Foreign Service Benefit Plan

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

American Foreign Service Protective Association
Foreign Service Benefit Plan
Caring for Your Health Worldwide®

2015

A fee-for-service Plan (high option) with network providers

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

IMPORTANT
- Rates: Back Cover
- Changes for 2015: Page 13
- Summary of benefits: Page 114

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

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

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

(1) Department of State; (2) Department of Defense; (3) Agency for International Development; (4) Foreign Commercial Service; (5) Foreign Agricultural Service; (6) Department of Homeland Security; (7) Central Intelligence Agency; (8) National Security Agency; (9) Office of Director of National Intelligence (ODNI); and to (10) Executive Branch civilian employees assigned overseas or to U.S. possessions and territories; and the direct hire domestic employees assigned to support those activities. Executive Branch includes all Federal civilian employees except those working for the Legislative (Congress) or Judicial (Courts) Branches of the Federal government.

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

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

Enrollment codes for this Plan:
401 High Option - Self Only
402 High Option - Self and Family

Coventry Heath Care (administrator): URAC accredited for Health Utilization Review and Disease and Case Management Programs; NCQA, URAC and CMS credentialed and recredentialed for AETNA Choice POS II (Open Access) Product. See the 2015 Guide for more information.

Express Scripts (ESI – Pharmacy Benefit Manager): URAC accredited for Pharmacy Benefit Management and Mail Service Pharmacy; National Association of Boards of Pharmacy for Verified Internet Pharmacy Practice Site. See the 2015 Guide for more information.

FEHB
Federal Employees Health Benefits Program

Authorized for distribution by the:
United States Office of Personnel Management
Healthcare and Insurance
http://www.opm.gov/insure

Important Notice from the Foreign Service Benefit Plan About

Our Prescription Drug Coverage and Medicare

The Office of Personnel Management (OPM) has determined that the **Foreign Service Benefit Plan's (FSBP)** 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. This means you do not need to enroll in Medicare Part D and pay extra for prescription drug coverage. If you decide to enroll in Medicare Part D later, you will not have to pay a penalty for late enrollment as long as you keep your FEHB coverage.

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

Medicare's Low Income Benefits

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

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

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

Table of Contents

Introduction

This brochure describes the benefits of the **Foreign Service Benefit Plan (FSBP)** 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 administered by the Claims Administration Corporation, which is an Aetna Company. Customer service may be reached at 1-202-833-4910 or through our website: www.AFSPA.org/FSBP. The address for the **Foreign Service Benefit Plan** administrative office is:

Foreign Service Benefit Plan

1716 N Street, NW

Washington, DC 20036-2902

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

Fax: 202-833-4918

E-mail:

- **Non-secure: health@AFSPA.org and enrollment@AFSPA.org;**
- **Secure e-mail and secure claim submission instructions:** Visit our secure Member Portal at www.myafspa.org. Login to the Member Portal with your username and password. Once inside the portal, scroll down to the Foreign Service Benefit Plan section. Click on the "Secure Docs" tab on the right and select "Submit A Claim". Follow the screen prompts to upload your PDF claim documents. You have the options to include questions or comments and send your secure claims to a specific customer service representative.

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, 2015, unless those benefits are also shown in this brochure.

OPM negotiates benefits and rates with each plan annually. Benefit changes are effective January 1, 2015, and changes are summarized on page 13. Rates are shown on the back cover of this brochure.

Coverage under this plan qualifies as minimum essential coverage (MEC) and satisfies the Patient Protection and Affordable Care Act's (ACA) individual shared responsibility requirement. Please visit the Internal Revenue Service (IRS) website at www.irs.gov/uac/Questions-and-Answers-on-the-Individual-Shared-Responsibility-Provision for more information on the individual requirement for MEC.

The ACA establishes a minimum value for the standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). The health coverage of this plan does meet the minimum value standard for the benefits the plan provides.

Plain Language

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

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

Stop Health Care Fraud!

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

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

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

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

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

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

  - If we do not resolve the issue:

CALL -- THE HEALTH CARE FRAUD HOTLINE

877-499-7295

OR go to www.opm.gov/oig

You can also write to:

United States Office of Personnel Management

Office of the Inspector General Fraud Hotline

1900 E Street, NW, Room 6400

Washington, DC 20415-1100

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

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

  - Your child age 26 or over (unless he/she was disabled and incapable of self-support prior to age 26).

- If you have any questions about the eligibility of a dependent, check with your personnel office if you are employed, with your retirement office (such as OPM) if you are retired, or with the National Finance Center if you are enrolled under Temporary Continuation of Coverage.

- Fraud or intentional misrepresentation of material fact is prohibited under the Plan. You can be prosecuted for fraud and your agency may take action against you. Examples of fraud include falsifying a claim to obtain FEHB benefits, trying to or obtaining service or coverage for yourself or someone who is not eligible for coverage, or enrolling in the Plan when you are no longer eligible.
- If your enrollment continues after you are no longer eligible for coverage (i.e., you have separated from Federal service) and premiums are not paid, you will be responsible for all benefits paid during the period in which premiums were not paid. You may be billed by your provider for services received. You may be prosecuted for fraud for knowingly using health insurance benefits for which you have not paid premiums. It is your responsibility to know when you or a family member is no longer eligible to use your health insurance coverage.

Preventing Medical Mistakes

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

1. Ask questions if you have doubts or concerns.

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

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

- Bring the actual medicines or give your doctor and pharmacist a list of all the medicines and dosage that you take, including non-prescription (over-the-counter) medicines and nutritional supplements.
- Tell your doctor and pharmacist about any drug, food, and other allergies you have, such as latex.
- Ask about any risks or side effects of the medication and what to avoid while taking it. Be sure to write down what your doctor or pharmacist says.
- Make sure your 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 or nutritional supplements you are taking.

Patient Safety Links

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

Never Events

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

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

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

FEHB Facts

Coverage information

- **No pre-existing condition limitation**

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

- **Minimum essential coverage (MEC)**

  Coverage under this plan qualifies as minimum essential coverage (MEC) and satisfies the Patient Protection and Affordable Care Act's (ACA) individual shared responsibility requirement. Please visit the Internal Revenue Service (IRS) website at www.irs.gov/uac/Questions-and-Answers-on-the-Individual-Shared-Responsibility-Provision for more information on the individual requirement for MEC.

- **Minimum value standard**

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

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

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

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

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

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

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

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

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

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

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

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

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

- **Family Member Coverage**

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

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

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

- **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 2015 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 2014 benefits until the effective date of your coverage with your new plan. Annuitants' coverage and premiums begin on January 1. If you joined at any other time during the year, your employing office will tell you the effective date of coverage.

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

- **When you retire**

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

When you lose benefits

- **When FEHB coverage ends**

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

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

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

You may be eligible for spouse equity coverage or Temporary Continuation of Coverage (TCC).

- **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 website, www.opm.gov/healthcare-insurance/healthcare/plan-information/guides.

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

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

  You may not elect TCC if you are fired from your Federal or Tribal 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/healthcare-insurance/healthcare/plan-information/guides. It explains what you have to do to enroll.

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

- **Finding replacement coverage**

  In lieu of offering a non-FEHB plan for conversion purposes, we will assist you, as we would assist you in obtaining a plan conversion policy, in obtaining health benefits coverage inside or outside the Affordable Care Act's Health Insurance Marketplace. For assistance in finding coverage, please contact us at 202-833-4910 or visit our website at www.AFSPA.org/FSBP.

- **Health Insurance Marketplace**

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

Section 1. How this Plan works

This Plan is a fee-for-service (FFS) plan. 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 network providers:

Our network providers offer services through our fee-for-service Plan. The Plan uses the Aetna Choice POS II (Open Access) Product as its network. This means that certain hospitals and other health care providers are in-network. When you use an in-network provider, generally you will receive covered services at reduced cost. We encourage you to establish a primary care provider to assist in coordinating your medical care in the safest and most cost effective manner. Aetna is solely responsible for the selection of in-network providers in your area. Contact us for names of in-network providers and to verify their continued participation. Access our network directory as a link through our website www.AFSPA.org/FSBP or call 202-833-4910 for additional information. In addition, you can reach our website through the FEHB website, http://www.opm.gov/healthcare-insurance/.

