transplant coverage at PPO facilities and eliminated transplant coverage at non-PPO facilities (see page 39-40).
- The Plan has increased coverage for treatment of medical emergencies received from non-PPO providers (see page 47).
- The Plan has removed the $60 per visit maximum for inpatient mental health/substance abuse individual therapy provided by non-PPO providers (see page 50).
- The Plan has removed the $30 per visit maximum for inpatient mental health/substance abuse group therapy provided by non-PPO providers (see page 50).
- The Plan has increased the minimum retail copay for Level III (multi-source brand name) prescription medication from $30 to $40 (see page 55).
- The Plan has reduced the mail order copay for Level I (generic) prescription medication from $20 to $15 (see page 56).
- The Plan now coordinates benefits with Medicare Part B prescription claims (see pages 55-56)
- The Plan now requires prior authorization of certain prescription drugs (see pages 53 and 55-56).
- The Plan has increased its catastrophic protection benefit maximum (see page 17).

Section 3. How you get care

Identification cards

We will send you a Foreign Service Benefit Plan/Medco Prescription Drug Identification (ID) Card when you enroll. You should carry your ID Card with you at all times. You must show it whenever you receive services from a Plan provider or fill a prescription at a Plan pharmacy. Until you receive your ID Card, use your copy of the Health Benefits Election Form, SF-2809, your health benefits enrollment confirmation (for annuitants), or your electronic enrollment system (such as Employee Express) confirmation letter. Call us if you need to purchase prescriptions and have not received your card.

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

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.).
- **Qualified Clinical Psychologist** — An individual who has earned either a Doctoral or Masters Clinical Degree in psychology or an allied discipline and who is licensed or certified in the state where services are performed (such as Licensed Professional Counselors).
- **Nurse Midwife** — A person who is certified by the American College of Nurse Midwives or is licensed or certified as a nurse midwife in states requiring licensure or certification.
- **Nurse Practitioner / Clinical Specialist** — A person who
  - Has an active R.N. license in the United States;
  - Has a baccalaureate or higher degree in nursing; and
  - Is licensed or certified as a nurse practitioner or clinical nurse specialist in states requiring licensure or certification.
- **Clinical Social Worker** — A social worker who
  - Has a Masters or Doctoral Degree in social work;
  - Has at least two years of clinical social work practice; and
  - In states requiring licensure, certification, or registration, is licensed, certified, or registered as a social worker where the services are rendered.
- **Nursing School Administered Clinic** — A clinic that is
  - Licensed or certified in the state where the services are performed; and
  - Provides ambulatory care in an outpatient setting – primarily in rural or inner city areas where there is a shortage of physicians. Services billed by these clinics are considered outpatient “office” services rather than facility charges.
- **Physician Assistant** — A person who is licensed, registered or certified in the state where services are performed.
- **Licensed Professional Counselor or Master’s Level Counselor** — A person who is licensed, registered, or certified in the state where services are performed.

- **Licensed Physical Therapist** — A professional who is licensed or meets state requirements where the services are performed to provide physical therapy services.
- **Licensed Speech Therapist** — A professional who is licensed or meets state requirements where the services are performed to provide speech therapy services.
- **Licensed Occupational Therapist** — A professional who is licensed or meets state requirements where the services are performed to provide occupational therapy services.
- **Dietician** – A professional who, in states requiring licensure, certification or registration, is licensed, certified, or registered as a dietician where the services are performed.
- **Nutritionist** – A professional who, in states requiring licensure, certification or registration, is licensed, certified, or registered as a nutritionist where the services are performed.
- **Audiologist** — A person who is licensed, registered, or certified in the state where services are performed.
- **Licensed Acupuncturist (L.Ac.)** — An individual who has completed the required schooling and licensure to perform acupuncture in the state where services are performed (see definition of acupuncture, page 34).
- **Massage Therapist** — An individual who has completed the required schooling and licensure or certification to perform massage therapy in the state where services are performed.

Medically underserved areas. Note: We cover any licensed medical practitioner for any covered service performed within the scope of that license in the states OPM determines are "medically underserved". For 2009, the states are: Alabama, Arizona, Idaho, Illinois, Kentucky, Louisiana, Mississippi, Missouri, Montana, New Mexico, North Dakota, South Carolina, South Dakota, 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.
- **Hospice Care Facility** — A facility providing hospice care services that is appropriately licensed or certified as such under the law of the jurisdiction in which it is located, and that:
  - Is certified (or is qualified and could be certified) under Medicare;
  - Is accredited by the Joint Commission on Accreditation of Healthcare Organizations;
  - Meets the standards established by the National Hospice Organization.
- **Hospital** —

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

   b) Specialized inpatient medical care and treatment of sick or injured persons through medical and diagnostic facilities (including X-ray and laboratory) on its premises, under its control, or through a written agreement with a hospital (as defined above) or with a specialized provider of those facilities.
3. For inpatient and outpatient treatment of mental health and substance abuse, the term hospital also includes a free-standing residential treatment center facility approved by the JCAHO.

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

- Is used principally as a convalescent facility, rest facility, nursing facility or facility for the aged;
- Furnishes primarily domiciliary or custodial care, including training in the routines of daily living; or
- Is operated as a school.

- **Skilled Nursing Facility** — An institution or that part of an institution, which provides convalescent skilled nursing care 24-hours-a-day and is classified as a skilled nursing facility under Medicare.
- **Urgent Care Center** – A free-standing facility offering ambulatory medical service, which:
  - Is not part of a hospital; and
  - Is licensed by the proper authority in the jurisdiction in which it is located.

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

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

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

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

We pay for covered services from the effective date of your enrollment. However, if you are in the hospital when your enrollment in our Plan begins, call our customer service department immediately at 202-833-4910. If you are new to the FEHB Program, we will reimburse you for your covered services while you are in the hospital beginning on the effective date of your coverage.

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

- You are discharged, not merely moved to an alternative care center; 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. If your plan terminates participation in the FEHB in whole or in part, or if OPM orders an enrollment change, this continuation of coverage provision does not apply. In such cases, the hospitalized family member's benefits under the new plan begin on the effective date of enrollment.

How to get approval for…

- **Your hospital stay**

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

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

Warning: We will reduce our benefits for the inpatient hospital stay or residential treatment care by $500 if no one contacts us for precertification. If the stay is not medically necessary, we will not pay any benefits.

- **How to precertify an admission**

- You, your representative, your physician, or your hospital must call us before the admission or care. The toll-free number is 1-800-593-2354.
- If you have an emergency admission due to a condition that you reasonably believe puts your life in danger or could cause serious damage to bodily function, you, your representative, the physician, or the hospital must telephone us within two business days following the day of the emergency admission, even if you have been discharged from the hospital.
- Provide the following information:
  - Enrollee's name and Plan identification number;
  - Patient's name, birth date and phone number;
  - Reason for hospitalization, proposed treatment or surgery;
  - Name and phone number of admitting physician;
  - Name of hospital, facility or home health agency; and
  - Number of planned days of hospital stay or care.
- We will then tell the physician and/or hospital the number of approved inpatient days and we will send written confirmation of our decision to you, your physician and the hospital.

- **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 physician or the hospital must ask us to approve the additional days.

What happens when you do not follow the precertification rules

If no one contacts us, we will decide whether the hospital stay was medically necessary.

- If we determine that the stay was medically necessary, we will pay the inpatient 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 only pay for any covered medical supplies and services that are otherwise payable on an outpatient basis.

If we denied the precertification request, we will not pay inpatient hospital benefits. We will only pay for any covered medical supplies and services that are otherwise payable on an outpatient basis.

When we precertified the 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 medical services and supplies otherwise payable on an outpatient basis and will not pay inpatient benefits.

Exceptions:

You do not need precertification in these cases:

- You are admitted to a hospital or residential treatment center outside the 50 United States. However, the Plan will review all services to establish medical necessity. We may request medical records in order to determine medical necessity.
- You have another group health insurance policy that is the primary payer for the hospital stay.
- 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**

Other services require precertification or prior authorization. You, your representative, your doctor, or treating facility must call us at 1-800-593-2354 (except for prior authorization on prescription drugs – see below) before the admission or care, such as:

- Home health care (see page 33);
- Hospice care (see page 44);
- Organ/tissue transplants (see pages 39-40);
- Skilled nursing facility admission (see page 44); and
- Mental health and substance abuse treatment (see pages 48-51).
- Prescription drugs (see pages 53 and 55-56). Some medications are not covered unless you receive approval through a coverage review (prior authorization). This review uses Plan rules based on FDA-approved prescribing and safety information, clinical guidelines and uses that are considered reasonable, safe, and effective. To request a coverage review, contact Medco Health Solutions, Inc. (Medco), the Plan's Pharmacy Benefit Manager at 1-800-818-6717 (TDD: 1-800-759-1089 for the hearing impaired).

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

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

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

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

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 certain services.

Example:

- When you purchase prescriptions from Medco By Mail, you pay a copayment of $15 for generic, or $40 for single-source brand name, or $55 for multi-source brand name prescriptions.
- When you go in a non-PPO hospital, you pay $200 per person per hospital stay.

We do not reimburse you for copayments.

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

Cost-sharing

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

Deductible

A deductible is a fixed amount of covered expenses you must incur for certain covered services and supplies before we start paying benefits for them. We do not reimburse you for the deductible. Benefits paid by us do not count towards the deductible. Copayments and coinsurance amounts do not count toward any deductible. When a covered service or supply is subject to a deductible, only the Plan allowance for the service or supply counts toward the deductible.

The calendar year deductible is $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.

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

Example: If the billed amount is $100, the provider has an agreement with us to accept $80, and you have not paid any amount toward meeting your calendar year deductible, you must pay $80. We will apply $80 to your deductible. We will begin paying benefits once the remaining portion of your calendar year deductible ($300) has been satisfied.

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

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

Coinsurance

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

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

If your provider routinely waives your cost

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

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

Waivers

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

Differences between our allowance and the bill

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

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

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

- **PPO providers** agree to limit what they will bill you. Because of that, when you use a preferred provider, your share of covered charges consists only of your deductible and coinsurance. Here is an example about coinsurance: You see a PPO physician who charges $150, but our allowance is $100. If you have met your deductible, you are only responsible for your coinsurance. That is, you pay just 10% of our $100 allowance ($10). Because of the agreement, your PPO physician will not bill you for the $50 difference between our allowance and his/her bill. **Follow these procedures when you use a PPO provider in order to receive PPO benefits:**
  - **Verify that the provider is in the PPO Network when you make your appointment;**
  - **Present your Foreign Service Benefit Plan Identification (ID) Card at the time you visit your health care provider, confirming your PPO participation in order to receive PPO benefits and the provider's continued participation in our Network. If you do not present your ID Card, the provider may not give you the PPO discount; and**
  - **Generally, you do not pay a PPO provider at the time of service. PPO providers must bill us directly. We must reimburse the provider directly. PPO providers will bill you for any balance after our payment to them.**
- **Non-PPO providers,** on the other hand, have no agreement to limit what they will bill you. For instance:
  - **When you use a non-PPO provider,** you will pay your deductible and coinsurance plus any difference between our allowance and charges on the bill. Here is an example: You see a non-PPO physician who charges $150 and our allowance is again $100. If you have met your deductible, you are responsible for your coinsurance, so you pay 30% of our $100 allowance ($30). Plus, because there is no agreement between the non-PPO physician and us, the physician can bill you for the $50 difference between our allowance and his/her bill.
- **Providers outside the 50 United States** charges generally are not subject to a Plan allowance. Similar to the PPO example above, when you use a provider outside the 50 United States and you have met your deductible, you are responsible for your coinsurance. You will pay just 10% of the charge ($15).

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

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

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

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

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

- $3,500 for Self Only and $4,000 for Self and Family enrollment (PPO providers and providers outside the 50 United States)
- $5,500 for Self Only and $6,000 for Self and Family enrollment (non-PPO providers).

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

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

- Expenses in excess of Plan allowances, maximum benefit or visit limitations;
- Expenses for a transplant above the $400,000 maximum PPO benefit or expenses at a non-PPO facility;
- Expenses for dental care;
- Any amounts you pay because benefits have been reduced for non-compliance with precertification or preauthorization requirements (see Section 3);
- Coinsurance and copayments you pay for prescription drugs obtained through Medco retail and/or Medco By Mail;
- Expenses for prescriptions purchased at pharmacies in the 50 United States without using the Plan's Foreign Service Benefit Plan/Medco Prescription Drug Identification Card or purchased from a source other than the Plan's Medco By Mail; and
- Non-covered services and supplies.

Carryover	If you changed to this Plan during Open Season from a plan with a catastrophic protection benefit and the effective date of the change was after January 1, any expenses that would have applied to that plan's catastrophic protection benefit during the prior year will be covered by your old plan if they are for care you received in January before your effective date of coverage in this Plan. If you have already met your old plan's catastrophic protection benefit level in full, it will continue to apply until the effective date of your coverage in this Plan. If you have not met this expense level in full, your old plan will first apply your covered out-of-pocket expenses until the prior year's catastrophic level is reached and then apply the catastrophic protection benefit to covered out-of-pocket expenses incurred from that point until the effective date of your coverage in this Plan. Your old plan will pay these covered expenses according to this year's benefits; benefit changes are effective January 1.
If we overpay you	We will make diligent efforts to recover benefit payments we made in error but in good faith. We may reduce subsequent benefit payments to offset overpayments.
When Government facilities bill us	Facilities of the Department of Veteran Affairs, the Department of Defense, and the Indian Health Service are entitled to seek reimbursement from us for certain services and supplies they provide to you or a family member. They may not seek more than their governing laws allow.