The out-of-network benefits are the standard benefits of this Plan. In-network benefits apply only when you use an in-network provider. Provider networks may be more extensive in some areas than others. In-network benefit levels also apply to providers outside the 50 United States. We cannot guarantee the availability of every specialty in all areas. We cannot guarantee the continued participation of any specific provider. In the network, if no network provider is available or you do not use a network provider, the standard out-of-network benefits apply. **Follow these procedures when you use an in-network provider in order to receive in-network benefits:**

- **Verify that the provider is in the network when you make your appointment. Confirm that the address for your appointment is the same location as on our website. Providers may choose to be an in-network provider at one location but not at another;**
- **Present your Foreign Service Benefit Plan Identification (ID) Card at the time you visit your health care provider, confirming network participation in order to receive in-network 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 in-network discount; and**
- **Generally, you do not pay an in-network provider at the time of service. In-network providers must bill us directly. We must reimburse the provider directly. In-network providers will bill you for any balance after our payment to them.**

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

Other participating providers:

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

How we pay providers

We generally reimburse our in-network 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 an in-network or an out-of-network provider, generally we will pay the provider directly unless payment is noted on the bill we receive. If you have made payment to the provider, please advise us when you submit your claim.

We use National Standardized Criteria Sets and other recognized clinical guidelines in making determinations regarding inpatient hospital, acute rehabilitation, residential treatment precertification, and also skilled nursing facility stays, extended stay reviews, observation stay reviews, and reviews of procedures and therapies that require preauthorization (see Section 3, *You need prior Plan approval for certain services*). These determinations can affect how we provide benefits.

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

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

Your Rights

OPM requires that all FEHB plans provide certain information to their FEHB members. You may get information about us, our networks, and our providers. OPM's FEHB website (http://www.opm.gov/healthcare-insurance/) 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.

If you want more information about us, call 202-833-4910, or write to the **Foreign Service Benefit Plan**, 1716 N Street, NW, Washington, DC 20036-2902. You also may contact us by fax at 202-833-4918, by non-secure e-mail at health@AFSPA.org or enrollment@AFSPA.org, or through our secure Member Portal at www.myafspa.org. Login to the Member Portal with your username and password.

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, other health care professionals, or dispensing pharmacies.

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

Section 2. Changes for 2015

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

Changes to this Plan

- Your share of the premium will increase by $2.32 for Self Only or increase by $5.01 for Self and Family. See back cover.
- The Plan has combined the two separate medical and prescription catastrophic protection out-of-pocket maximums for in-network providers and providers outside the 50 United States into one that covers both medical and prescription costs. The catastrophic protection out-of-pocket maximum for Self Only is now $4,500 and for Self and Family is now $5,000 for in-network providers and providers outside the 50 United States. The out-of-pocket maximum for out-of-network providers remains $6,000/$6,500 (see Section 4, *Your catastrophic protection out-of-pocket maximum for deductibles, coinsurance, and copayments).*
- The Plan has added a benefit for Virtual Lifestyle Management (see Section 5(a), under *Educational classes and programs* and Section 5(h), *Special features).*
- The Plan has added coverage for medical foods and nutritional supplements when administered by catheter or nasogastric tubes (see Section 5(a), *Durable medical equipment* and Section 10, *Definitions*).
- The Plan has removed the exclusion for gender reassignment and sex transformation and added coverage for gender reassignment and sex transformations (see Sections 3, *Other services* and Section 5(b), *Surgical procedures*).
- The Plan now uses Aetna's Institutes of Excellence for organ and tissue transplants (see Section 5(b), *Organ/tissue transplants*).
- The Plan has added a telephone number to call to assist members in need of air ambulance that initiates outside the 50 United States (see Section 5(c), *Ambulance*; Section 5(d), *Ambulance*; and Section 10*, Plan allowance*).
- The Plan has removed the requirement for preauthorization of all mental health and substance abuse treatment except for partial hospitalization (see Section 3, *How you get care* and Section 5(e), *Mental health and substance abuse benefits*). Note: Precertification remains required for inpatient admissions.
- The Plan has changed its prescription benefit design from generic, single source brand, multi-source brand and specialty to generic, preferred brand, non-preferred brand and specialty (see Section 5(f), *Prescription drug benefits*).
- The Plan has expanded the existing categories of drugs that require prior authorization (see Section 5(f), *Prescription drug benefits*).
- The Plan requires all chronic specialty drugs to be filled through the Plan's home delivery Specialty Pharmacy, Accredo (see Section 5(f), *Prescription drug benefits).*
- The Plan requires all chronic specialty drugs (non-cancer and non-cancer related) that could be obtained from a physician or an outpatient facility to be obtained through the Plan's home delivery Specialty Pharmacy, Accredo (see Section 5(f), *Prescription drug benefits).*
- The Plan has added coverage for vitamins and minerals that require a prescription in order to be purchased (see Section 5(f), *Prescription drug benefits).*
- The Plan has added a gift card component for completion of the Health Risk Assessment (see Section 5(h), *Health Risk Assessment and Wellness Incentive*).

Clarification to this Plan

- The Plan's website (www.AFSPA.org/FSBP) was undergoing revision at press time. Specific URLs and instructions referenced in this brochure might have changed.

Section 3. How you get care

Identification cards

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

If you do not receive your ID card within 30 days after the effective date of your enrollment, or if you need replacement cards, call us at 202-833-4910 or write to us at 1716 N Street, NW, Washington, DC 20036-2902. You may also request replacement cards by secure e-mail through our secure Member Portal at www.myafspa.org. Login to the Member Portal with your username and password.

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 in-network providers, you will pay less.

- **Covered providers**

We provide benefits for the services of covered professional providers, as required by Section 2706(a) of the Public Health Service Act (PHSA). Coverage of practitioners is not determined by your state's designation as a medically underserved area (MUA).

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

- **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.
- **Convenient Care Clinic** — A small healthcare facility, usually located in a high-traffic retail outlet, with a limited pharmacy, that provides non-emergency, basic health care services on a walk-in basis. Examples include Minute Clinic® in CVS retail stores and Take Care Clinic℠ at Walgreens. Convenient care clinics are different from urgent care centers (see *Urgent Care Center*, next page).
- **Hospice Care Facility** — A facility providing hospice care services that is appropriately licensed or certified as such under the law of the jurisdiction in which it is located, and that:
  - Is certified (or is qualified and could be certified) under Medicare;
  - Is accredited by the Joint Commission on Accreditation of Healthcare Organizations;
  - Meets the standards established by the National Hospice Organization.
- **Hospital**
  - An institution that is accredited as a hospital under the hospital accreditation program of the Joint Commission on Accreditation of Healthcare Organizations (JCAHO); or
  - Any other institution that is operated pursuant to law, under the supervision of a staff of doctors and with 24-hour-a-day nursing services, and that is engaged primarily in providing: (a) General inpatient care and treatment of sick and injured persons through medical, diagnostic and major surgical facilities, all of which facilities must be provided on its premises or under its control; or (b) Specialized inpatient medical care and treatment of sick or injured persons through medical and diagnostic facilities (including X-ray and laboratory) on its premises, under its control, or through a written agreement with a hospital (as defined above) or with a specialized provider of those facilities.

- For inpatient and outpatient treatment of mental health and substance abuse, the term hospital also includes a free-standing residential treatment center facility approved by the JCAHO or the Commission for Accreditation of Rehabilitation Facilities (CARF).
- In no event shall the term hospital include a convalescent nursing home or institution or part thereof that: (a) Is used principally as a convalescent facility, rest facility, nursing facility or facility for the aged; (b) Furnishes primarily domiciliary or custodial care, including training in the routines of daily living; or (c) Is operated as a school.

- **Skilled Nursing Facility** — An institution or that part of an institution, which provides convalescent skilled nursing care 24-hours-a-day and is classified as a skilled nursing facility under Medicare.
- **Urgent Care Center** — A free-standing ambulatory care center, outside of a hospital emergency department, that provides emergency treatment for medical conditions that are not life-threatening, but need prompt attention, on a walk-in basis.

- **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 in-network 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 in-network 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 in-network benefits continue until the end of your postpartum care, even if it is beyond the 90 days.

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

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

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

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

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

You need prior Plan approval for certain services

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

- **Inpatient hospital admission**

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

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

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

Exceptions: You do not need precertification in these cases:

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

- **Other services**

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

- All High End Radiology procedures, such as but not limited to CT Scan, PET Scan, SPECT, MRI, except in the case of an accident or a medical emergency (see page 28);
- Chemotherapy and radiation therapy (see page 33);
- Home health care (see pages 38-39);
- Transgender surgical services (gender reassignment surgery) to treat gender dysphoria, *even if rendered outside the 50 United States* (see pages 43-44);
- Organ/tissue transplants (see pages 43 and 47-49);
- Extended care/Skilled nursing facility admission (see pages 51 and 54);
- Partial hospitalization for mental health or substance abuse treatment (pages 59-60); and
- Prescription drugs (see pages 61 and 63-64). Some medications are not covered unless you receive approval through a coverage review (prior authorization). This review uses Plan rules based on FDA-approved prescribing and safety information, clinical guidelines and uses that are considered reasonable, safe, and effective.