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

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

If you…

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

Then, for your inpatient hospital care,

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

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

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

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

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

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

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

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

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

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

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

If your physician does not accept Medicare assignment, then you pay the difference between the "limiting charge" or the physician's charge (whichever is less) and our payment combined with Medicare's payment.

It is important to know that a physician who does not accept Medicare assignment may not bill you for more than 115% of the amount Medicare bases its payment on, called the "limiting charge." The Medicare Summary Notice (MSN) that Medicare will send you will have more information about the limiting charge. If your physician tries to collect more than allowed by law, ask the physician to reduce the charges. If the physician does not, report the physician to the Medicare carrier that sent you the MSN form. Call us if you need further assistance.

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

High Option Benefits

See page 9 for how our benefits changed this year. Pages 88 - 90 are a benefits summary of our High Option.

High Option Overview

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

This section is divided into subsections. Please read *Important things you should keep in mind* at the beginning of the subsections. Also read the General Exclusions in Section 6; they apply to the benefits in the following subsections. To obtain claim forms, claims filing advice, or more information about High Option benefits, contact us by phone at 202-833-4910 (members) or 202-833-5751 (health care providers), by fax at 202-833-4918, by non-secure e-mail at health@AFSPA.org or enrollment@AFSPA.org, or by secure e-mail through our Web site at www.AFSPA.org/FSBP (click on the "Ask AFSPA" tab and then click on "FSBP").

The **High Option** offers unique features.

- Benefits available worldwide
- Providers' charges outside the 50 United States generally not subject to Plan allowance limitation
- Plan provides 100% coverage for covered inpatient hospital confinements in PPO network and outside the 50 United States
- Special wellness and preventive care benefits for children and adults payable at 100% of Plan allowance with no deductible (PPO and outside the 50 United States)
- Special benefit (age and frequency limitations do not apply) available for colorectal cancer screenings and breast cancer screenings (mammogram) when familial or high risk factors indicate the need for them
- Special Maternity care benefit payable at 100% of Plan allowance with no deductible (PPO and outside the 50 United States)
- Alternative treatments benefits available for acupuncture, chiropractic and massage therapy
- Weight management program available under Educational classes and programs benefit
- Special overseas disease management benefit
- Special overseas second opinion benefit through e-Cleveland Clinic
- Orthodontic benefits available
- Plan provides translations and exchange rates
- Special direct billing arrangements with hospitals in several foreign countries
- Web based customer service allows enrollee to view pending and finalized claims, print explanations of benefits (EOBs), search for providers participating in the Plan's PPO network, obtain quality information on providers and average costs of illnesses and procedures in the U.S.
- Secure method to submit claims to us via the Internet from overseas locations.
  - Visit our Web site (www.AFSPA.org/FSBP), click on the "Ask AFSPA" tab and then click on "FSBP".
  - Attach a scanned copy of your claim to an e-mail message you send to us.
  - Eliminate the lengthy mail time from your overseas post to our office.
  - Correspond with us via secure e-mail through this process; or
  - Fax us your claims from overseas. Our special fax number is: 202-464-4508.

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

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- The calendar year deductible is: $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 or when you use a provider outside the 50 United States. When no PPO provider is available in a PPO Network Area, non-PPO 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.

Benefits Description	You pay After the calendar year deductible...
Note: The calendar year deductible applies to almost all benefits in this Section. We say "(No deductible)" when it does not apply.	
Diagnostic and treatment services	
• Professional services of physicians during a hospital stay, skilled nursing facility stay, in the physician's office, at home, or consultations • Office consultation including second opinion • Psychological tests and pharmacological visits • Drugs and medical supplies billed by a physician	PPO: 10% of the Plan allowance Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount Providers outside the 50 United States: 10% of the Plan allowance
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	
Tests, such as: • Blood tests • Urinalysis • Non-routine pap tests • Pathology • X-rays • Non-routine mammograms • CAT Scans/MRI • Ultrasound • Electrocardiogram and EEG • Hearing exam for non-auditory illness or disease	PPO: 10% of the Plan allowance Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount Providers outside the 50 United States: 10% of the Plan allowance

Benefits Description	You pay After the calendar year deductible...
Preventive care, adult	
One routine physical examination to include a history and physical, chest X-ray, urinalysis, blood tests, and EKG (electrocardiogram) per person, per calendar year	PPO: Nothing (No deductible) Providers outside the 50 United States: Nothing (No deductible)
One routine physical examination to include a history and physical, chest X-ray, urinalysis, blood tests, and EKG (electrocardiogram) – limited to a maximum charge of $750 per person, per calendar year	Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount
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 - Colonoscopy, screening – one every 10 years for members age 50 and older - Double Contrast Barium Enema (DCBE) – one every five years for members age 50 and older Note: Age and frequency limitations do not apply if there is a family history or high risk factor that indicates the need for screenings. • Breast Cancer Screening (Mammogram) – one annually for women age 35 and older Note: Age and frequency limitations do not apply if there is a family history or high risk factor that indicates the need for the screening. • 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 • One-time ultrasonography for abdominal aortic aneurysm screening for males between the ages of 65 to 75 who have smoked • Annual chlamydial screening • Fasting lipoprotein profile test – one every five years for members age 20 and older • Annual osteoporosis routine screening for members age 60 and older	PPO: Nothing (No deductible) Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount Providers outside the 50 United States: Nothing (No deductible)

Preventive care, adult - continued on next page

Benefits Description	You pay After the calendar year deductible...
Preventive care, adult (cont.)	
Adult routine immunizations (including administration) endorsed by the Centers for Disease Control and Prevention (CDC) per their Recommended Adult Immunization Schedule by Vaccine and Age Group. Note: The Plan has no age limitations on Influenza, Pneumococcal, Human Papillomavirus (HPV) and Zostavax (Shingles) vaccines. Note: These benefits do not apply to children under age 22 (See *Preventive care, children*).	PPO: Nothing (No deductible) Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount Providers outside the 50 United States: Nothing (No deductible)
Preventive care, children	
Immunizations for children (including administration) 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) Providers outside the 50 United States: Nothing (No deductible)
Preventive care for children is limited to: • All healthy newborn visits including routine screening (inpatient or outpatient) • Retinal screening exam performed by an ophthalmologist for infants with low birth weight, less than 1 year of age and with an unstable clinical course • Screening, testing, diagnosis and treatment (including hearing aids) for hearing loss • The following routine services as recommended by the American Academy of Pediatrics for children up to the age of 22, including children living, traveling or adopted from outside the 50 United States: - Routine physical examinations - Routine hearing tests - Laboratory tests - Related office visits	PPO: Nothing (No deductible) Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount (No deductible) Providers outside the 50 United States: Nothing (No deductible)
Maternity care	
Complete maternity (obstetrical) care, such as: • Prenatal care (including laboratory tests) • Delivery • Postnatal care • Sonograms Note: Here are some things to keep in mind: • You do not need to precertify your normal delivery; see page 13 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. See page 13 for other circumstances.	PPO: Nothing (No deductible) Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount (No deductible) Providers outside the 50 United States: Nothing (No deductible)

Maternity care - continued on next page

Benefits Description	You pay After the calendar year deductible...
Maternity care (cont.)	
• For facility care related to maternity, including care at birthing facilities, we pay at the inpatient hospital rate in accordance with Section 5(c) of the brochure. We pay surgeon services (delivery) the same as for illness and injury. See *Surgical benefits* page 36 and *Hospital benefits* page 42. • 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. *Surgical benefits,* not *Maternity benefits,* apply to circumcision.	Note: If your child stays after your discharge and is covered under a Self and Family enrollment, you must pay a separate hospital copayment of $200 for non-PPO facilities. *If your child is not covered under a Self and Family enrollment, you pay all of your child's charges after your discharge.*
Not covered: • *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 range of voluntary family planning services, limited to surgery, medicine and IUDs. Surgery limited to (See *Surgical procedures* page 36): • Voluntary sterilization • Surgically implanted contraceptives	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) Providers outside the 50 United States: 10% of the Plan allowance (No deductible)
Medicine and IUDs, limited to: • Injectable contraceptive drugs (such as Depo provera) • Intrauterine devices (IUDs) and diaphragms to include fitting, inserting or removing Note: We cover FDA-approved drugs, prescriptions, and devices for birth control under *Prescription drug benefits* page 55. Note: We cover surgical procedures under *Surgical procedures* page 36.	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) Providers outside the 50 United States: 10% of the Plan allowance (No deductible on surgery)
Not covered: • *Reversal of voluntary surgical sterilization* • *Genetic counseling* • *Contraceptive management*	*All charges*

Benefits Description	You pay After the calendar year deductible...
Infertility services	
Diagnosis and treatment of infertility, except as shown in *Not covered*, includes: • Initial diagnostic tests and procedures done only to identify the cause of infertility; • Fertility drugs, hormone therapy and related services; and • Medical or surgical procedures done to create or enhance fertility. Note: The Plan will pay up to $5,000 per person per lifetime for covered infertility services, including prescription drugs.	PPO: 10% of the Plan allowance until benefits stop at $5,000 and 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 and all charges after the Plan's maximum payment of $5,000 Providers outside the 50 United States: 10% of the Plan allowance until benefits stop at $5,000 and 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 Providers outside the 50 United States: 10% of the Plan allowance
Not covered: • *Provocative food testing, end point titration techniques, sublingual allergy desensitization, RAST tests and hair analysis*	*All charges*

Benefits Description	You pay After the calendar year deductible...
Treatment therapies	
• 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 pages 39-40. • Intravenous (IV)/Infusion Therapy (supplies) – Home IV and antibiotic therapy (supplies) Note: See also *Home health services* this Section. • 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 Providers outside the 50 United States: 10% of the Plan allowance
• 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*.	PPO: Nothing (No deductible) Non-PPO: Only the difference between our allowance and the billed amount (No deductible) Providers outside the 50 United States: Nothing (No deductible)
Physical, occupational and speech therapies	
100 total combined outpatient physical, occupational and speech therapy visits per calendar year for all three listed therapies provided by: • Licensed physical therapists; • Licensed physicians; • Licensed occupational therapists; and • Licensed speech therapists. Note: We only cover physical, occupational and speech therapy when a physician: • Orders the care; • Identifies the specific professional skills the patient requires and the medical necessity for skilled services; and • Indicates the frequency and length of time the services are needed. 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. Note: Physical, occupational and speech therapies rendered in a home health care setting are included in this benefit and do not require precertification.	PPO: 10% of the Plan allowance Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount Providers outside the 50 United States: 10% of the Plan allowance
Not covered: • *Custodial care (see definition Section 10)* • *Exercise programs*	*All charges*

Benefits Description	You pay After the calendar year deductible...
Hearing services (testing, treatment, and supplies)	
Limited to: • Initial hearing exam for auditory hearing loss Note: Non-auditory hearing loss exams are covered under *Lab, X-ray and other 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 Providers outside the 50 United States: 10% of the Plan allowance
Limited to: • Adult hearing aid exam and adult hearing aid – once every 5 consecutive years Note: Child hearing aid exams and child hearing aids are covered under Preventive care, children.	PPO, Non-PPO and Providers outside the 50 United States: Nothing (No deductible) up to the Plan maximum of $1,200 per aid per ear per person once every 5 years and all charges after the Plan maximum
Not covered: • *Hearing aids and examinations for them, except for the initial exam and except as provided in Preventive care, children*	*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 - Glaucoma Note: Expenses in relation to an accident or removal of cataract or keratoconus must be incurred within one year of the date of the accident or surgery.	PPO: 10% of the Plan allowance Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount Providers outside the 50 United States: 10% of the Plan allowance
Not covered: • *Routine eye examinations* • *Eyeglasses or contact lenses, except as shown above* • *Eye exercises and visual training (orthoptics)* • *Refractions* • *All refractive surgeries*	*All charges*
Foot care	
Routine foot care when you are under active treatment for a metabolic or peripheral vascular disease, such as diabetes	PPO: 10% of the Plan allowance Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount Providers outside the 50 United States: 10% of the Plan allowance