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

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

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

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

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

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

Next, provide the following information:

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

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

- **Non-urgent care claims**

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

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

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

- **Urgent care claims**

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

If you fail to provide sufficient information, we will contact you within 24 hours after we receive the claim to provide notice of the specific information we need to complete our review of the claim. We will allow you up to 48 hours from the receipt of this notice to provide the necessary information. We will make our decision on the claim within 48 hours of (1) the time we received the additional information or (2) to end of the time frame, whichever is earlier.

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

You may request that your urgent care claim on appeal be reviewed simultaneously by us and OPM. Please let us know that you would like a simultaneous review of your urgent care claim by OPM either in writing at the time you appeal our initial decision or by calling us at 202-833-4910 between 8:30 a.m. and 5:30 p.m. Eastern Time. You may also call OPM's Health Insurance II at 202-606-3818 between 8 a.m. and 5 p.m. Eastern Time to ask for the simultaneous review. We will cooperate with OPM so they can quickly review your claim on appeal. In addition, if you did not indicate that your claim was a claim for urgent care, call us at 202-833-4910. If it is determined that your claim is an urgent care claim, we will expedite our review (if we have not yet responded to your claim).

- **Concurrent care claims**

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

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

- **Emergency inpatient admission**

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

- **Maternity care**

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

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

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

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

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

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

If you disagree with our pre-service claim decision

If you have a **pre-service claim** and you do not agree with our decision regarding precertification of an inpatient admission or prior approval of other services, you may request a review in accord with the procedures detailed on the next page.

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

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

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

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

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

- **To reconsider an urgent care claim**

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

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

- **To file an appeal with OPM**

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

Section 4. Your costs for covered services

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

Cost-sharing

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

Copayments

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

Example:

- When you purchase prescriptions from the Express Scripts Pharmacy^{SM} (home delivery), you pay a copayment of $10 for generic, or $55 for preferred brand name, or $70 for non-preferred brand name prescriptions.
- When you go into an out-of-network hospital, you pay $200 per person, per hospital stay.

We do not reimburse you for copayments.

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

Deductible

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

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

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

Example: If the billed amount is $100, the provider has an agreement with us to accept $80, and you have not paid any amount toward meeting your calendar year deductible, you must pay $80. We will apply $80 to your deductible. We will begin paying benefits once the remaining portion of your calendar year deductible ($250 for in-network and providers outside the 50 United States or $300 for out-of-network providers) has been satisfied.

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

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

Coinsurance

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

Example: You pay 10% of the Plan allowance for surgery performed by an in-network 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 out-of-network physician or other health care professional 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, an in-network provider may ask you to sign a "waiver" prior to receiving care. This waiver may state that you accept responsibility for the total charge, including any charges above the negotiated amount, for any care that is not covered by your health plan. If you sign such a waiver, whether you are responsible for the total charge depends on the contracts that the Plan has with its providers. If you are asked to sign this type of waiver, please be aware that, if benefits are denied for the services, you could be legally liable for the related expenses. If you would like more information about waivers, please contact us at 202-833-4910.

Differences between our allowance and the bill

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

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

You should use an in-network provider. The following two examples explain how we will handle your bill when you go to an in-network provider and when you go to an out-of-network provider. When you use an in-network provider, the amount you pay is much less.

- **In-network providers** agree to limit what they will bill you. Because of that, when you use an in-network provider, your share of covered charges consists only of your deductible and coinsurance. Here is an example about coinsurance: You see an in-network physician or other health care professional 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 in-network physician or other health care professional will not bill you for the $50 difference between our allowance and his/her bill. **Follow these procedures when you use an in-network provider in order to receive in-network benefits:**
  - **Verify that the provider is in the network when you make your appointment. Confirm that the address for your appointment is the same location as on our website. Providers may choose to be an in-network provider at one location but not at another;**
  - **Present your Foreign Service Benefit Plan Identification (ID) card at the time you visit your health care provider, confirming in-network participation in order to receive in-network 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 in-network discount; and**

- **Generally, you do not pay an in-network provider at the time of service. In-network providers must bill us directly. We must reimburse the provider directly. In-network providers will bill you for any balance after our payment to them.**

- **Out-of-network providers,** on the other hand, have no agreement to limit what they will bill you. For instance:
  - **When you use an out-of-network 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 an out-of-network physician or other health care professional 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 out-of-network physician or other health care professional and us, the physician other health care professional can bill you for the $50 difference between our allowance and his/her bill.
- **Other participating providers (See Section 1, *Facts about this fee-for-service Plan*)** agree to limit what they will bill you. You still will have to pay your deductible and the out-of-network benefit level. These providers have agreed not to bill you for the difference between the billed charges and the discounted amount.
- **Providers outside the 50 United States** charges generally are not subject to a Plan allowance, that is, our Plan allowance is the amount billed by the provider or as part of our Direct Billing Arrangements. Similar to the in-network example on the previous page, when you use a provider outside the 50 United States and you have met your deductible, you are responsible for your coinsurance. You will pay just 10% of the charge ($15). Generally, you do not pay a provider in our Direct Billing Arrangement. We must reimburse the provider directly for any covered expenses. You are responsible, however, for any deductible and coinsurance, which we do not reimburse. See Section 7 for more information.

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

EXAMPLE	**In-network provider**	**Out-of-network provider**	**Provider outside the 50 United States**
Provider'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 an in-network provider or any other provider.

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

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

- $4,500 for Self Only and $5,000 for Self and Family enrollment (in-network providers and providers outside the 50 United States and when you use the Plan's network retail pharmacy through Express Scripts (ESI), or home delivery (mail order) through the Express Scripts Pharmacy^{SM}, or purchase prescriptions outside the 50 United States from a retail pharmacy or Military Treatment Facility);
- $6,000 for Self Only and $6,500 for Self and Family enrollment (in- and out-of-network providers and when you use the Plan's network retail pharmacy through Express Scripts or home delivery (mail order) through the Express Scripts Pharmacy^{SM});

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

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 in-network benefit or expenses at an out-of-network facility;
- Expenses for dental care;
- Any amounts you pay because benefits have been reduced for non-compliance with precertification or preauthorization requirements (see Section 3, *How you get care*);
- Expenses for prescriptions purchased at pharmacies in the 50 United States without using the Plan's identification card or purchased from a source other than the Plan's mail order pharmacy; and
- Non-covered services and supplies.

Carryover

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

If we overpay you

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

When Government facilities bill us

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

High Option Benefits

See page 13 for how our benefits changed this year. Pages 115 - 117 are a benefits summary of our High Option.

High Option Overview

"Caring for Your Health Worldwide®"

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

This Section is divided into subsections. Please read *Important things you should keep in mind* at the beginning of the subsections. Also read the general exclusions in Section 6; they apply to the benefits in the following subsections. To obtain claim forms, claims filing advice, or more information about High Option benefits, contact us by phone at 202-833-4910 (members) or 202-833-5751 (health care providers), by fax at 202-833-4918, or by e-mail through our secure Member Portal at www.myafspa.org. Login to the Member Portal with your username and password.

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

- Benefits available worldwide
- Electronic Funds Transfer (EFT) of claim payments to your U.S. bank account
- Secure method to submit claims and correspondence via the Internet or fax – eliminate lengthy mail time
  - Visit our secure Member Portal at www.myafspa.org. Login to the Member Portal with your username and password. Once inside the portal, scroll down to the Foreign Service Benefit Plan section. Click on the "Secure Docs" tab on the right and select "Submit A Claim." Follow the screen prompts to upload your PDF claim documents. You have the options to include questions or comments and send your secure claims to a specific customer service representative.
- Charges from providers outside the 50 United States generally considered at the billed amount
- Plan translates claims and uses currency exchange rates provided by member
- Low calendar year deductible for using in-network providers (applies to providers outside the 50 United States also)
- Direct billing arrangements with hospitals in several foreign countries
- Overseas second opinion program
- Wellness and preventive care benefits for children and adults payable at 100% of Plan allowance with no deductible (in-network providers and providers outside the 50 United States)
- Living Well Together Program (health coaching program)
- Virtual Lifestyle Management
- Healthy Pregnancy Program
- Health Risk Assessment and Incentive
- 24-Hour FSBP Nurse Advice and Translation Lines
- Generous Alternative treatments benefits for massage therapy, acupuncture and chiropractic
- Nutritional counseling, Weight Management Program and Diabetic education benefits
- Mediterranean Wellness Program and Incentive
- Orthotic benefit
- Orthodontic benefits
- Web based customer service
  - *My Online Services* website allows members access to Web based claim information (electronic copies of Explanations of Benefits), in-network provider search, health information, digital coaching programs, and other tools.
  - Prescription management website allows members to refill and renew prescriptions, obtain prescription information, locate Network pharmacies, compare costs of prescriptions, obtain refill reminders, and use other tools.