Foot care - continued on next page

Benefits Description	You pay After the calendar year deductible...
Foot care (cont.)	
Orthotic devices prescribed by a physician and custom fitted for the feet Note: Orthotic devices for the feet include, but are not limited to: a) impression casting; and b) corrective shoes for treatment of malformation and weakness of the foot.	PPO, Non-PPO and Providers outside the 50 United States: Nothing (No deductible) up to $200 per person per calendar year and all charges after $200 per person per calendar year
Not covered: • *Cutting, trimming or removal of corns, calluses, or the free edge of toenails, and similar routine treatment of conditions of the foot, except as stated on the previous page* • *Treatment of flat feet*	*All charges*
Orthopedic and prosthetic devices	
• Artificial limbs and eyes to replace natural limbs and eyes; stump hose • Externally worn breast prostheses and surgical bras, including necessary replacements following a mastectomy • Internal prosthetic devices, such as artificial joints, pacemakers, intraocular lenses, cochlear implants, and surgically implanted breast implant following mastectomy • Elastic stockings and support hose that require a physician's written prescription 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. Note: See Section 5(b) for coverage of the surgery to insert the device and Section 5(c) if billed by the facility.	PPO: 10% of the Plan allowance Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount Providers outside the 50 United States: 10% of the Plan allowance
• Wigs needed as a result of chemotherapy or radiation treatment for cancer	PPO, Non-PPO and Providers outside the 50 United States: Nothing (No deductible) up to $350 per person per calendar year and all charges after $350 per person per calendar year
Not covered: • *Orthopedic shoes, orthotics and other supportive devices for the feet (except as provided in Foot care), such as:* - *Arch supports* - *Heel pads and heel cups* • *Corsets* • *Elastic stockings and support hose that do not require a physician's written prescription*	*All charges*

Benefits Description	You pay After the calendar year deductible...
Durable medical equipment (DME)	
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. We cover rental, up to the purchase price, or purchase (at our option), including necessary repair and adjustment, of durable medical equipment such as: • Wheelchairs • Hospital beds • Oxygen and equipment for its administration • Dialysis equipment • Crutches • Braces • Casts, splints, and trusses • Walkers Also included are: • Medical supplies, appliances, medical equipment, and any covered items billed by a hospital for use at home (Note: calendar year deductible applies).	PPO: 10% of the Plan allowance Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount Providers outside the 50 United States: 10% of the Plan allowance
Augmentative and alternative communications (AAC) devices such as: • Computer story boards • Light talkers • Enhanced vision systems • Speech aid prostheses for pediatrics • Speech aid prostheses for adults Note: For surgical insertion of speech aid prostheses, see Section 5(b), *Surgical procedures.*	PPO, Non-PPO and Providers outside the 50 United States: Nothing (No deductible) up to $1,000 per person per calendar year and all charges after $1,000 per person per calendar year
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*

Benefits Description	You pay After the calendar year deductible...
Home health services	
For services provided on a **part-time basis** (less than an 8-hour shift): **If you precertifyyour home health care**, 90 visits per calendar year up to a maximum Plan payment of $80 per visit when: • A Registered Nurse (R.N.) or Licensed Practical Nurse (L.P.N.) provides the services; • A licensed social worker provides the services (limited to two visits per calendar year); • A home health aide provides services under the supervision of a Registered Nurse (R.N.) consisting of mainly medical care and therapy provided solely for the care of the insured person; • The attending physician orders the care; and • The physician identifies the specific professional skills required by the patient and the medical necessity for skilled services; and indicates the length of time the services are needed. A home health agency (or visiting nurses where services of a home health agency are not available) must furnish the care in accord with a home health care plan (see definition below). The home health care plan must be certified by your physician and furnished in your home. Note: We define Home Health Agency as a public or private agency or organization appropriately licensed, qualified and operated under the law of the state in which it is located. Note: We define Home Health Care Plan as a written plan, approved in writing by a physician, for continued care and treatment of a Plan member: - Who is under the care of a physician; and - Who would need a continued stay in a Hospital or Skilled Nursing Facility without the home health care. Note: Physical, occupational and/or speech therapy services performed in an outpatient setting and/or at home will count toward the 100-therapy visit limitation per calendar year, as listed under *Physical, occupational and speech therapy* in Section 5(a).	For precertified home health care: Nothing (No deductible) up to $80 per visit up to 90 visits per calendar year and all charges above $80 per visit and/or 90 visits per calendar year and all charges above one visit per day
For services provided on a **part-time basis** (less than an 8-hour shift): **If you do not precertify your home health care**, 40 visits per calendar year up to a maximum Plan payment of $40, subject to the provisions above. Note: Precertified and Non-precertified visits are combined. Visit limit not to exceed 90 visits per calendar year.	For non-precertified home health care: Nothing (No deductible) up to $40 per visit up to 40 visits per calendar year and all charges above $40 per visit and/or 40 visits per calendar year and all charges above one visit per day
For private duty nursing we pay $12 per hour when provided on a **full-time basis** (more than an 8-hour shift) by a Registered Nurse (R.N.) or Licensed Practical Nurse (L.P.N.) when: • The care is ordered by the attending physician; and • Your physician identifies the specific professional nursing skills that you require, as well as the length of time needed.	Nothing (No deductible) up to $12 per hour and all charges above $12 per hour and all charges after 500 hours per calendar year

Home health services - continued on next page

Benefits Description	You pay After the calendar year deductible...
Home health services (cont.)	
Not covered: • *Nursing care requested by, or for the convenience of, the patient or the patient's family* • *Home care primarily for personal assistance that does not include a medical component and is not diagnostic, therapeutic, or rehabilitative* • *Custodial care (see definition Section 10)*	*All charges*
Chiropractic	
Covered services are limited to: • Manipulation of the spine and extremities Note: Chiropractic is a system of therapy that attributes disease to abnormal function of the nervous system and attempts to restore normal function by manipulation of the spinal column and other body structures.	PPO, Non-PPO and Providers outside the 50 United States: Nothing (No deductible) up to the Plan maximum of $40 per visit and all charges above $40 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. Massage therapy only when performed by a Licensed Massage Therapist (LMT) or a Certified Massage Therapist (CMT) Note: The Plan defines acupuncture as the practice of insertion of needles into specific exterior body locations to relieve pain, to induce surgical anesthesia, or for therapeutic purposes. Note: Acupuncture and massage therapy visits have a separate calendar year maximum of 30 visits per person. Note: These providers are required to submit itemized bills and their Federal Tax I.D. Number as outlined in Section 7.	PPO, Non-PPO and Providers outside the 50 United States: Nothing (No deductible) up to the Plan maximum of $30 per visit and all charges above $30 per visit and/or 30 visits per person per calendar year
Not covered: • *Chelation therapy except for acute arsenic, gold, mercury or lead poisoning; or use of Desferoxamine in iron poisoning* • *Naturopathic services and medicines* • *Homeopathic services and medicines* *(Note: Services of certain alternative treatment providers may be covered in medically underserved areas; see page 11.)*	*All charges*

Benefits Description	You pay After the calendar year deductible...
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 calendar year. Note: Prescription drugs are covered only under *Prescription drug benefits,* 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, Non-PPO and Providers outside the 50 United States: Nothing (No deductible) up to $100 and all charges after $100
Coverage is limited to: • Nutritional counseling Note: We cover dieticians and nutritionists who bill independently for nutritional counseling.	PPO, Non-PPO and Providers outside the 50 United States: Nothing (No deductible) up to $200 per person per calendar year and all charges after $200 per person per calendar year
Coverage is limited to: • Weight Management Program – Includes non-surgical outpatient treatment when diagnosed by a physician as having a Body Mass Index (BMI) of over 30. Benefits will be payable for the following medically necessary services: - Initial evaluation by your physician; - Follow-up visits to your physician; - Individual or group nutritional counseling; - Individual or group behavioral counseling; - Initial and follow-up lab tests; and - Maintenance counseling and follow-up visits for maintenance. Expense incurred for prescription drugs for weight loss and/or maintenance will be payable only as shown under Section 5(f) *Prescription drug benefits* and will not be applied to the maximum benefit limitation. Note: This benefit is limited to one program per person per lifetime. Note: We cover dieticians and nutritionists who bill independently for nutritional counseling.	PPO, Non-PPO and Providers outside the 50 United States: 50% of the Plan allowance (No deductible) until benefits stop at $1,000 and all charges after the Plan's maximum payment of $1,000
Not covered: • *Body composition analysis* • *Nutritional supplements or food* • *Non-prescription items* • *Exercise or weight loss programs or equipment* • *Services that are not considered medically necessary*	*All charges*

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

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- The calendar year deductible is: $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 when the calendar year deductible does not apply.
- The non-PPO benefits are the standard benefits of this Plan. PPO benefits apply only when you use a PPO provider or when you use a provider outside the 50 United States. When no PPO provider is available in a PPO Network Area, non-PPO 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.).

Benefits Description	You pay
Note: The calendar year deductible does not apply to benefits in this Section. We say "(No deductible)" when it does not apply.	
Surgical procedures	
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 (bariatric surgery) – a condition in which an individual: 1) is the greater of 100 pounds or 100% over his or her normal weight (in accordance with the Plan's underwriting standards) with complicating conditions; 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 and older. • Insertion of internal prosthetic devices. See Section 5(a), *Orthopedic and prosthetic devices* for device coverage information. • Voluntary sterilization (e.g., tubal ligation, vasectomy) • Surgical implantation and removal of intrauterine devices (IUDs) • Surgical implantation and removal of contraceptive devices • Treatment of burns	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) Providers outside the 50 United States: 10% of the Plan allowance (No deductible)

Surgical procedures - continued on next page

Benefits Description	You pay
Surgical procedures (cont.)	
• Amniocentesis • Routine circumcision of a newborn child (only when the child is covered under a Self and Family enrollment) 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) Providers outside the 50 United States: 10% of the Plan allowance (No deductible)
• 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: 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) Providers outside the 50 United States: 20% of the Plan allowance (based on 20% of the Plan allowance allocated to the surgery charge) (No deductible)
When multiple or bilateral surgical procedures performed during the same operative session add time or complexity to patient care, our benefits are: • For the primary procedure: - PPO: 90% of the Plan allowance - Non-PPO: 70% of the Plan allowance • For the secondary procedure(s): - PPO: 90% of one-half of the Plan allowance - Non-PPO: 70% of one-half 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 one-half 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 one-half of the Plan allowance for the secondary procedure(s); and any difference between our allowance and the billed amount (No deductible) Providers outside the 50 United States: 10% of the Plan allowance for the primary procedure and 10% of one-half of the Plan allowance for the secondary procedure(s) (No deductible)
Not covered: • *Cosmetic surgery except for the repair of accidental injuries; 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 charges*

Surgical procedures - continued on next page

Benefits Description	You pay
Surgical procedures (cont.)	
Not covered (cont.) • *All refractive surgeries* • *Routine surgical treatment of conditions of the foot (see Foot care page 31)* • *Services of a standby surgeon* • *Reversal of voluntary sterilization* • *Surgeries related to impotency, sex transformation, sexual dysfunction or sexual inadequacy*	*All charges*
Reconstructive surgery	
• 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; 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 of breasts; - Treatment of any physical complications, such as lymphedemas; - Breast prostheses; and surgical bras and replacements (see *Orthopedic and 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) Providers outside the 50 United States: 10% of the Plan allowance (No deductible)
Not covered: • *Cosmetic surgery except for the repair of accidental injuries; 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*

Benefits Description	You pay
Oral and maxillofacial surgery	
Oral surgical procedures, limited to: • Reduction of fractures of the jaws or facial bones • Surgical correction of severe functional malocclusion only when we determine the correction of the malocclusion to be medically necessary • Removal of stones from salivary ducts • Excision of leukoplakia or malignancies • Excision of non-dentigerous cysts and incision of non-dentigerous abscesses • Surgical correction of temporomandibular joint (TMJ) dysfunction • Surgical removal of impacted teeth, including anesthesia charges • 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) Providers outside the 50 United States: 10% of the Plan allowance (No deductible)
Not covered: • *Oral implants and transplants and related services* • *Procedures that involve the teeth or their supporting structures (such as the periodontal membrane, gingival and alveolar bone) except as provided under Dental benefits* • *Pre- and post-operative medical examinations* • *Excision of non-impacted teeth*	*All charges*
Organ/tissue transplants	
Solid organ transplants limited to: • Cornea • Heart • Heart/lung • Kidney • Kidney/Pancreas • Liver • Lung: Single, double, or lobar • 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 Blood or marrow stem cell transplants limited to the stages of the following diagnoses: • Allogeneic bone marrow transplants for: - Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia - Chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL) - Advanced Hodgkin's lymphoma - Advanced non-Hodgkin's lymphoma - Chronic myelogenous leukemia - Hemoglobinopathies (i.e., Fanconi's syndrome, Thalassemia major) - Myelodysplasia/myelodysplastic syndromes	Plan designated transplant network (see Centers of Excellence page 60) for organ/tissue transplant facility: 10% of the Plan allowance (No deductible) PPO: 20% of the Plan allowance (No deductible) subject to a maximum payable of $400,000 per transplant (no catastrophic coverage) Non-PPO: 100% of all charges (no catastrophic coverage) Providers outside the 50 United States: 10% of the Plan allowance (No deductible)