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

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- The calendar year deductible is: $250 per person for in-network providers and providers outside the 50 United States or $300 for out-of-network providers ($500 per family for in-network providers and providers outside the 50 United States or $600 per family for out-of-network providers). The calendar year deductible applies to almost all benefits in this Section. We added "(No deductible)" to show when the calendar year deductible does not apply.
- The out-of-network benefits are the standard benefits of this Plan. In-network benefits apply only when you use an in-network provider or when you use a provider outside the 50 United States. When no in-network provider is available in the network, out-of-network benefits apply.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost-sharing works. Also, read Section 9 for information about how we pay if you have other coverage, or if you are age 65 or over.
- **YOU MUST GET PREAUTHORIZATION FOR ALL HIGH END RADIOLOGY PROCEDURES (SUCH AS, BUT NOT LIMITED TO, CT SCAN, PET SCAN OR MRI).** Please refer to the preauthorization information shown in Section 3, *Other services,* for additional details on preauthorization and to this Section (*Lab, X-ray and other diagnostic tests*).
- **YOU MUST GET PREAUTHORIZATION OR CONCURRENT REVIEW (FOR SERVICES NEEDING CERTIFICATION BEYOND THE PLAN'S INITIAL APPROVAL) FOR CHEMOTHERAPY AND RADIATION THERAPY.** Please refer to the preauthorization information shown in Section 3, *Other services,* for additional details on preauthorization and to this Section (*Treatment therapies*).

Note: We do not require preauthorization or concurrent review in this section 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 before and/or during continued treatment.

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

Benefits Description	You pay After the calendar year deductible...
Note: The calendar year deductible applies to almost all benefits in this Section. We say "(No deductible)" when it does not apply.	
Diagnostic and treatment services	
• Professional services of physicians or other health care professionals during a hospital stay, skilled nursing facility stay, in the physician's or other health care professional's office, at home, or consultations (including video conferencing if performed when a member is hospitalized outside the United States) • Office consultation including second opinion • Psychological tests and pharmacological visits • Office visits by a dentist in relation to covered oral and maxillofacial surgical procedures • Drugs and medical supplies billed by a physician or other health care professional	In-network: 10% of the Plan allowance Out-of-network: 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

Diagnostic and treatment services - continued on next page

Benefits Description	You pay After the calendar year deductible...
Diagnostic and treatment services (cont.)	
• Outpatient care in an urgent care facility Note: We pay medical supplies, medical equipment, prosthetic, and orthopedic devices for use at home under this Section, *Durable medical equipment (DME).* Note: Services received from an in-network provider for routine preventive care are paid under this Section, *Preventive care, adult* or *Preventive care, children.* Note: For services related to an accidental injury or medical emergency, see Section 5(d).	In-network: $35 copayment per occurrence (No deductible) Out-of-network: $35 copayment per occurrence and any difference between our allowance and the billed amount (No deductible) Providers outside the 50 United States: $35 copayment per occurrence (No deductible)
• Professional non-emergency services provided in a convenient care clinic (see Section 3, *Covered facilities*). Note: For services related to an accidental injury or medical emergency, see Section 5(d). Note: Services received from an in-network provider for routine preventive care are paid under this Section, *Preventive care, adult* or *Preventive care, children.*	In-network: $10 copayment per visit (No deductible) Out-of-network: 30% of the Plan allowance and any difference between our allowance and the billed amount Providers outside the 50 United States: $10 copayment per visit (No deductible)
Not covered: • *Telephone consultations* • *Procedures, services, drugs, and supplies related to impotency, sex transformations, sexual dysfunction, or sexual inadequacy*	*All charges*
Lab, X-ray and other diagnostic tests	
Tests, such as: • Blood tests • Urinalysis Note: Urinalysis for drug testing/screening purposes is covered only as described in "FEHBP Urine Drug Testing Coverage", available on our website www.AFSPA.org/FSBP or by calling us at 202-833-4910. • Non-routine Pap tests • Pathology • X-rays • Non-routine mammograms • CT Scan/PET Scan/SPECT/MRI Note: Preauthorization is required for all High End Radiology procedures, such as but not limited to, CT Scans, PET Scans, SPECT Scans, and MRIs except in the case of an accident or a medical emergency (see Section 3, *Other services*). • Ultrasound • Electrocardiogram and EEG • Hearing exam for non-auditory illness or disease • FDA recommended pharmacogenetic testing to optimize prescription drug therapies used to treat certain conditions, such as: - For prevention of major adverse cardiovascular events (Plavix) - For prevention of blood clots (Warfarin)	In-network: 10% of the Plan allowance Out-of-network: 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

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

Benefits Description	You pay After the calendar year deductible...
Lab, X-ray and other diagnostic tests (cont.)	
Note: These tests are covered also under Section 5(f), *Prescription drug benefits.* Note: The Plan may add tests as they are recommended by the FDA.	In-network: 10% of the Plan allowance Out-of-network: 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: • *Automated laboratory professional fee charges* • *3D breast tomosynthesis*	*All charges*
Preventive care, adult	
One routine physical examination to include a history and physical, chest X-ray, urinalysis, blood tests such as general health panel basic or comprehensive metabolic test, CBC, electrocardiogram, (EKG), Body Mass Index (BMI) measurement and other biometric screenings per person, per calendar year Note: This includes a separate gynecological exam once per calendar year for women.	In-network: Nothing (No deductible) Out-of-network: 30% of the Plan allowance and any difference between our allowance and the billed amount Providers outside the 50 United States: Nothing (No deductible)
Well woman benefits including: • Routine Pap test once per calendar year • Human papillomavirus testing for women • Counseling for sexually transmitted infections • Screening and counseling for interpersonal and domestic violence	In-network: Nothing (No deductible) Out-of-network: 30% of the Plan allowance and any difference between our allowance and the billed amount Providers outside the 50 United States: Nothing (No deductible)
In addition Routine Cancer Screenings, including: • Colorectal Cancer Screening: - Fecal occult blood test – once per calendar year - Sigmoidoscopy screening – one every five years for members age 50 and older - Colonoscopy screening, including facility and anesthesia charges related to the colonoscopy exam – one every 10 years for members age 50 and older Note: Age and frequency limitations do not apply to colorectal cancer screenings if there is a family history or high risk factor that indicates the need for screenings. • Breast Cancer Screening (Mammogram – not including 3D breast tomosynthesis) – once per calendar year for women age 35 and older Note: Age and frequency limitations do not apply to breast cancer screenings if there is a family history or high risk factor that indicates the need for screenings. • Cervical Cancer Screening - Pap smear – once per calendar year for women • Prostate Cancer Screening - Prostate Specific Antigen (PSA) – once per calendar year for men age 40 and older	In-network: Nothing (No deductible) Out-of-network: 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.)	
Other routine services, including: • Blood cholesterol and/or lipid panel/profile – one per person, per calendar year • One-time ultrasonography for abdominal aortic aneurysm screening for males between the ages of 65 to 75 who have smoked • Chlamydial screening once per calendar year • Osteoporosis routine screening for members age 50 and older once per calendar year • Counseling and screening for human immune-deficiency virus (HIV) Note: We cover preventive services that have a rating of "A" or "B" from the United States Preventive Services Task Force (USPSTF) without cost sharing when delivered by an in-network provider or providers outside the 50 United States. See Section 10, *Definitions, Routine preventive services/immunizations.*	In-network: Nothing (No deductible) Out-of-network: 30% of the Plan allowance and any difference between our allowance and the billed amount Providers outside the 50 United States: Nothing (No deductible)
• 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 • Travel immunizations recommended by the Centers for Disease Control and Prevention (CDC) Note: The Plan has no age limitations on Influenza, Pneumococcal, Human Papillomavirus (HPV) and Zostavax (Shingles) vaccines. Note: Immunizations obtained from a participating retail network pharmacy have a $0 copay and are covered under Section 5(f), *Prescription drug benefits.* Note: These benefits do not apply to children under age 22 (see *Preventive care, children*). Note: See Section 10, *Definitions*, *Routine preventive services/immunizations.*	In-network: Nothing (No deductible) Out-of-network: 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) limited to: • Childhood immunizations recommended by the American Academy of Pediatrics for members under age 22 • Travel immunizations recommended by the Centers for Disease Control and Prevention (CDC) Note: Immunizations obtained from a participating retail network pharmacy have a $0 copay and are covered under Section 5(f), *Prescription drug benefits.* Note: See Section 10, *Definitions, Routine preventive services/immunizations.*	In-network: Nothing (No deductible) Out-of-network: 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) • Body Mass Index (BMI) measurements beginning at age 24 months	In-network: Nothing (No deductible) Out-of-network: 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)