Organ/tissue transplants - continued on next page

Benefits Description	You pay
Organ/tissue transplants (cont.)	
- Severe combined immunodeficiency - Severe or very severe aplastic anemia - Phagocytic deficiency diseases (e.g., myelogenous leukemia) - Amyloidosis • Autologous bone marrow transplants (autologous stem cell support) and autologous peripheral stem cell support for: - Acute lymphocytic or non-lymphocytic leukemia - Advanced Hodgkin's lymphoma - Advanced non-Hodgkin's lymphoma - Advanced neuroblastoma - Testicular, mediastinal, retroperitoneal and ovarian germ cell tumors - Breast cancer - Multiple myeloma - Epithelial ovarian cancer - Amyloidosis • Autologous tandem transplants for: - Recurrent germ cell tumors (including testicular cancer) - Multiple myeloma (recurrent or de novo) 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. Note: The Plan has special arrangements with facilities (Centers of Excellence) to provide services for tissue and organ transplants (See page 60). The network was designed to give you an opportunity to access providers that demonstrate high quality medical care for transplant patients. We also may assist you and one family member or caregiver with travel and lodging arrangements if you use one of our Centers of Excellence. Your physician can coordinate arrangements by calling a case manager in the Plan's Medical Management Department at 1-800-593-2354. For additional information regarding the transplant network, please call this number.	Plan designated transplant network (see Centers of Excellence page 60) for organ/tissue transplant facility: 10% of the Plan allowance (No deductible) PPO: 20% of the Plan allowance (No deductible) subject to a maximum payable of $400,000 per transplant (no catastrophic coverage) Non-PPO: 100% of all charges (no catastrophic coverage) Providers outside the 50 United States: 10% of the Plan allowance (No deductible)
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* • *Services or supplies for, or related to, surgical transplant procedures performed at non-PPO facilities*	*All charges*

Benefits Description	You pay
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 *Oral and maxillofacial surgery* this Section).	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) Providers outside the 50 United States: 10% of the Plan allowance (No deductible)

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

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- In this Section, unlike other subsections in Section 5, the calendar year deductible applies to only a few benefits. We added "(calendar year deductible applies)". The calendar year deductible is: $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 or when you use a provider outside the 50 United States. When no PPO provider is available in a PPO Network Area, non-PPO benefits apply.
- When you use a PPO facility, some professionals who provide services to you in the facility may not be preferred providers. If they are not, they will be paid by this Plan as non-PPO providers. However, if the services are rendered at a PPO facility, we will pay up to the Plan allowance at the preferred provider rate for services of radiologists, anesthesiologists, emergency room physicians, pathologists and neonatologists who are not preferred providers.
- 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 FOR HOSPITAL STAYS; FAILURE TO DO SO WILL RESULT IN A $500 PENALTY.** Please refer to the precertification information shown in Section 3 for additional details on precertification.
- **YOU ALSO MUST GET PRECERTIFICATION FOR CARE YOU RECEIVE IN SKILLED NURSING FACILITIES and HOSPICE and also HOME HEALTH CARE.** Please refer to this Section (*Skilled nursing care facility* and *Hospice*) and Section 5(a) (*Home health services*) 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.

Benefits 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 • 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. Other services and supplies you receive while in a hospital, such as: • Use of operating, recovery, maternity, and other treatment rooms • Rehabilitative services	PPO: Nothing Non-PPO: $200 copayment per hospital stay and 20% of the covered charges Providers outside the 50 United States: Nothing

Inpatient hospital - continued on next page

Benefits Description	You pay
Inpatient hospital (cont.)	
• 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 • 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 physician, even when billed by the hospital. For example, when the hospital bills for such professional services as surgery, anesthesiology, medical or therapy services, etc., we pay the specific surgery, anesthesia, medical or therapy benefit. Note: We cover hospital services and supplies related to dental procedures when necessitated by a non-dental physical impairment to safeguard the health of the patient, even though we may not cover the services of dentists or physicians in connection with the dental treatment.	PPO: Nothing Non-PPO: $200 copayment per hospital stay and 20% of the covered charges Providers outside the 50 United States: Nothing
Not covered: • *Admission to nursing homes, rest homes, places for the aged, convalescent homes, or any place that is not a hospital, skilled nursing care facility, or hospice (see Section 3, Covered providers and Covered facilities)* • *Custodial care (see definition Section 10)* • *Any part of a hospital admission that is not medically necessary (see definition Section 10), such as when you do not need acute hospital inpatient (overnight) care, but could receive care in some other setting without adversely affecting your condition or the quality of your medical care. Note: In this event, we pay benefits for services and supplies other than room and board and in-hospital physician care at the level we would have covered if provided in an alternative setting.* • *Inpatient private duty nursing except as provided above* • *Personal comfort items, such as radio, television, beauty and barber services, identification tags, baby beads, footprints, guest cots and meals, newspapers and similar items* • *Inpatient hospital services and supplies for surgery that we do not cover except as noted above for non-covered dental procedures*	*All charges*

Benefits Description	You pay
Outpatient hospital or ambulatory surgical center	
• 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 physicians in connection with the dental treatment.	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) Providers outside the 50 United States: 10% of the Plan allowance (calendar year deductible applies)
Not covered: • *Outpatient hospital services and supplies for surgery that we do not cover except as noted above for non-covered dental procedures*	*All charges*
Extended care benefits/Skilled nursing care facility benefits	
If you precertify your admission, we cover semiprivate room, board, services and supplies in a Skilled Nursing Facility (SNF) for up to 90 days per calendar year when the admission is: 1. Medically necessary; and 2. Under the supervision of a physician.	For precertified care: Nothing up to the Plan allowance for up to 90 days per calendar year and all charges after 90 days
If you do not precertify your admission, we cover semiprivate room, board, services and supplies in a Skilled Nursing Facility (SNF) for up to 45 days per calendar year subject to the above conditions. Note: Precertified and non-precertified days are combined. Day limit not to exceed 90 days per calendar year.	For non-precertified care: 20% up to the Plan allowance for up to 45 days per calendar year and all charges after 45 days
Not covered: • *Custodial care (see definition Section 10)*	*All charges*
Hospice care	
If you precertify your Hospice care, we pay up to a lifetime maximum of $7,500. Note: This benefit does not apply to services covered under any other provisions of the Plan. Note: We define Hospice Care Program as a coordinated program of home or inpatient pain control and supportive care for a terminally ill patient and the patient's family. Care must be provided by a medically supervised team under the direction of an independent hospice administration that we approve.	For precertified care: Nothing up to the Plan allowance until benefits stop at $7,500 and all charges after $7,500
If you do not precertify your Hospice care, we pay up to a lifetime maximum of $4,500. The note and definition above apply.	For non-precertified care: Nothing up to the Plan allowance until benefits stop at $4,500 and all charges after $4,500

Benefits Description	You pay
Ambulance	
• Professional ambulance service to or from the hospital Note: This benefit includes air ambulance service when medically necessary to transport you to the nearest facility equipped to handle your medical condition. Note: See Section 5(d) for ambulance services as a result of an accident.	PPO: 10% of the Plan allowance Non-PPO: 10% of the Plan allowance and any difference between our allowance and the billed amount Providers outside the 50 United States: 10% of the Plan allowance
Not covered: • *Ambulance transport for you or your family's convenience*	*All charges*

Section 5(d). Emergency services/accidents

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- The calendar year deductible 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 or when you use a provider outside the 50 United States. When no PPO provider is available in a PPO Network Area, non-PPO benefits apply.
- When you use a PPO facility, the professionals who provide services to you in the facility may not be preferred providers. If they are not, they will be paid by this Plan as non-PPO providers. However, if the services are rendered at a PPO facility, we will pay up to the Plan allowance at the preferred provider rate for services of radiologists, anesthesiologists, emergency room physicians, pathologists and neonatologists who are not preferred providers.
- 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.

What is an accidental injury?

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

What is a 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. Medical emergencies include heart attacks, cardiovascular accidents, loss of consciousness or respiration, convulsions, and such other acute conditions that we determine to be medical emergencies.

Benefits Description	You pay After the calendar year deductible…
Note: The calendar year deductible applies to some benefits in this Section. We say "(No deductible)" when it does not apply.	
Accidental injury	
We pay 100% of the Plan allowance for the following care you receive as a result of an accidental injury: • Emergency Room (ER) charge, ER physician's charge and ancillary services performed at the time of the ER visit; **or** • Initial office visit and ancillary services performed at the time of the initial office visit for accidental injury. Note: We pay for services performed outside the ER facility under the appropriate Plan benefit. Note: We pay Hospital benefits as specified in Section 5(c) if you are admitted to the hospital. Note: We pay medical supplies, medical equipment, prosthetic and orthopedic devices for use at home under Section 5(a). Note: We pay prescription medications for use at home under Sections 5(a), 5(c) or 5(f) as appropriate.	PPO: Nothing (No deductible) Non-PPO: Only the difference between the Plan allowance and the billed amount (No deductible) Providers outside the 50 United States: Nothing (No deductible)

Benefits Description	You pay After the calendar year 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: 10% of the Plan allowance and any difference between our allowance and the billed amount Providers outside the 50 United States: 10% of the Plan allowance
Ambulance	
• Professional ambulance service as a result of an accident Note: See Section 5(c) for non-emergency service. 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 (No deductible) Non-PPO: 10% of the Plan allowance and any difference between our allowance and the billed amount (No deductible) Providers outside the 50 United States: 10% of the Plan allowance (No deductible)
Not covered: • *Ambulance transport for you or your family's convenience*	*All charges*

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

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

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- The calendar year deductible or, for facility care, the inpatient copayment applies to almost all benefits in this Section. We added "(No deductible)" to show when the calendar year deductible does not apply.
- The non-PPO benefits are the standard benefits of this Plan. PPO benefits apply only when you use a PPO provider or when you use a provider outside the 50 United States. When no PPO provider is available in a PPO Network Area, non-PPO 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 PRECERTIFICATION/PREAUTHORIZATION/CONCURRENT REVIEW FOR THESE SERVICES.** The Plan will reduce your benefits if you fail to get precertification/preauthorization/concurrent review for these services. See the precertification information shown in Section 3 and the instructions after the benefits descriptions on pages 49-50 and 51.
- PPO and providers outside the 50 United States mental health and substance abuse benefits are below and on pages 49-50; and non-PPO benefits begin on page 50.

Benefits Description	You pay After the calendar year deductible…
Note: The calendar year deductible applies to almost all benefits in this Section. We say "(No deductible)" when it does not apply.	
In-Network Area benefits (PPO and Providers outside the 50 United States)	
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. **Note: If you receive care outside the 50 United States, we do not require precertification, preauthorization or concurrent review for continuing care. However, the Plan will review all services to establish medical necessity. We may request medical records in order to determine medical necessity. See Section 3 for details.**	Your cost sharing responsibilities are no greater than for other illnesses or conditions.
Professional services including: • Individual or group therapy when rendered by covered providers • Medication management – Note: We cover this under Section 5(a) pharmacological visits, no preauthorization required.	PPO: 10% of the Plan allowance Providers outside the 50 United States: 10% of the Plan allowance

In-Network Area benefits (PPO and Providers outside the 50 United States) - continued on next page

Benefits Description	You pay After the calendar year deductible…
In-Network Area benefits (PPO and Providers outside the 50 United States) (cont.)	
• Diagnostic tests including psychological testing	PPO: 10% of the Plan allowance Providers outside the 50 United States: 10% of the Plan allowance
• Services provided by a hospital (including residential treatment center) or other facility	PPO inpatient facility: Nothing for room and board and other services (No deductible) Providers outside the 50 United States: Nothing for room and board and other services (No deductible)
Services in approved alternative 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: 10% of the Plan allowance Providers outside the 50 United States: 10% of the Plan allowance
Not covered: • *See Section 6, General exclusions, for non-covered services* *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 / Concurrent Review

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 Section 3 for more details**. These include:

- **Precertification** to establish the medical necessity of your admission to a hospital, residential treatment center or other facility for you to receive full Plan benefits. **You must precertify any inpatient care before you receive it.** If you do not precertify, we will reduce the benefits payable by $500. You must report emergency admissions within two business days following the day of admission even if you have been discharged.
- **Preauthorization** to establish the medical necessity for all levels of outpatient or office care. **You must preauthorize any outpatient or office care before you receive it.** If you do not preauthorize, we will request information from your provider to review the services for medical necessity. This will delay your claim. If you do not preauthorize, even if we determine the services are medically necessary, we will reduce any available benefits by 50% of what we would have paid had you preauthorized your care.

Precertification/Preauthorization/Concurrent Review - continued on next page

- **Concurrent review (which means review of continuing treatment)** to establish the medical necessity for all levels of *continuing* outpatient or office care. **You must obtain concurrent review for any continuing outpatient or office care you receive before you receive continuing care.** If you do not obtain concurrent review or follow your treatment plan, we will request information from your provider to review the continued services for medical necessity. This will delay your claim. If you do not obtain concurrent review, even if we determine the services are medically necessary, we will reduce any available benefits by 50% of what we would have paid had you obtained concurrent review or followed your treatment plan.
- **To precertify or preauthorize care and obtain concurrent review for continuing care,** you, your representative, your doctor or your hospital **must** call the Plan at 1-800-593-2354 prior to the admission or care.

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

Note: We do not require precertification, preauthorization or concurrent review when Medicare Part A and/or B, or another group health insurance policy is the primary 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.