Preventive care, children - continued on next page

Benefits Description	You pay After the calendar year deductible...
Preventive care, children (cont.)	
• 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 - Counseling and screening for human immune-deficiency virus (HIV) Note: A gynecological exam and Pap smear once per calendar year for women under the age of 22, if medically recommended, are covered under Preventive care, adult. Note: Dependent children 22 and older are covered under Preventive care, adult. Note: See Section 10, *Definitions, Routine preventive services/immunizations*. Note: We cover preventive services that have a rating of "A" or "B" from the United States Preventive Services Task Force (USPSTF) without cost sharing when delivered by an in-network provider or providers outside the 50 United States. See Section 10, *Definitions, Routine preventive services/immunizations*.	In-network: Nothing (No deductible) Out-of-network: 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) Note: See Section 5(h), *Special features* for information on the Plan's Healthy Pregnancy Program. • Emergency room and specialty visits for complication of pregnancy • Delivery • Postnatal care • Sonograms • Amniocentesis • Gestational diabetes screening – once per pregnancy • Breastfeeding support, supplies and counseling for each birth Note: Breast pump and supplies are limited to: • Purchase or rental of (standard non-hospital grade) breastfeeding equipment to an amount no greater than what we would have paid if the equipment had been purchased. We will cover only the cost of standard equipment. Note: Supplies do not include coverage for other breastfeeding supplies such as maternity bras, nursing pads or additional bottles. Note: When standard (non-hospital grade) breastfeeding equipment and supplies are purchased at a participating Express Scripts (ESI) Pharmacy, you pay nothing (No deductible). Note: Here are some things to keep in mind:	In-network: Nothing (No deductible) Out-of-network: 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.)	
You do not need to precertify your normal delivery; see Section 3, *How you get care* 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 Section 3, *How you get care* for other circumstances.	In-network: Nothing (No deductible) Out-of-network: 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)
• For facility care related to maternity, including care at birthing facilities, we pay at the inpatient hospital rate in accordance with Section 5(c), *Inpatient hospital* of the brochure. • We consider bassinet or nursery charges during the covered portion of the mother's maternity stay to be the expenses of the mother and not expenses of the newborn child. We consider expenses of the child after the mother's discharge to be the expenses of the child. We cover these expenses only if the child is covered by a Self and Family enrollment. *Surgical benefits,* not *Maternity benefits,* apply to circumcision. Note: Maternity care expenses incurred by a Plan member serving as a surrogate mother are covered by the Plan subject to reimbursement from the other party to the surrogacy contract or agreement. The involved Plan member must execute our Reimbursement Agreement against any payment she may receive under a surrogacy contract or agreement. Expenses of the new-born child are not covered under this or any other benefit in a surrogate mother situation.	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 out-of-network facilities. *If your child is not covered under a Self and Family enrollment, you pay all of your child's charges after your discharge.*
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, including patient education and counseling, limited to: • Contraceptive methods and counseling • Voluntary sterilization (see Section 5(b), *Surgical procedures*) • Injection of contraceptive drugs (such as Depo-Provera) • Contraceptive drugs supplied by your physician or other health care professional • Surgically implanted contraceptives to include fitting, inserting or removing intrauterine devices (IUDs) (see Section 5(b), *Surgical procedures*) Note: We cover oral contraceptive drugs, diaphragms, cervical caps, vaginal rings, and contraceptive hormonal patches (see Section 5(f), *Prescription Drug Benefits*).	In-network: Nothing (No deductible) Out-of-network: 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)
Not covered: • *Reversal of voluntary surgical sterilization* • *Genetic counseling, testing or screening*	*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: Prescription drugs may not be purchased through the Plan's Prescription drug benefit. You must file a claim for them under this benefit.	In-network: 10% of the Plan allowance Out-of-network: 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: • *Infertility services after voluntary sterilization* • *Assisted reproductive technology (ART) procedures, such as:* - *Artificial insemination* - *In vitro fertilization* - *Embryo transfer and gamete intrafallopian transfer (GIFT)* - *Zygote intrafallopian transfer (ZIFT)* - *Intracytoplasmic sperm injection (ICSI)* - *Intravaginal insemination (IVI)* - *Intracervical insemination (ICI)* - *Intrauterine insemination (IUI)* • *Services and supplies related to ART procedures* • *Infertility drugs used in conjunction with ART Procedures* • *Costs of donor sperm and donor egg*	*All charges*
Allergy care	
Testing, treatment, and injections including materials (such as allergy serum)	In-network: 10% of the Plan allowance Out-of-network: 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 and hair analysis*	*All charges*
Treatment therapies	
• Chemotherapy and radiation therapy (includes radium and radioactive isotopes) Note: Chemotherapy and radiation therapy require preauthorization (see Section 3, *Other services).* Note: High dose chemotherapy in association with autologous bone marrow transplants is limited to those transplants listed in Section 5(b), *Organ/tissue transplants.*	In-network: 10% of the Plan allowance Out-of-network: 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

Treatment therapies - continued on next page

Benefits Description	You pay After the calendar year deductible...
Treatment therapies (cont.)	
Note: See Section 5(h), *Special features* for more information on how you can take advantage of the Plan's Cancer Management Program that provides education and nursing support for cancer patients. • 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) • Cardiac rehabilitation therapy Note: The Plan provides benefits only for Phase 1 and Phase 2 cardiac rehabilitation therapy. • Renal dialysis (includes other covered charges associated with the dialysis treatment)	In-network: 10% of the Plan allowance Out-of-network: 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
Physical, occupational, and speech therapies	
125 total combined outpatient physical, occupational and speech therapy visits per calendar year for all three listed therapies Note: Coverage for the diagnosis of autism is included in the above benefit. Note: Physical, occupational and speech therapies rendered in a home health care setting are included in this benefit and do not require preauthorization.	In-network: 10% of the Plan allowance Out-of-network: 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 Section 10, Definitions)* • *Exercise programs*	*All charges*
Hearing services (testing, treatment, and supplies)	
• For treatment related to illness or injury, including evaluation and diagnostic hearing tests Note: For benefits for the devices, see this Section, *Orthopedic and prosthetic devices.* Note: For child hearing aid exams and child hearing aids see this Section, *Preventive care, children.*	In-network: Nothing (No deductible) Out-of-network: Nothing up to the Plan allowance and any difference between our allowance and the billed amount (No deductible) Providers outside the 50 United States: Nothing (No deductible)
Not covered: • *Hearing services that are not shown as covered*	*All charges*

Benefits Description	You pay After the calendar year deductible...
Vision services (testing, treatment, and supplies)	
One pair of eyeglasses or contact lenses (including fitting) and refractions per incident if required to correct an impairment directly caused by: • Accidental ocular injury • Intraocular surgery for removal of cataracts • Keratoconus • Glaucoma Note: Routine eye examinations are not covered, except when needed for covered eyeglasses or contact lenses above. Note: Diabetic retinal eye exams are covered in this Section, *Lab, X-ray and other diagnostic tests.* Note: Expenses in relation to an accident or intraocular surgery for removal of cataracts must be incurred within one year of the date of the accident or surgery.	In-network: 10% of the Plan allowance Out-of-network: 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, except when needed for covered eyeglasses or contact lenses above* • *Deluxe lens features for eyeglasses or contact lenses such as special coating, polarization, UV treatment, etc.* • *Multifocal, accommodating, toric, or other premium intraocular lenses (IOLs) including Crystalens, ReStor, and ReZoom* • *Eyeglasses or contact lenses, except as shown above* • *Eye exercises and visual training (orthoptics)* • *Refractions, except as noted above* • *All refractive surgeries, except as noted above*	*All charges*
Foot care	
Routine foot care when you are under active treatment for a metabolic or peripheral vascular disease, such as diabetes	In-network: 10% of the Plan allowance Out-of-network: 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 orthotic devices prescribed by a physician or other health care professional and custom fitted for the feet, including necessary repair and adjustment Note: Foot orthotic devices for the feet include, but are not limited to: • Impression casting; and • Corrective shoes for treatment of malformation and weakness of the foot.	In-network, out-of-network, and providers outside the 50 United States: Nothing (No deductible) up to $500 per foot, per person, per calendar year and all charges after $500 per foot, per person, per calendar year or one replacement per foot, 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 above*	*All charges*