Benefits description	You pay After the calendar year deductible...
Non-PPO	
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.	Your cost sharing responsibilities are greater and limitations apply when you use a non-PPO provider.
Professional inpatient services when rendered by covered providers including: • Non-PPO inpatient individual therapy limited to 50 visits per person per calendar year	Non-PPO professional fees: • Individual therapy inpatient: 30% of the Plan allowance and any difference between our allowance and the billed amount and all visits above 50 per person per calendar year
• Non-PPO inpatient group therapy	• Group therapy inpatient: 30% of the Plan allowance and any difference between our allowance and the billed amount
Professional outpatient services when rendered by covered providers including: • Non-PPO outpatient individual therapy benefits limited to 60 visits per person per calendar year	Non-PPO professional fees: • Individual therapy outpatient: 30% of the Plan allowance and any difference between our allowance and the billed amount up to 60 visits per person per calendar year and all visits above 60 per person per calendar year

Non-PPO - continued on next page

Benefits description	You pay After the calendar year deductible...
Non-PPO (cont.)	
• Non-PPO outpatient group therapy benefits limited to $40 per session	• Group therapy outpatient: All charges in excess of Plan maximum allowance of $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. • Diagnostic tests including psychological testing	• Non-PPO medication management: 30% of the Plan allowance and any difference between our allowance and the billed amount • Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount
• Services provided by a hospital (including residential treatment center) or other facility	Non-PPO inpatient facility: $200 copayment per person per hospital stay and 30% of covered charges for room and board and other services (No deductible)
Services in approved alternative 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: 30% of the Plan allowance and any difference between our allowance and the billed amount
Not covered: • *See Section 6, General exclusions, for other non-covered services.* *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 / Concurrent Review	We have the same precertification, preauthorization and concurrent review (which means review of continuing treatment) requirements for non-PPO services as we do for PPO. See pages 49-50 for details.
Non-PPO limitation	We will limit your benefits if you do not follow all of our authorization processes and your treatment plan.

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

- Section 4, *Your costs for covered se*rvices, for information about catastrophic protection for these benefits.
- Section 7, *Filing a claim for covered services*, for information about submitting non-PPO and providers outside the 50 United States claims.

Section 5(f). Prescription drug benefits

Important things you should keep in mind about these benefits:

- We cover prescribed drugs and medications, as described on pages 54-56.
- Please remember that all benefits are subject to the definitions, limitations and exclusions in this brochure and are payable only when we determine they are medically necessary.
- In this Section, unlike other subsections in Section 5, the calendar year deductible applies to only a few benefits. The calendar year deductible is: $300 per person ($600 per family). 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.
- **YOU MUST GET PRIOR AUTHORIZATION FOR CERTAIN DRUGS; AND PRIOR AUTHORIZATION MUST BE RENEWED PERIODICALLY.** Prior authorization uses Plan rules based on FDA-approved prescribing and safety information, clinical guidelines and uses that are considered reasonable, safe and effective. See the prior authorization information shown in Section 3 and on pages 53 and 55-56 for more information about this important program.

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

Who can write your prescription. A licensed physician or prescriber such as a nurse practitioner or physician assistant must write the prescription.

When you have to purchase a prescription.

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

Where you can obtain your prescription.

- **Network Pharmacies within the 50 United States -** *Your prescriber must be licensed in the United States.*
  - You must fill your prescription at a network pharmacy participating with Medco. You may obtain the names of network pharmacies by calling 1-800-818-6717, on the Internet at www.medco.com, or as a link through our Web site at www.AFSPA.org/FSBP. **You must present your Foreign Service Benefit Plan/Medco Prescription Drug ID Card when filling your prescription in order to receive this benefit. See dispensing limitations on next page.** ***Prescriptions you purchase at network pharmacies without the use of your card are not covered.***
- **Non-Network Pharmacies in the 50 United States**
  - Prescriptions you purchase at non-network pharmacies in the 50 United States are **not** covered.
- **Mail Order -** *Your prescriber must be licensed in the United States.*
  - You will receive forms for refills and future prescription orders each time you receive drugs or supplies through Medco By Mail. You may also order refills over the Internet directly from Medco By Mail by visiting www.medco.com. If you have any questions about a particular drug or a prescription, or to request order forms, you may call 1-800-818-6717 in the United States or 1-800-497-4641 (available in over 140 countries) from outside the 50 United States. You also can call Medco collect at 412-829-5932 or 412-829-5933 if the toll-free number for outside the 50 United States does not work for you. If you are posted, living or traveling outside the United States, you may request up to a 1-year supply of most medications. ***Prescriptions you purchase by mail order from a source other than Medco By Mail or Accredo Health Group, Medco's specialty pharmacy, are not covered.***
  - To order by mail: 1) Complete the initial mail order form; 2) Enclose your prescription and copayment; 3) **Mail your order to Medco By Mail** *(do not mail your order to the Plan);* and 4) Allow approximately two weeks for delivery.

Prescription drug benefits - continued on next page

Prescription drug benefits *(continued)*

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

These are the dispensing limitations.

- The Plan follows Food and Drug Administration (FDA) guidelines.
- You may purchase up to a 30-day supply of medication at a network pharmacy. Refills cannot be obtained until 50% of the drug has been used. You may not obtain more than a 30-day supply through the network pharmacy arrangement except in the following situations. If you do not contact us prior to purchasing your prescription when either of the following applies, the Plan will not supply more than a 30-day supply of medication and we will not reimburse you if you purchase more than a 30-day supply without the use of your Foreign Service Benefit Plan/Medco Prescription Drug ID Card:
  - You are traveling to a foreign country, do not have time to use Medco By Mail and need to purchase more than a 30-day supply of prescriptions to take with you.
  - You are visiting the United States for a short time period, do not have time to use Medco By Mail and need to purchase more than a 30-day supply of prescriptions to take with you.
- You may purchase long-term (up to a 90-day supply) prescription needs through Medco By Mail to receive higher benefits. Medco By Mail will fill your prescription.
  - If you are posted, living or traveling outside the 50 United States, you may request up to a 1-year supply of most medications through Medco By Mail. Ask your prescriber to write you a prescription for a 1-year supply with no refills. Contact the Plan or refer to our Web site if you need additional assistance.
  - We cover all drugs and supplies referenced on the next page except for those that require constant temperature control, are too heavy to mail, or that must be administered by a physician.
- **Per Federal regulations, Medco By Mail can mail only to addresses in the United States or to APO and FPO addresses.**
- You may not obtain hormone therapy treatment (for infertility) with your Foreign Service Benefit Plan/Medco Prescription Drug ID Card or through Medco By Mail.
- **Coverage Management**
  - The Plan utilizes coverage management programs to help ensure that you receive the prescription drugs you need at a reasonable cost. The information below describes a feature of your prescription drug plan known as coverage management. This program determines how the Plan will cover certain medications.
    - **Prior authorization review may be required: Some medications are not covered unless you receive approval through a coverage review (prior authorization).**
    - **Prior authorization review** uses Plan rules based on FDA-approved prescribing and safety information, clinical guidelines and uses that are considered reasonable, safe and effective. There are other medications that may be covered with limits (for example, only for a certain amount or for certain uses) unless you receive approval through a coverage review. Examples of drug categories requiring prior authorization, include but are not limited to, growth hormones, interferons, erythroid stimulants and oncologic agents. During this review, Medco asks your doctor for more information than what is on the prescription before the medication may be covered under the Plan. If coverage is approved, you simply pay your normal copayment for the medication. *If coverage is not approved, you will be responsible for the full cost of the medication.*
  - The Plan will participate in other approved managed care programs, as deemed necessary, to insure patient safety and appropriate quantities in accordance with the Plan rules based on FDA-approved guidelines referenced above.
  - To find out if your prescription requires prior authorization or more about our coverage management program, visit Medco online at www.medco.com. If you're a first-time visitor to the site, register (with your member ID and a recent prescription number); or call Medco Member Services at 1-800-818-6717. Members outside the U. S. may call Medco at 1-800-497-4641.

Prescription drug benefits - continued on next page

Prescription drug benefits *(continued)*

- **Specialty Pharmaceuticals are drugs/pharmaceuticals or category of drugs/pharmaceuticals, as determined by the Plan, that generally meet most of the following criteria:** 1) Are produced through biotechnology or recombinant DNA technology mechanisms; 2) Are extremely high cost (typically over $6,000 per year); 3) Are generally, but not always, administred by injection; 4) Require specialized patient monitoring, special handling, or unique education prior to use; or 5) Have restricted distribution procedures.
- Examples of drugs that qualify as Specialty Pharmaceuticals include but are not limited to drugs/pharmaceuticals that are used to treat Crohn's disease, hemophilia, growth hormone deficiency, RSV, cystic fibrosis, multiple sclerosis, hepatitis C, rheumatoid arthritis, and Gaucher's disease.
- **For drugs that are classified as Specialty Pharmaceuticals, you may obtain only an initial 30-day supply and one refill of that medication at a Plan network retail pharmacy. All future refills of that medication must be purchased through the Plan's mail service benefit, through Accredo Health Group, Medco's specialty pharmacy.** The Plan will provide you instructions on purchasing future refills. Purchases of Specialty Pharmaceuticals made after the first refill at a network pharmacy are not covered by the Plan. For inquiries about this benefit, please call the Plan's Specialty Pharmacy number at 1-800-803-2523 Monday – Friday 8 a.m. to 9 p.m. Eastern Time and Saturday 8 a.m. to 5 p.m. Eastern Time. Also, please note the following items:
  - Accredo provides patient support and instructions on administering the medication.
  - Most Specialty Pharmaceuticals require special handling and cannot be shipped to APO/FPO/Pouch Mail addresses.
  - Not all network pharmacies carry Specialty Pharmaceuticals. Contact Accredo at 1-800-803-2523 for information.
  - Fertility drugs are covered only as specified under Section 5(a), *Infertility services*.
- **Four-level drug benefit** – we divide prescription drugs into four levels:
  - **Level I (generic drug):** Generic drugs are chemically and therapeutically equivalent to their corresponding brand name drugs, but cost less. The FDA must approve all generic versions of a drug and assure that they meet strict standards for quality, strength and purity. The FDA requires that generic equivalent medications contain the same active ingredients and be equivalent in strength and dosage to brand name drugs. The main difference between a generic and its brand name drug is the cost of the product.
  - **Level II (single-source brand name drug):** Single-source brand name drugs are available from only one manufacturer and are patent-protected. No generic equivalent is available.
  - **Level III (multi-source brand name drug):** Multi-source brand name drugs are brand name drugs for which the patent protection has expired. As a result, generic equivalent drugs are available. When an approved generic equivalent is available, that is the drug you will receive, unless you or your physician specifies that the prescription must be filled as written ("Dispense as Written – DAW"). When an approved generic equivalent is not available, you will pay the single-source brand name coinsurance/copayment. **If an approved generic equivalent is available, but you or your physician specifies that the prescription must be filled as written, you will pay the multi-source brand name coinsurance/copayment.**
  - **Level IV (Specialty Pharmaceuticals):** Specialty medications are described above.
  - **The four-level drug benefit is not applicable to prescription drugs you purchase from a retail pharmacy outside the 50 United States and file as a claim.**

When you do have to file a claim.

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

Prescription drug benefits begin on the next page

Benefits Description	You Pay
Note: The calendar year deductible does not apply to benefits in this Section. We say "(No deductible)" when it does not apply.	
Covered medications and supplies	
We will send each new enrollee a Foreign Service Benefit Plan/Medco Prescription Drug Identification Card, a description of our prescription drug program, a Health, Allergy & Medication Questionnaire and several mail order forms and envelopes. **You must present your Foreign Service Benefit Plan/Medco Prescription Drug ID 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 or by mail through Medco By Mail: • Drugs that by Federal law of the United States require a physician's prescription for their purchase except those listed as not covered • Insulin and diabetic supplies • FDA-approved drugs, prescriptions, and devices for birth control • Prescription drugs for smoking cessation • Prescription drugs for weight management • Needles and syringes for the administration of covered medications Prescription drugs you receive from a physician or facility are covered only as specified under Section 5(a) and 5(c) and below. Note: **The Plan requires a coverage review (prior authorization) of certain prescription drugs based on FDA-approved prescribing and safety information, clinical guidelines and uses that are considered reasonable, safe and effective.** See pages 14 and 53 for more information. To find out if your prescription requires prior authorization or more about your prescription drug plan, visit Medco online at www.medco.com. If you're a first-time visitor to the site register with your member ID and a recent prescription number; or call Medco Member Services at 1-800-818-6717. Members outside the U. S. may call Medco at 1-800-497-4641. Note: We do not require prior authorization for the purchase of certain prescription drugs when Medicare Part B or Part D is the primary payer or you are outside the 50 United States and purchase them from a retail pharmacy outside the 50 United States.	• Network Retail (non-Medicare): - Level I (generic drug): $10 copay (No deductible) - Level II (single-source brand name drug): 25% ($25 minimum) (No deductible) - Level III (multi-source brand name drug): 30% ($40 minimum) (No deductible) - Level IV (Specialty Pharmaceuticals): 25% (No deductible) (Note: After your first refill, you must use Accredo (see previous pages) if the Plan instructs you to do so. If you continue to use retail and the Plan has instructed you to use Medco By Mail, you pay 100% of the cost.) • Network Retail (Medicare): - The Plan coordinates benefits with Medicare Part B and Part D coverage. - Be sure to present your Medicare ID card whenever using a retail pharmacy. If your medication or supplies are eligible for Medicare B or D, the retail pharmacy will submit your claim first to Medicare and then to the Plan for you. Most independent pharmacies and national chains are Medicare providers. To find a retail pharmacy near you that is a Medicare B- or D-participating pharmacy, please visit the Medicare website at www.medicare.gov/supplier/home.asp or call Medicare Customer Service at 1-800-633-4227. • Non-Network Retail (in the 50 United States, including Medicare): 100% of cost • Non-Network Retail (outside the 50 United States, including Medicare): 10% of cost (No deductible) See next page for Mail Order (Medco By Mail).