Benefits Description	You pay After the calendar year deductible...
Orthopedic and prosthetic devices	
• Artificial 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, and surgically implanted breast implants following mastectomy • Elastic stockings and support hose that require a physician's or other health care professional's written prescription Note: For information on the professional charges for the surgery to insert an implant, see Section 5(b), *Surgical and anesthesia services*. For information on the hospital and/or ambulatory surgery center benefits, see Section 5(c), *Services provided by a hospital or other facility, and ambulance services*. Note: 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), *Surgical and anesthesia services* for coverage of the surgery to insert the device and Section 5(c), *Services provided by a hospital or other facility, and ambulance services,* if billed by the facility.	In-network: 10% of the Plan allowance Out-of-network: 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	In-network, out-of-network, and providers outside the 50 United States: Nothing (No deductible) up to $500 per wig limited to one wig per person, per calendar year and all charges after $500 per wig, per person, per calendar year
• One adult hearing aid device, per ear and related devices, including implanted hearing-related devices such as bone anchored hearing aids (BAHA) and cochlear implants or one replacement per device, per ear, per person every 5 consecutive years Note: Child hearing aid exams and child hearing aids are covered under *Preventive care, children*.	In-network, out-of-network, and providers outside the 50 United States: Nothing (No deductible) up to the Plan maximum of $1,500 per device, per ear, per person or one replacement per device, per ear, per person every 5 years and all charges after the Plan maximum
Not covered: • *Orthopedic and corrective shoes, arch supports, heel pads, and heel cups, except as listed in Foot care, page 35* • *Lumbosacral supports* • *Corsets, elastic stockings, support hose, and other supportive devices except as noted above* • *Prosthetic replacements provided less than 3 years after the last one we covered unless a replacement is needed for medical reasons* • *Foot orthotics, except as provided under Foot care, page 35*	*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 or other medical professional 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 • CPAP machines and supplies Note: We will cover only the cost of medically necessary standard equipment. Coverage for specialty items (such as all-terrain wheelchairs, sports prosthetics, etc.) is limited to the cost of the standard equipment. Seat lift mechanisms for lift chairs based on the following criteria: • The patient must have severe arthritis of the hip or knee or a severe neuromuscular disease; • The seat lift mechanism must be a part of the physician's or other health care professional's course of treatment and be prescribed to affect movement, or arrest or retard deterioration in the patient's condition; • The patient must be completely incapable of standing up from a regular armchair or any chair in their home; • Once standing, the patient must have the ability to walk; and • Coverage is limited to seat lift mechanism even if incorporated into a chair. Medical supplies: • Medical supplies, appliances, medical equipment, and any covered items billed by a hospital for use at home (Note: calendar year deductible applies.) • Medical foods and nutritional supplements only when administered by catheter or nasogastric tubes Note: For colostomy, ostomy, insulin, and diabetic supplies, see Section 5(f), *Covered medications and supplies.*	In-network: 10% of the Plan allowance Out-of-network: 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

Durable medical equipment (DME) - continued on next page

Benefits Description	You pay After the calendar year deductible...
Durable medical equipment (DME) (cont.)	
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 • Magnifier Viewing System • Script Talk reader devices Note: For surgical insertion of speech aid prostheses, see Section 5(b), *Surgical procedures.*	In-network, out-of-network, and providers outside the 50 United States: Nothing (No deductible) up to one device per person, per calendar year up to the Plan allowance of $1,000 per device, per person, per calendar year and all charges after $1,000 per device
Not covered: • *Other items that do not meet the definition of durable medical equipment such as sun or heat lamps, whirlpool baths, heating pads, cold therapy units, air purifiers, humidifiers, air conditioners, and exercise devices* • *Charges for service contracts for purchased or rented equipment, except for purchased oxygen concentrators* • *Equipment replacements provided less than 3 years after the last one we covered unless damaged or defective and unrepairable* • *Oral nutritional supplements that do not require a prescription under Federal law even if your physician or other health care professional prescribes them or if a prescription is required under your state law, or are not administered by catheter or nasogastric tubes*	*All Charges*
Home health services	
For services provided on a **part-time basis** (less than an 8-hour shift): **If you preauthorize your home health care**, 90 visits per calendar year when: • The attending physician or other health care professional orders the care; • The physician or other health care professional 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. Note: Services of a licensed social worker are limited to two visits per calendar year. Note: A home health aide must provide the 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. 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 on next page). The home health care plan must be certified by your physician or other health care professional 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.	For preauthorized home health care: In-network: 10% of Plan allowance and any visits above 90 visits per calendar year (No deductible); and all charges above one visit per day Out-of-network: 30% of Plan allowance and any difference between our allowance and the billed amount and any visits above 90 visits per calendar year (No deductible); and all charges above one visit per day Providers outside the 50 United States: 10% of Plan allowance and any visits above 90 visits per calendar year (No deductible); and all charges above one visit per day. Preauthorization not required.

Home health services - continued on next page

Benefits Description	You pay After the calendar year deductible...
Home health services (cont.)	
Note: We define home health care plan as a written plan, approved in writing by a physician or other health care professional, for continued care and treatment of a Plan member: • who is under the care of a physician or other health care professional; 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 125-therapy visit limitation per calendar year, as listed in this Section, *Physical, occupational and speech therapy.* **Note: Home health services rendered outside the 50 United States do not require preauthorization.**	For preauthorized home health care: In-network: 10% of Plan allowance and any visits above 90 visits per calendar year (No deductible); and all charges above one visit per day Out-of-network: 30% of Plan allowance and any difference between our allowance and the billed amount and any visits above 90 visits per calendar year (No deductible); and all charges above one visit per day Providers outside the 50 United States: 10% of Plan allowance and any visits above 90 visits per calendar year (No deductible); and all charges above one visit per day. Preauthorization not required.
For services provided on a **part-time basis** (less than an 8-hour shift): **If you do not preauthorize your home health care**, 40 visits per calendar year subject to the provisions on the previous page and above. Note: Preauthorized and Non-preauthorized visits are combined. Visit limit not to exceed 90 visits per calendar year. **Note: Home health services rendered outside the 50 United States do not require preauthorization. See benefit for preauthorized care on the previous page and above.**	For non-preauthorized home health care: In-network: 10% of Plan allowance and any visits above 40 visits per calendar year (No deductible); and all charges above one visit per day Out-of-network: 30% of Plan allowance and any difference between our allowance and the billed amount and any visits above 40 visits per calendar year (No deductible); and all charges above one visit per day Providers outside the 50 United States: Preauthorization not required. See benefit for preauthorized home health care.
For private duty nursing we pay $12 per hour when provided on a **full-time basis** (more than an 8-hour shift) when: • The care is ordered by the attending physician or other health care professional; and • Your physician or other health care professional 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
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* • *Services rendered by a Home Health Aide are covered only as stated on the previous page* • *Custodial care (see Section 10, Definitions)*	*All charges*

Benefits Description	You pay After the calendar year deductible...
Chiropractic	
Covered services are limited to 40 visits per person, per calendar year: • Manipulation of the spine and extremities Note: Chiropractic is a system of therapy that attributes disease to abnormal function of the nervous system and attempts to restore normal function by manipulation of the spinal column and other body structures. Note: Initial consultation and X-rays are covered under, Section 5(a) *Diagnostic and treatment services* and also *Lab, X-ray and other diagnostic tests*.	In-network: Nothing (No deductible) up to the Plan maximum of $60 per visit and then all charges up to the Plan allowance; and all charges above 40 visits per person, per calendar year Out-of-network and providers outside the 50 United States: Nothing (No deductible) up to the Plan maximum of $60 per visit; and all charges above $60 per visit and/or 40 visits per person, per calendar year
Alternative treatments	
Acupuncture limited to 40 visits per person, per calendar year Note: The Plan defines acupuncture as the practice of insertion of needles into specific exterior body locations to relieve pain, to induce surgical anesthesia, or for therapeutic purposes. Note: These providers are required to submit itemized bills and their Federal Tax I. D. Number (if a United States provider) as outlined in Section 7, *Filing a claim for covered services*.	In-network: Nothing (No deductible) up to the Plan maximum of $60 per visit and then all charges up to the Plan allowance; and all charges above 40 visits per person, per calendar year Out-of-network and providers outside the 50 United States: Nothing (No deductible) up to the Plan maximum of $60 per visit; and all charges above $60 per visit and/or 40 visits per person, per calendar year
Massage therapy only when performed by a covered provider (see Section 3) limited to 40 visits per person, per calendar year Note: These providers are required to submit itemized bills and their Federal Tax I. D. Number (if a United States provider) as outlined in Section 7, *Filing a claim for covered services*.	In-network: Nothing (No deductible) up to the Plan maximum of $60 per visit and then all charges up to the Plan allowance; and all charges above 40 visits per person, per calendar year Out-of-network and providers outside the 50 United States: Nothing (No deductible) up to the Plan maximum of $60 per visit; and all charges above $60 per visit and/or 40 visits per person, per calendar year
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* • *Rolfing*	*All charges*

Benefits Description	You pay After the calendar year deductible...
Educational classes and programs	
Coverage is limited to: **Tobacco Cessation Program** • Two quit attempts per calendar year as part of the Plan's Tobacco Cessation Program. The quit attempts include proactive telephone counseling and up to four tobacco cessation counseling sessions of at least 30 minutes each in each quit attempt. - Over-the-counter (OTC) medications approved by the FDA to treat tobacco dependence can be obtained through the Tobacco Cessation Program at no charge (see Section 5(f), *Prescription drug benefits* for more details). Note: To enroll in the program, contact a Health Coach at 1-855-406-5122 or 1-479-973-7168. Coaches are available Monday – Thursday from 8:00 a.m. – 10:00 p.m. E.T. and Friday from 8:00 a.m. – 6:00 p.m. E.T. You may also enroll online at http://enroll.trestletree.com (passcode: FSBP).	In-network, out-of-network, and providers outside the 50 United States: Nothing (No deductible)
Living Well Together (health coaching program) The Living Well Together Program provides you and your covered dependents the opportunity to work one-on-one with a Health Coach to improve your health. A Health Coach is a healthcare professional who partners with you to transform your health goals into action. Your Health Coach will provide guidance, support, and resources to help you overcome obstacles that may be keeping you from realizing optimal health. You can talk to a Health Coach about the following health-related matters: • Tobacco Cessation • Weight Management • Exercise • Nutrition • Stress Management See the Plan's benefit, Living Well Together, in Section 5(h), *Special features.*	In-network, out-of-network, and providers outside the 50 United States: Nothing (No deductible)
Virtual Lifestyle Management The Virtual Lifestyle Management Program is an Internet-enabled program that includes online self-management education, tools and the involvement of a trained coach for members who have a Body Mass Index (BMI) of 30 or greater or have symptoms of pre-diabetes to assist you with nutrition and weight management. We will contact candidates and invite them to participate in the program. Participation is voluntary. If you would like to participate in the program you may enroll by telephone at 1-866-312-8144, by e-mail at afspa@vlmservice.com or by visiting http://afspa.vlmservice.com. See Section 5(h), *Special features.*	In-network, out-of-network, and providers outside the 50 United States: Nothing (No deductible)
Coverage is limited to: • Diabetic Education or training	In-network and providers outside the 50 United States: 10% of the Plan allowance (No deductible) Out-of-network: 30% of the Plan allowance and any difference between our allowance and the billed amount (No deductible)

Educational classes and programs - continued on next page

Benefits Description	You pay After the calendar year deductible...
Educational classes and programs (cont.)	
Coverage is limited to: • Nutritional counseling Note: We cover dieticians and nutritionists who bill independently for nutritional counseling. Note: In addition, see the Plan's Mediterranean Wellness Program and Incentive in Section 5(h), *Special features*. This Program is designed to assist you with weight management. You may enroll in the Program and receive reimbursement for its expense upon completion of 80% of the Program. Upon completion of the program, you will be eligible to receive the Wellness Incentive described in Section 5(h), *Special features*. Note: See the Plan's benefit, TherapEase, in Section 5(h), *Special features*. This Program is tailored specifically to assist patients with cancer to achieve proper nutrition. There is no cost to you.	In-network and providers outside the 50 United States: 10% of the Plan allowance (No deductible) Out-of-network: 30% of the Plan allowance and any difference between our allowance and the billed amount (No deductible) Note: The Plan's Mediterranean Wellness Program is reimbursed at 100% (No deductible) once you complete at least 80% of the Program (see Section 5(h), *Special features*). Note: TherapEase is reimbursed at 100% (No deductible)
Weight Management Program $2,000 maximum benefit per program, per person, per calendar year Includes non-surgical outpatient treatment when diagnosed by a physician or other health care professional as having a Body Mass Index (BMI) of 30 or higher. Benefits are payable for the following medically necessary services: • Initial evaluation by your physician or other health care professional • Follow-up visits to your physician or other health care professional • Individual or group behavioral counseling • Initial and follow-up lab tests • Maintenance counseling and follow-up visits for maintenance. Expenses incurred for prescription drugs for weight loss and/or maintenance are payable only as shown under Section 5(f), *Prescription drug benefits* and are not applied to the maximum benefit limitation.	In-network, out-of-network, and providers outside the 50 United States: Nothing (No deductible) up to $2,000 per person, per calendar year and all charges after $2,000 per person, per calendar year
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: $250 per person for in-network providers and providers outside the 50 United States or $300 for out-of-network providers ($500 per family for in-network providers and providers outside the 50 United States or $600 per family for out-of-network providers). The calendar year deductible does not apply to any benefits in this Section. We added "(No deductible)" to show when the calendar year deductible does not apply.
- The out-of-network benefits are the standard benefits of this Plan. In-network benefits apply only when you use an in-network provider or when you use a provider outside the 50 United States. When no in-network provider is available in the network, out-of-network benefits apply.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost-sharing works. Also, read Section 9 for information about how we pay if you have other coverage, or if you are age 65 or over.
- The services listed below are for the charges billed by a physician or other health care professional for your surgical care. See Section 5(c) for charges associated with the facility (i.e., hospital, surgical center, etc.).
- **YOU MUST GET PREAUTHORIZATION FOR TRANSGENDER SURGICAL SERVICES (GENDER REASSIGNMENT SURGERY) AND FOR ORGAN/TISSUE TRANSPLANTS.** Please refer to this section, *Surgical procedures* and *Organ/tissue transplants*. Also, please refer to the preauthorization information shown in Section 3 for additional details on preauthorization.

Note: We do not require preauthorization in this section for services you receive outside the 50 United States *except for transgender surgical services (gender reassignment surgery)*. However, the Plan will review all services to establish medical necessity. We may request medical records in order to determine medical necessity before and/or during continued treatment. In addition, we do not require preauthorization when Medicare Part A and/or Part B or another group health insurance policy is the primary payor. However, preauthorization is required when Medicare or the other group health insurance policy stops paying benefits for any reason.