Covered medications and supplies - continued on next page

Benefits Description	You Pay
Covered medications and supplies (cont.)	
Note: Information in the left hand column of the previous page applies here.	• Network Mail Order – Medco By Mail (non-Medicare): - Level I (generic drug): $15 (No deductible) - Level II (single-source brand name drug): $40 (No deductible) - Level III (multi-source brand name drug): $55 (No deductible) - Level IV (Specialty Pharmaceuticals): 25% up to a maximum of $150 (No deductible) • Network Mail Order – Medco By Mail (Medicare): - The Plan coordinates benefits with Medicare Part B and Part D coverage. - To receive your Medicare Part B-eligible medications and supplies by mail, send your mail order prescriptions to Medco By Mail. Medco will review the prescriptions to determine if they could be eligible for Medicare Part B coverage. - When Medicare Part B is primary, contact Medicare at www.medicare.gov/supplier/home.asp or call Medicare Customer Service at 1-800-633-4227 about your options for submitting claims for Medicare-covered medications and supplies, whether you use a Medicare-approved supplier or Medco By Mail. Prescriptions typically covered by Medicare Part B include diabetes supplies (test strips and meters), specific medications used to aid tissue acceptance (such as with organ transplants), certain oral medications used to treat cancer, and ostomy supplies. - Once Medicare Part B pays the claim, it will submit the claim to the Plan for you. - To receive your Medicare Part D-eligible medications and supplies by mail, send your mail order prescriptions to your Medicare Part D Prescription Drug Plan (PDP). If your Medicare Part D PDP is Medco, they will submit a claim first to Medicare and then to the Plan for you. If your Medicare Part D PDP is not Medco, you will need to submit a paper claim to the Plan. Note: If there is no generic equivalent available, you will still have to pay the single-source brand name coinsurance/copay. Note: A separate copay applies per prescription fill.

Covered medications and supplies - continued on next page

Benefits Description	You Pay
Covered medications and supplies (cont.)	
The following are covered: • If you are outside the 50 United States and purchase prescriptions only from a retail pharmacy outside the 50 United States or a military treatment facility outside the 50 United States • If you do not use your prescription card to purchase colostomy, ostomy or diabetic supplies	• 10% of the cost (including Medicare) (No deductible)
Not covered: • *Drugs and supplies you purchase at a non-network pharmacy in the 50 United States except as covered under Section 5(a) and 5(c) and except when Medicare Part B and Part D are primary* • *Specialty Pharmaceuticals you purchase at a non-network pharmacy except when Medicare Part B and Part D are primary* • *Specialty Pharmaceuticals you purchase at a network pharmacy after your first refill and/or you purchase from a source other than through Accredo Health Group, Medco's specialty pharmacy, except when Medicare Part B and Part D are primary* • *Drugs and supplies you purchase without using your Foreign Service Benefit Plan/Medco Prescription Drug ID Card at a network pharmacy except as covered under Section 5(a) and 5(c) and except when Medicare Part B and Part D are primary* • *Drugs and supplies (except colostomy, ostomy, or diabetic supplies) you purchase by mail order from a source other than the Plan's Medco By Mail, Accredo Health Group, Medco's specialty pharmacy, or Liberty Medical, and except when Medicare Part B and Part D are primary* • *Medications for which you did not obtain prior authorization and which require prior authorization* • *Prescription drug coinsurance* • *Medco By Mail 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 physician 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 Section 5(a), Infertility services). You may not obtain hormone therapy treatment with your Foreign Service Benefit Plan/Medco Prescription Drug ID Card or through Medco By Mail.* • *Drugs and supplies related to impotency, sex transformations, sexual dysfunction, or sexual inadequacy*	*All charges*

Section 5(g). Dental benefits

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- If you are enrolled in a Federal Employees Dental/Vision Insurance Program (FEDVIP) Dental Plan, your FEHB Plan will be First/Primary payer of any Benefit payments and your FEDVIP Plan is secondary to your FEHB Plan. See Section 9 *Coordinating benefits with other coverage*.
- The calendar year deductible is: $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 physicians in connection with the dental treatment. See Section 5(c) for inpatient hospital benefits.

Accidental injury benefit	You pay
Accidental injury benefit	
We cover dental work (including dental X-rays) to repair or initially replace sound natural teeth under the following condition: • You must receive these services as a result of an accidental injury to the jaw or sound natural teeth. Note: We cover dental care required as a result of accidental injury from an external force such as a blow or fall to sound natural teeth (not from biting or chewing) that requires immediate attention. 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. Note: The Plan will ask for information from your dentist that documents the teeth involved in the accident were sound natural teeth prior to the accident if such information is not submitted with the claim.	PPO: 20% of the Plan allowance (calendar year deductible applies) Non-PPO : 20% of the Plan allowance and any difference between our allowance and the billed amount (calendar year deductible applies) Providers outside the 50 United States: 20% of the Plan allowance (calendar year deductible applies)

Dental benefits - continued on next page

Dental benefits		
Only those services listed below are covered	**We pay**	**You pay**
Preventive care, limited to two services per person per calendar year • Oral exam • Prophylaxis (cleaning), adult • Prophylaxis, child (thru age 14) • Prophylaxis with fluoride, child (thru age 14)	Only the following amounts are payable **(scheduled allowance)**: • $13 per exam • $23 per cleaning • $16 per cleaning • $26 per cleaning	All charges in excess of the scheduled amounts listed to the left
Surgery • Apicoectomy (tooth root amputation) • Alveolectomy (excision of alveolar bone) • Alveolar abscess, incision and drainage • Gingivectomy (excision of gum tissue) Note: Excision of impacted teeth and non-dental oral surgical procedures are covered under Section 5(b), *Oral and maxillofacial surgery*.	Only the following amounts are payable **(scheduled allowance)**: • $50 per root • $40 per quadrant • $10 per abscess • $50 per quadrant	All charges in excess of the scheduled amounts listed to the left
Orthodontic services	**We pay**	**You pay**
We define orthodontics as the realignment of natural teeth or correction of malocclusion.	50% of the Plan allowance up to a lifetime maximum of $1,000 per person	50% of the Plan allowance until benefits stop at $1,000 and all charges after $1,000

Section 5(h). Special features

Special feature	Description
Flexible benefits option	Under the flexible benefits option, we determine the most effective way to provide services. • We may identify medically appropriate alternatives to traditional care and coordinate other benefits as a less costly alternative benefit. If we identify a less costly alternative, we will ask you to sign an alternative benefits agreement that will include all of the following terms. Until you sign and return the agreement, regular contract benefits will continue. • Alternative benefits will be made available for a limited time period and are subject to our ongoing review. You must cooperate with the review process. • By approving an alternative benefit, we cannot guarantee you will get it in the future. • The decision to offer an alternative benefit is solely ours, and except as expressly provided in the agreement, we may withdraw it at any time and resume regular contract benefits. • If you sign the agreement, we will provide the agreed-upon alternative benefits for the stated time period (unless circumstances change). You may request an extension of the time period, but regular benefits will resume if we do not approve your request. • Our decision to offer or withdraw alternative benefits is not subject to OPM review under the disputed claims process.
Centers of Excellence for tissue and organ transplants	The Plan has special arrangements with facilities to provide services for tissue and organ transplants. The network was designed to give you an opportunity to access providers that demonstrate high quality medical care for transplant patients. Note: If a qualified tissue/organ transplant is medically necessary and performed at a transplant network facility, you may be eligible for benefits related to expenses for travel, lodging and meals for the transplant recipient and one family member or caregiver. We also may assist you and one family member or caregiver with travel and lodging arrangements. Your physician can coordinate arrangements by calling a case manager in the Plan's Medical Management Department at 1-800-593-2354. For additional information regarding the transplant network, please call this number.
Healthy Pregnancy Program	You have access to the Plan's Healthy Pregnancy Program, which provides educational material and support to pregnant women. Contact the Plan at 1-800-593-2354 for more information.
Overseas Second Opinion	The Plan has a special arrangement with the Cleveland Clinic to provide patients who receive treatment in foreign countries a second opinion for certain diagnoses through the e-Cleveland Clinic. Patients who receive treatment in foreign countries and with qualifying diagnoses as determined by the Plan will have convenient access to the Cleveland Clinic's nationally-recognized specialists for a second opinion. This second opinion program is available in most locations throughout the world. To determine if you are an appropriate candidate for this second opinion benefit, e-mail the Plan at secondopinion@cvty.com. If your diagnosis qualifies for this program, they will ask you to submit medical history information and answer questions specific to the diagnosis. You also may need to gather information from your local doctor or hospital, such as pathology (biopsy) slides or x-rays and mail them to the Plan as instructed. The appropriate physician will review the medical history and original tests before rendering a second opinion. You will be notified by e-mail within three to five days that the opinion is ready and can be viewed on-line at a secure Web site. Once a second opinion is obtained, you may proceed with the treatment that was originally recommended by your own physician or you may decide you want to seek another opinion or arrange care with another physician.

Special features - continued on next page

Special feature (cont.)	Description
Disease management programs	Disease management programs for members and covered dependents with asthma, chronic obstructive pulmonary disease (COPD), coronary artery disease (CAD), diabetes, or heart failure (HF). Disease management programs are provided at no additional cost to participants. **Domestic Disease Management Program** 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 the Plan for more information about this program, please call 1-800-593-2354. **Overseas Disease Management Program** The program is tailored specifically to meet the needs of members who reside in a foreign country. This is an exclusive arrangement that the Plan has with Coventry. The program provides: • Information and support to you via secure e-mail; • Educational materials and notifications about your condition; and • Direct consultations with case managers. We will contact candidates and ask them to participate voluntarily. If you are posted back to the United States, you will remain enrolled in the program and will continue to receive information. If you would like to contact the Plan for more information about this program, please e-mail FSBPhealth@cvty.com.

Special features continued on next page

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Special feature (cont.)	Description
Web based customer service	Check the status of your claims and look up providers participating in the Plan's PPO Network. Log on to our Web site www.AFSPA.org/FSBP. Click on "Web Based Access". This link will take you to the Plan's customer access page. Once you register at this secure on-line site with your own password, you will be able to perform functions such as: • View a list of pending and finalized claims. While you will not be able to obtain details on pending claims, you will be able to view and print explanations of benefits (EOBs) on finalized claims. Once you send your claim, please allow at least 10 business days in addition to mailing time for your claim to appear on-line; • Search for providers participating in the Plan's PPO Network and obtain driving directions to their locations; and • Obtain important health and wellness information, such as: - Quality information on providers; and - Outcomes on treatment and average costs for illnesses and procedures. The Plan provides members detailed information about accessing, registering and using the site. If you have questions about your claims, PPO providers or how to use the Web site, please contact the Plan directly by phone at 202-833-4910, fax at 202-833-4918 or e-mail at health@AFSPA.org. In addition, the Plan provides for a secure method for you to submit claims to us via the internet from overseas locations. Visit our Web site (www.AFSPA.org/FSBP), click on the "Ask AFSPA" tab and then "FSBP". You can attach a scanned copy of your claim to an e-mail message you send to us. We designed this secure process to eliminate the lengthy mail time from your overseas post to our office. Also, you may correspond with us via secure e-mail through this process. In addition, you may fax us your claims from overseas. Our special fax number is 202-464-4508.

Non-FEHB benefits available to Plan members

The benefits on this page are not part of the FEHB contract or premium, **and you cannot file an FEHB disputed claim about them**. Fees you pay for these services do not count toward FEHB deductibles, copayments or catastrophic protection out-of-pocket maximums. These programs and materials are the responsibility of the Plan, and all appeals must follow their guidelines. For additional information contact the Plan at 202-833-4910 or visit the **AMERICAN FOREIGN SERVICE PROTECTIVE ASSOCIATION'S** Web site at www.AFSPA.org.

Long Term Care	The **AMERICAN FOREIGN SERVICE PROTECTIVE ASSOCIATION (AFSPA)** offers excellent policies with group rates. These plans provide benefits for all levels of nursing home care, 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 Plan** - $100 daily benefit - 5% simple inflation - 5 year benefit period - Benefit Increase Option - International coverage - Reduced elimination period for home health care **John Hancock Plan** - Up to $500 daily benefit or up to $15,000 monthly benefit - CPI compound inflation protection - 100% of benefit for home health care - International coverage (one year limit) - 3 years, 5 years, or 5 years + $1 million benefit period
Discount on Non-Covered Prescription Drugs	You may purchase non-covered (off-plan) prescription drugs at a discount directly from Medco such as: - Dermatologicals (Renova) - Anorexiants - Rx Vitamins - Erectile dysfunction agents - Drugs labeled for cosmetic indications (Propecia) You pay 100% of the discounted price. You cannot file a claim for off-plan prescriptions. • Call Medco first at 1-800-818-6717 to find out the price of off-plan prescriptions. • Obtain the prescription from your physician. • 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.
Discount on Over-the-Counter (OTC) Nonprescription Products	You may purchase OTC products directly from Medco. • To search for nonprescription items on Medco's Web site, log on to www.medco.com and click on "Nonprescription items" (left menu or tab at top). • If you are a first time visitor to the site, take a moment to register. Please have your member ID and a recent prescription number available. You will find a wide selection of products including such items as nonprescription medications, vitamins, herbal products and personal care products. • Follow the on-screen instructions to search for items and add them to your shopping cart. • If you plan to purchase products on a regular basis, you can create an online shopping list that will simplify future shopping.

Term Life Insurance	• Up to $300,000 of coverage • Includes a living care and a dependent education benefit • Covers acts of terrorism or war • Keep after leaving government service
Immediate Benefit Plan	• This is a $15,000 term life insurance plan ($7,500 at age 70) to help cover some of the immediate expenses such as mortgage, funeral expenses and other medical costs. This benefit is paid to the beneficiary(ies) generally within two business days after notification of enrollee's death is received by **AFSPA**. • This optional term life insurance plan is issued by the Prudential Insurance Company of America, a leader in the insurance industry for over 125 years. • No physical exam is required when enrolling in the Plan during a qualifying event. • See our Web site (www.AFSPA.org/IBP) for eligibility requirements and online enrollment.
Expanded Dental Benefits	The **PROTECTIVE ASSOCIATION** offers several varied plans to suit our members' needs. **CIGNA HMO:** This is a dental health maintenance organization (DHMO) that provides dental coverage nationwide. • No deductibles or annual maximums; and no claim forms to file. • You pay reduced fees for procedures and there are no waiting periods. • Orthodontia is covered for dependents up to age 19, with a lifetime benefit of $1,500. **CIGNA PPO:** This dental plan allows you the freedom to use a dentist in the network for a higher benefit level or you can use your own dentist even if he/she is not in the network and be paid at a lower level. • Annual deductible is $100 for individuals and $300 for family. • Annual maximum of benefits is $1,200 per covered person. PPO dentists file claims. • Class III - Major Restorative Services are covered after a 12-month waiting period. • Class IV- Orthodontia is covered for dependents up to age 19, with a $1,500 lifetime maximum after a 24-month waiting period. **DentaQuest:** This dental plan is a DHMO available in DC, MD and VA only. • No deductibles or annual maximums; and no claim forms to file. • You pay reduced fees for covered procedures and there are no waiting periods. • Orthodontia is covered with no age restrictions. **CIGNA International: This plan is exclusively for our overseas population.** • Annual maximum is $1,200 per covered person. • Multi-lingual Customer Service is available 24 hours a day, 365 days a year. • Referrals to screened/qualified dentists worldwide are available. • Class III – Major Restorative Services are covered after a 12-month waiting period. • Class IV – Orthodontia is covered for dependents up to age 19, with a $1,500 lifetime benefit after a 24-month waiting period. • The plan also provides benefits for services rendered in the United States, but at a reduced rate and annual deductibles apply.

Legal Services	**Legal Services:** A number of firms located in the Washington DC metropolitan area serve our members at special rates. Services include, but are not limited to: civil litigation, wills, immigration, estate planning, real estate, family law and adoptions (international and domestic).
Travel Assistance Services	• Emergency medical evacuation; on-the-spot medical payments; worldwide medical referrals and medical monitoring; prescription replacement assistance; and repatriation of remains benefit • 10% discount for **AFSPA** members
Accidental Death and Dismembership Insurance	• Up to $300,000 of coverage • Covers loss by act of terrorism or a declared or undeclared war at 50% of the Principal sum • Dependent education benefit included

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

AMERICAN FOREIGN SERVICE PROTECTIVE ASSOCIATION

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

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

E-mail: Insurance@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. There may be other exclusions and limitations listed in Section 5 of this brochure. **Although we may list a specific service as a benefit, we will not cover it unless we determine it is medically necessary to prevent, diagnose, or treat your illness, disease, injury, or condition.** The fact that one of our covered providers has prescribed, recommended or approved a service or supply does not make it medically necessary or eligible for coverage under this Plan.

We do not cover the following:

- Services, drugs, or supplies you receive while you are not enrolled in this Plan;
- Services, drugs, or supplies that are not medically necessary;
- Services, drugs, or supplies not required according to accepted standards of medical, dental, or psychiatric practice;
- Experimental or investigational procedures, treatments, drugs or devices;
- Services, drugs, or supplies related to abortions, except when the life of the mother would be endangered if the fetus were carried to term, or when the pregnancy is the result of an act of rape or incest;
- Services, drugs, or supplies related to impotency, sex transformations, sexual dysfunction or sexual inadequacy;
- Services, drugs, or supplies you receive from a provider or facility barred from the FEHB Program;
- Any part of a provider's fee or charge ordinarily due from you that has been waived. If a provider routinely waives (does not require you to pay) a deductible, copayment or coinsurance, we will calculate the actual provider fee or charge by reducing the fee or charge by the amount waived;
- Charges you or we have no obligation to pay, such as excess charges for an annuitant 65 or older who is not covered by Medicare Part A and/or Part B (see Section 4), provider charges exceeding the amount specified by the Department of Health and Human Services when benefits are payable under Medicare (limiting charge) (see Section 4), or State premium taxes however applied;
- Services, drugs, or supplies you receive without charge while in active military service;
- Services, drugs, or supplies for which you would not be charged if you had no health insurance coverage;
- Services and supplies not recommended or approved by a covered provider;
- Services for cosmetic purposes;
- Services, drugs, or supplies related to weight control or any treatment of obesity except as described in Sections 5(a) and 5(f) and except surgery for morbid obesity as described in Section 5(b);
- Services, drugs, or supplies furnished or billed by a noncovered facility, except that medically necessary prescription drugs are covered;
- Services, drugs, or supplies you receive from immediate relatives or household members, such as spouse, parents, child, brother or sister by blood, marriage, or adoption;
- Services, drugs, or supplies not specifically listed as covered; or
- Charges that we determine are over our Plan allowance.

Listed below are examples of some of our exclusions:

- All charges for chemical aversion therapy, conditioned reflex treatments, narcotherapy or any similar aversion treatments and all related charges (including room and board);
- Any provider not specifically listed as covered;
- Counseling or therapy for marital, educational, sexual, or behavioral problems; or related to mental retardation or learning disabilities;
- Community-based programs such as self-help groups or 12 step programs;
- Services by pastoral, marital, or drug/alcohol counselors;

- Biofeedback (except for treatment of incontinence), conjoint therapy, hypnotherapy or milieu therapy;
- Charges for completion of reports or forms, interest, and missed or canceled appointments;
- Charges related to medical records submission if the medical records are needed to process a claim. If the Plan requests medical records inappropriately, the expenses may be covered.
- Bank fees including those associated with currency exchange;
- Custodial care;
- Mutually exclusive procedures. These are procedures that typically are not provided to the same patient on the same date of service;
- Non-medical services such as social services, recreational, educational, visual and nutritional counseling except as described in Section 5(a);
- Non-surgical treatment of temporomandibular joint (TMJ) dysfunction including dental appliances, study models, splints and other devices;
- Telephone consultations, mailings, faxes, e-mails or any other communication to or from a physician, hospital or other medical provider except as provided for in Section 5(h); or
- Treatment for learning disabilities and mental retardation.

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

Section 7. Filing a claim for covered services

How to claim benefits

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

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 providers or when another group health plan is primary – submit it on the HCFA-1500 or a claim form that includes the information shown below. Claims from foreign providers do not need to be filed on a HCFA-1500 (see *Foreign Claims* on next page). 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. Also, the Plan cannot accept a claim as an e-mail attachment, except as described on the next page by using our secure electronic method.

In addition:

- Generally, you need to fill out only one claim form per year. You should fill out a claim form if you submit a claim due to accidental injury, you have changed your address, or if the member's other insurance/Medicare status has changed.
- You must send a copy of the explanation of benefits (EOB) form you received from any primary payer (such as the Medicare Summary Notice (MSN)) with your claim. See Section 9 for Medicare claims.
- Bills for private duty nursing care must show that the nurse is a Registered Nurse (R.N.) or Licensed Practical Nurse (L.P.N.). You also should include the initial history and physical, treatment plan indicating expected duration and frequency from your attending physician and the nurse's notes from the nurse.
- Claims for rental or purchase of durable medical equipment must include the purchase price, a prescription and a statement of medical necessity including the diagnosis and estimated length of time needed.
- Claims for physical, occupational, and speech therapy must include an initial evaluation and treatment plan indicating length of time needed for therapy and progress (therapy) notes for each date of service from the therapist.
- Claims for dental services must include a copy of the dentist's itemized bill (including the information required above) and the dentist's Federal Tax ID Number. We do not have separate dental claim forms.
- Claims for alternative treatment services must include a copy of the provider's itemized bill (including the information required above) and the provider's Federal Tax ID Number.

Foreign Claims

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

If you are posted outside the 50 United States and both the Medical and Health Program of the Department of State – Office of Medical Services (OMS) and we cover you, submit claims to us as described on the previous page or as directed by OMS, through your 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 convert them to U.S. Dollars using the exchange rate applicable at the time the expense was incurred if you do not supply us with a translation or conversion. You do not need to file foreign claims on HCFA-1500 or UB-92 forms.

We have **special direct billing arrangements** with hospitals in several countries, including Brazil, China, Colombia, Germany, Italy, Korea, Panama and Russia. We also have a fast track payment process if you reside in Korea. In addition, overseas Seventh-day Adventist Hospitals and Clinics participate in our special billing arrangement. Please contact us for more information on these arrangements if you are in these locations.

The Plan provides a secure electronic method for you to submit claims to us via the internet from overseas locations. Visit our Web site (www.AFSPA.org/FSBP), click on the "Ask AFSPA" tab and then "FSBP". You can attach a scanned copy of your claim to an e-mail message you send to us. We designed this secure process to eliminate the lengthy mail time from your post to our office and to protect your private health information (PHI). Also, you may correspond with us via secure e-mail through this process. In addition, you may fax us your claims from overseas. Our special fax number is 202-464-4508.

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

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

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

Records

Keep a separate record of the medical expenses of each covered family member as deductibles and maximum allowances apply separately to each person. Save copies of all medical bills, including those you accumulate to satisfy a deductible. In most instances they will serve as evidence of your claim.

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

Deadline for filing your claim

Send us all of the documents for your claim as soon as possible. You should submit the claim within 90 days after you incur the expense. You must submit the claim within 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 benefits for 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 required by Section 3:

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: United States Office of Personnel Management, Insurance Services Programs, Health Insurance Group 2, 1900 E Street, NW, Washington, DC 20415-3620.

Send OPM the following information:

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

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

Note: You are the only person who has a right to file a disputed claim with OPM. Parties acting as your representative, such as medical providers, must include a copy of your specific written consent with the review request.

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. OPM will send you a final decision within 60 days. There are no other administrative appeals.

If you do not agree with OPM's decision, your only recourse is to sue. If you decide to sue, you must file the suit against OPM in Federal court by December 31 of the third year after the year in which you received the disputed services, drugs, or supplies or from the year in which you were denied precertification or prior approval. This is the only deadline that may not be extended.

OPM may disclose the information it collects during the review process to support their disputed claim decision. This information will become part of the court record.

You may not sue until you have completed the disputed claims process. Further, Federal law governs your lawsuit, benefits, and payment of benefits. The Federal court will base its review on the record that was before OPM when OPM decided to uphold or overturn our decision. You may recover only the amount of benefits in dispute.

Note: If you have a serious or life threatening condition (one that may cause permanent loss of bodily functions or death if not treated as soon as possible), and

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 may call OPM's Health Insurance Group HIG 2 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 or a covered family member has coverage under any other group health plan or has automobile insurance that pays health care expenses without regard to fault. This is called "double coverage".

When you have double coverage, one plan normally pays its benefits in full as the primary payer and the other plan pays a reduced benefit as the secondary payer. We, like 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.

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

What is Medicare?

Medicare is a health insurance program for:

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

Medicare has four parts:

- Part A (Hospital Insurance). Most people do not have to pay for Part A. If you or your spouse worked for at least 10 years in Medicare-covered employment, you should be able to qualify for premium-free Part A insurance. (If you were a Federal employee at any time both before and during January 1983, you will receive credit for your Federal employment before January 1983.) Otherwise, if you are age 65 or older, you may be able to buy it. Contact 1-800-MEDICARE for more information.
- Part B (Medical Insurance). Most people pay monthly for Part B. Generally, Part B premiums are withheld from your monthly Social Security check or your retirement check.
- Part C (Medicare Advantage). You can enroll in a Medicare Advantage plan to get your Medicare benefits. Please review the information on coordinating benefits with Medicare Advantage plans on page 74.
- Part D (Medicare prescription drug coverage). There is a monthly premium for Part D coverage. If you have limited savings and a low income, you may be eligible for Medicare's Low-Income Benefits. For people with limited income and resources, extra help in paying for a Medicare prescription drug plan is available. Information regarding this program is available through the Social Security Administration (SSA). For more information about this extra help, visit SSA online at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778). Before enrolling in Medicare Part D, please review the important disclosure notice from us about the FEHB prescription drug coverage and Medicare. The notice is on the first inside page of this brochure. The notice will give you guidance on enrolling in Medicare Part D.

- **Should I enroll in Medicare?**

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

If you can get premium-free Part A coverage, we advise you to enroll in it. Most Federal employees and annuitants are entitled to Medicare Part A at age 65 **without cost**. When you don't have to pay premiums for Medicare Part A, it makes good sense to obtain the coverage. It can reduce your out-of-pocket expenses as well as costs to the FEHB, which can help keep FEHB premiums down.

Everyone is charged a premium for Medicare Part B coverage. The Social Security Administration can provide you with premium and benefit information. Review the information and decide if it makes sense for you to buy the Medicare Part B coverage.

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

Please refer to page 19 for information about how we provide benefits when you are age 65 or older and do not have Medicare.

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

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

When you are enrolled in Original Medicare along with this Plan, you still need to follow the rules in this brochure for us to cover your care. We do not require precertification of inpatient hospital stays when Medicare Part A is primary. We do not require preauthorization and concurrent review of mental health and 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 through our secure e-mail process from our Web site at www.AFSPA.org/FSBP (click on the "Ask AFSPA" tab and then "FSBP") to find out if your claims are being electronically filed or you have questions about the process described below. You probably will not need to file a claim form when you have both our Plan and the Original Medicare Plan.

When we are the primary 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 claim automatically and provide secondary benefits for covered charges. There are exceptions:

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

We waive some costs if the Original Medicare Plan is your primary 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 stays.
  - If you are enrolled in Medicare Part B, we will waive the deductible and coinsurance for outpatient hospital, ambulatory surgical center and ambulance.
- **Services provided by facilities and providers covered under Emergency services/ accidents in Section 5(d).**
  - If you are enrolled in Medicare Part B, we will waive the deductible 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 stays.
  - If you are enrolled in Medicare Part B, we will waive the deductible and coinsurance.
- **Services provided under Prescription benefits in Section 5(f).**
  - If you are enrolled in Medicare Part B, the Plan will coordinate benefits and waive the deductible, coinsurance and/or copayment for prescription drugs you purchase only at Network pharmacies.
  - If you are enrolled in Medicare Part B, the Plan will coordinate benefits and waive the deductible, coinsurance and/or copayment for colostomy, ostomy and diabetic supplies you purchase from any Medicare Part B provider.
- **Services provided under Dental benefits in Section 5(h).**
  - We do **not** waive the coinsurance under Dental benefits.

- **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. You may be responsible for paying the difference between the billed amount and the amount we paid.

- **Medicare Advantage (Part C)**

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

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

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

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

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

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

Medicare always makes the final determination as to whether they are the primary payer. The following chart illustrates whether 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. **(Having coverage under more than two health plans may change the order of benefits determined on this chart.)**

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

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

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

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

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

TRICARE and CHAMPVA

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

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

Workers' Compensation

We do not cover services that:

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

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

Medicaid

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

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

When other Government agencies are responsible for your care

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

When others are responsible for injuries

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

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

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

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

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

If we invoke this provision:

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

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

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

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

Some FEHB plans already cover some dental and vision services. When you are covered by more than one health/dental plan, federal law permits your insurers to follow a procedure called "coordination of benefits" to determine how much each should pay when you have a claim. The goal is to make sure that the combined payments of all plans do not add up to more than your covered expenses.

Coverage provided under your FEHB plan remains as your primary coverage. FEDVIP coverage pays secondary to that coverage. When you enroll in a dental and/or vision plan on BENEFEDS.com, you will be asked to provide information on your FEHB plan so that your plans can coordinate benefits. Providing your FEHB information may reduce your out-of-pocket cost.

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 also may be responsible for additional amounts. See page 15.

Copayment

A fixed amount of money you pay to the provider when you receive covered services. See page 15.

Cost Sharing

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

Covered services

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

Custodial care

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 15.

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 covered provider. 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 service

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

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.

Hospital stay

An admission (or series of admissions separated by less than 60 days) to a hospital as an inpatient for any illness or injury. You start a new hospital stay when:

1. The admission is for a cause unrelated to the previous admission;
2. An employee returns to work for at least one day before the next admission; or
3. The hospital stays are separated by at least 60 days for a dependent or retiree.

Intensive day treatment

Outpatient treatment of mental conditions or substance abuse rendered at and billed by a facility that meets the definition of a hospital. Treatment program must be established which consists of individual or group psychotherapy and/or psychological testing.

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 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 Healthcare Charges Database (HCD);
- 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.

Providers outside the 50 United States – We generally do not reduce claims from providers outside the 50 United States 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.

Routine testing/screening

Health care services provided to an individual without apparent signs and symptoms of an illness, injury or disease for the purpose of identifying or excluding an undiagnosed illness, disease or condition.

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

Coverage information

- **No pre-existing condition limitation**

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

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

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

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

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

- When you may change your enrollment;
- How you can cover your family members;
- What happens when you transfer to another Federal agency, go on leave without pay, enter military service, or retire;
- What happens when your enrollment ends; 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 benefits, nor will we. Please tell us immediately when you add or remove family members from your coverage for any reason, including family members are added or lose coverage for any reason, including your marriage, divorce, annulment, or when your child under age 22 turns age 22 or has a change in marital status, divorce, or when your child under age 22 marries.

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.

- **Children's Equity Act**

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

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

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

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

- **When benefits and premiums start**

The benefits in this brochure are effective January 1. If you joined this Plan during Open Season, your coverage begins on the first day of your first pay period that starts on or after January 1. **If you changed plans or plan options during Open Season and you receive care between January 1 and the effective date of coverage under your new plan or option, your claims will be paid according to the 2009 benefits of your old plan or option.** However, if your old plan left the FEHB Program at the end of the year, you are covered under that plan's 2008 benefits until the effective date of your coverage with your new plan. Annuitants' coverage and premiums begin on January 1. If you joined at any other time during the year, your employing office will tell you the effective date of coverage.

- **When you retire**

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

When you lose benefits

- **When FEHB coverage ends**

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

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

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

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

- **Upon divorce**

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

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

If you leave Federal service, or if you lose coverage because you no longer qualify as a family member, you may be eligible for Temporary Continuation of Coverage (TCC). For example, you can receive TCC if you are not able to continue your FEHB enrollment after you retire, if you lose your Federal job, if you are a covered dependent child and you turn 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 Benefits for Temporary Continuation of Coverage and Former Spouse Enrollees,* from your employing or retirement office or from www.opm.gov/insure. It explains what you have to do to enroll.

- **Converting to individual coverage**

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

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

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

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

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

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

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

Section 12. Three Federal Programs complement FEHB benefits

Important information

OPM wants to be sure you are aware of three Federal programs that complement the FEHB Program.

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

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

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

The Federal Flexible Spending Account Program – *FSAFEDS*

What is an FSA?

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

There are three types of FSAs offered by FSAFEDS. Each type has a minimum annual election of $250 and a maximum annual election of $5,000.

- **Health Care FSA (HCFSA)** – Reimburses you for eligible health care expenses (such as copayments, deductibles, over-the-counter medications and products, vision and dental expenses, and much more) for you and your dependents which are not covered or reimbursed by FEHBP or FEDVIP coverage or any other insurance.
- **Limited Expense Health Care FSA (LEX HCFSA)** – Designed for employees enrolled in or covered by a High Deductible Health Plan with a Health Savings Account. Eligible expenses are limited to dental and vision care expenses for you and your dependents which are not covered or reimbursed by FEHBP or FEDVIP coverage or any other insurance.
- **Dependent Care FSA (DCFSA)** – Reimburses you for eligible non-medical day care expenses for your child(ren) under age 13 and/or for any person you claim as a dependent on your Federal Income Tax return who is mentally or physically incapable of self-care. You (and your spouse if married) must be working, looking for work (income must be earned during the year), or attending school full-time to be eligible for a DCFSA.

Where can I get more information about FSAFEDS?

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

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

Important Information

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

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

Dental Insurance

Dental plans provide a comprehensive range of services, including all the following:

- Class A (Basic) services, which include oral examinations, prophylaxis, diagnostic evaluations, sealants and x-rays.

- Class B (Intermediate) services, which include restorative procedures such as fillings, prefabricated stainless steel crowns, periodontal scaling, tooth extractions, and denture adjustments.
- Class C (Major) services, which include endodontic services such as root canals, periodontal services such as gingivectomy, major restorative services such as crowns, oral surgery, bridges and prosthodontic services such as complete dentures.
- Class D (Orthodontic) services with up to a 24-month waiting period.

Vision Insurance

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

Additional information

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

How do I enroll?

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

The Federal Long Term Care Insurance Program – *FLTCIP*

It's important protection

The Federal Long Term Care Insurance Program (FLTCIP) can help you pay for the potentially high cost of long term care services, which are not covered by FEHB plans. Long term care is help you receive to perform activities of daily living – such as bathing or dressing yourself – or supervision you receive because of a severe cognitive impairment. To qualify for coverage under the FLTCIP, you must apply and pass a medical screening (called underwriting). Certain medical conditions, or combinations of conditions, will prevent some people from being approved for coverage. You must apply to know if you will be approved for enrollment. To request an Information Kit and application, call 1-800-LTC-FEDS (1-800-582-3337) (TTY 1-800-843-3557) or visit www.ltcfeds.com.

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.**

Summary of benefits for the High Option of the Foreign Service Benefit Plan - 2009

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 physician or other health care professional.

High Option Benefits	You pay	Page
Medical services provided by physicians:		
• Diagnostic and treatment services provided in the hospital and office	PPO: 10% of our allowance* Non-PPO: 30% of our allowance and any difference between our allowance and the billed amount* Providers outside the 50 United States: 10% of our allowance*	24-25
Services provided by a hospital:		
• Inpatient	PPO: Nothing Non-PPO: $200 per hospital stay and 20% of charges Providers outside the 50 United States: Nothing	42-43
• Outpatient	Surgical: PPO: 10% of our allowance* Non-PPO: 30% of our allowance and any difference between our allowance and the billed amount* Providers outside the 50 United States: 10% of our allowance* Medical: PPO: 10% of our allowance* Non-PPO: 30% of our allowance and any difference between our allowance and the billed amount* Providers outside the 50 United States: 10% of our allowance*	44
Emergency benefits:		
• Accidental injury (for emergency room charges, emergency room physician charge and ancillary services performed at the time of the ER visit **or** initial office visit and ancillary services performed at the time of the initial office visit)	PPO: Nothing Non-PPO: Only the difference between our allowance and the billed amount Providers outside the 50 United States: Nothing	46
• Medical emergency	PPO: 10% of our allowance* Non-PPO: 10% of our allowance and any difference between our allowance and the billed amount* Providers outside the 50 United States: 10% of our allowance*	47

High Option Benefits	You pay	Page
Mental health and substance abuse treatment:	PPO: Regular cost sharing* Non-PPO: Benefits are limited* Providers outside the 50 United States: Regular cost sharing*	48-51
Prescription drugs:		
• Retail pharmacy	Network Pharmacies in the 50 United States: Note – You must show your Plan ID card: • Level I (generic): $10 copay for up to a 30-day supply • Level II (single-source brand name): 25% ($25 minimum) for up to a 30-day supply • Level III (multi-source brand name): 30% ($40 minimum) for up to a 30-day supply • Level IV (Specialty Pharmaceuticals): 25% for up to a 30-day supply (Note: Restrictions apply on refills.) 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: 10% (claim reimbursement from the Plan)	55
• Mail order	Mail Order (Medco By Mail): • Level I (generic): $15 for up to a 90-day supply • Level II (single-source brand name): $40 for up to a 90-day supply • Level III (multi-source brand name): $55 for up to a 90-day supply • Level IV (Specialty Pharmaceuticals): 25% up to maximum of $150 for up to a 90-day supply	56
Dental care:		
• Routine preventive care and surgical procedures	The difference between our scheduled allowances and the actual billed amounts	59
• Orthodontics	50% of our allowance up to our maximum payment of $1,000 and 100% after our maximum payment of $1,000	59
Special features:		
• The Plan offers the following Special features: - Flexible benefits option - Centers of Excellence for tissue and organ transplants - Healthy Pregnancy Program - Disease management program (domestic and overseas) - Web based customer service - Overseas second opinion		60-62

High Option Benefits	You pay	Page
Protection against catastrophic costs (out-of-pocket maximum):	PPO and providers outside the 50 United States: Nothing after $3,500/Self Only or $4,000/Self and Family enrollment per year Non-PPO: Nothing after $5,500/Self Only or $6,000/Self and Family enrollment per year Note: Benefit maximums still apply and some costs do not count toward this protection.	17

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2009 Rate Information for the Foreign Service Benefit Plan

2009 rates for this Plan follow. If you are in a special enrollment category, refer to the *Guide to Federal Benefits* for that category or contact the agency that maintains your health benefits enrollment.

Type of Enrollment	Enrollment Code	Non-Postal Premium			
		Biweekly		Monthly	
		Gov't Share	Your Share	Gov't Share	Your Share
High Option Self Only	401	$145.21	$ 48.40	$314.62	$104.87
High Option Self and Family	402	$352.56	$125.95	$763.88	$272.89