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 pre- and post-operative care by the surgeon • Correction of amblyopia and strabismus • Endoscopy procedures • Biopsy procedures • Removal of tumors and cysts	In-network: 10% of the Plan allowance (No deductible) Out-of-network: 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.)	
• Transgender surgical services (gender reassignment surgery) to treat gender dysphoria – In order for the Plan to consider benefits, all of the following Plan requirements must have been met: 1) You must be at least 18 years old; 2) You have been diagnosed as a transexual, as determined by the Plan; 3) You have completed a recognized program of transgender identity treatment, as determined by the Plan; and 4) You have obtained preauthorization for the surgery *even if the proposed treatment is outside of the 50 United States* (see Section 3, *Other services*). Covered surgical procedures, limited to: - For female to male surgery: mastectomy, hysterectomy, vaginectomy, salpingo-oophorectomy, metoidioplasty, phalloplasty, urethroplasty, scrotoplasty, and placement of testicular and erectile prosthesis - For male to female surgery: penectomy, orchidectomy, vaginoplasty, clitoroplasty, and labiaplasty • Surgical treatment of morbid obesity (bariatric surgery) – a condition in which an individual has: 1) a Body Mass Index (BMI) equal to or greater than 40 or a BMI equal to or greater than 35 with comorbidities such as hypertension, heart disease, diabetes, sleep apnea, or hyperlipidemia which has persisted for a minimum of 5 years; and 2) has been under at least one medically supervised weight loss program for at least 6 months. The program should be multi-disciplinary by combining diet and nutritional counseling with an exercise program and a behavior modification program. Eligible members must be age 18 and older. • Insertion of internal prosthetic devices. See Section 5(a), *Orthopedic and prosthetic devices* for device coverage information. • Voluntary sterilization for men (e.g., vasectomy) • Treatment of burns Note: Second opinion is covered under Section 5(a), *Diagnostic and treatment services* and in Section 5(h), *Special features, Overseas Second Opinion.*	In-network: 10% of the Plan allowance (No deductible) Out-of-network: 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)
• Voluntary sterilization for women (e.g., tubal ligation) • Surgical implantation and removal of intrauterine devices (IUDs) • Surgical implantation and removal of contraceptive devices • Routine circumcision of a newborn child (only when the child is covered under a Self and Family enrollment) Note: Related and necessary services for voluntary sterilization, such as anesthesia and outpatient facility charges, are covered at 100% of the Plan allowance for in-network providers and providers outside the 50 United States and at regular Plan benefits for out-of-network providers. Note: Includes related services including anesthesia.	In-network: Nothing (No deductible) Out-of-network: 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)
When multiple or bilateral surgical procedures are performed during the same operative session by the same surgeon, the Plan's benefit is determined as follows: • For the primary procedure, the Plan's allowance • For the secondary procedure and any other subsequent procedures: - One-half of the Plan's allowance (unless the provider is an in-network or other participating provider in the United States and their contract provides for a different amount)	In-network: Nothing (No deductible) Out-of-network: 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)

Surgical procedures - continued on next page

Benefits Description	You pay
Surgical procedures (cont.)	
Note: This does not apply to providers outside the 50 United States. 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.	In-network: Nothing (No deductible) Out-of-network: 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)
• Assistant Surgeon Assistant surgical services provided by a surgeon when medically necessary to assist the primary surgeon. When a surgery requires an assistant surgeon, the Plan's allowance for the assistant surgeon is 16% of the allowance for the surgery (unless the provider is an in-network or other participating provider in the United States and their contract provides for a different amount). Note: This does not apply to providers outside the 50 United States.	In-network: 20% of the Plan allowance (No deductible) Out-of-network: 20% of the Plan allowance and any difference between our allowance and the billed amount (No deductible) Providers outside the 50 United States: 20% of the Plan allowance (No deductible)
• Co-surgeons (inpatient/outpatient) Note: When the surgery requires two surgeons with different skills to perform the surgery, the Plan's allowance for each surgeon is 62.5% of what it would allow for a single surgeon for the same procedure(s) (unless the provider is an in-network or other participating provider in the United States and their contract provides for a different amount). Note: This does not apply to providers outside the 50 United States.	In-network: 10% of the Plan allowance (No deductible) Out-of-network: 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 except for coverage for transgender surgery (gender reassignment surgery) as noted on the previous page.* • *All refractive surgeries, except as noted in Section 5(a) Vision services* • *Routine surgical treatment of conditions of the foot (see Section 5(a), Foot care)* • *Services of a standby surgeon* • *Reversal of voluntary sterilization* • *Surgeries related to impotency, sexual dysfunction or sexual inadequacy* • *Transgender surgical services (gender reassignment surgery), other than the surgeries listed as covered* • *Reversal of transgender surgeries (gender reassignment surgery)*	*All charges*

Benefits Description	You pay
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 Section 5(a), *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.	In-network: 10% of the Plan allowance (No deductible) Out-of-network: 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 repair of accidental injuries; to correct a congenital anomaly; or for reconstruction of a breast following 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 except for coverage for transgender surgery (gender reassignment surgery) as noted in Surgical procedures.* • *Surgeries related to impotency, sexual dysfunction or sexual inadequacy*	*All charges*
Oral and maxillofacial surgery	
Oral surgical procedures, limited to: • Reduction of fractures of the jaws or facial bones • Surgical correction of severe functional malocclusion only when we determine the correction of the malocclusion to be medically necessary • Removal of stones from salivary ducts • Excision of leukoplakia or malignancies • Excision of non-dentigerous cysts and incision of non-dentigerous abscesses • Surgical correction of temporomandibular joint (TMJ) dysfunction to include initial consultation and post operative medical exam • Surgical removal of impacted teeth, including anesthesia charges • Other surgical procedures not involving the teeth or their supporting structures	In-network: 10% of the Plan allowance (No deductible) Out-of-network: 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)

Oral and maxillofacial surgery - continued on next page

Benefits Description	You pay
Oral and maxillofacial surgery (cont.)	
Not covered: • *Oral implants, transplants and related services except those required to treat accidental injuries as described under Section 5(g), Dental benefits* • *Procedures that involve the teeth or their supporting structures (such as the periodontal membrane, gingival and alveolar bone) except as provided under Section 5(g), Dental benefits* • *Excision of non-impacted teeth*	*All charges*
Organ/tissue transplants	
Solid organ transplants are subject to medical necessity and experimental/ investigational review. Refer to Section 3, *Other services* for preauthorization procedures. The medical necessity limitation is considered satisfied for other tissue transplants if the patient meets the staging description. Solid organ transplants are limited to: • Cornea • Heart • Heart/lung • Intestinal transplants - Isolated Small intestine - Small intestine with the liver - Small intestine with multiple organs, such as the liver, stomach, and pancreas • Kidney • Liver • Lung single/bilateral/lobar • Pancreas • Autologous pancreas islet cell transplant (as an adjunct to total or near total pancreatectomy) only for patients with chronic pancreatitis The **tandem blood or marrow stem cell transplants for covered transplants** below are subject to medical necessity review by the Plan. Refer to Section 3, *Other services* for preauthorization procedures. • Autologous tandem transplants for: - AL Amyloidosis - Multiple myeloma (de novo and treated) - Recurrent germ cell tumors (including testicular cancer) **Blood or marrow stem cell transplants** limited to the stages of the following diagnoses. For the diagnoses listed below, the medical necessity limitation is considered satisfied if the patient meets the staging description. • Allogeneic transplants for: - Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia - Advanced Hodgkin's lymphoma with recurrence (relapsed) - Advanced non-Hodgkin's lymphoma with recurrence (relapsed) - Acute myeloid leukemia	Plan-designated transplant network facility for tissue and organ transplant (see Section 5(h) *Special features*, *Institutes of Excellence*): 10% of the Plan allowance (No deductible) In-network: 20% of the Plan allowance (No deductible) subject to a maximum payable of $400,000 per transplant (No catastrophic coverage) Out-of-network: 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.)	
- Advanced Myeloproliferative Disorders (MPDs) - Amyloidosis - Chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL) - Hemoglobinopathy - Marrow failure and related disorders (i.e., Fanconi's, PNH, Pure Red Cell Aplasia) - Myelodysplasia/Myelodysplastic syndromes - Paroxysmal Nocturnal Hemoglobinuria - Phagocytic/Hemophagocytic deficiency diseases (e.g., Wiskott-Aldrich syndrome) - Severe combined immunodeficiency - Severe or very severe aplastic anemia • Autologous transplants for: - Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia - Advanced Childhood kidney cancers - Advanced Ewing sarcoma - Advanced Hodgkin's lymphoma with recurrence (relapsed) - Advanced non-Hodgkin's lymphoma with recurrence (relapsed) - Aggressive non-Hodgkin's lymphomas (Mantle Cell lymphoma, adult T-cell leukemia/lymphoma, peripheral T-cell lymphomas, and aggressive Dendritic Cell neoplasms) - Amyloidosis - Childhood rhabdomyosarcoma - Epithelial ovarian cancer - Mantle Cell (non-Hodgkin lymphoma) - Multiple myeloma - Neuroblastoma - Testicular, mediastinal, retroperitoneal, and ovarian germ cell tumors Mini-transplants performed in a clinical trial setting (non-myeloablative, reduced intensity conditioning or RIC) for members with a diagnosis listed below are subject to medical necessity review by the Plan. Refer to Section 3, *Other services* for preauthorization procedures: • Allogeneic transplants for: - Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia - Acute myeloid leukemia - Advanced Myeloproliferative Disorders (MPDs) - Advanced Hodgkin's lymphoma with recurrence (relapsed) - Advanced non-Hodgkin's lymphoma with recurrence (relapsed) - Amyloidosis - Chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL) - Hemoglobinopathy	Plan-designated transplant network facility for tissue and organ transplant (see Section 5(h) *Special features*, *Institutes of Excellence*): 10% of the Plan allowance (No deductible) In-network: 20% of the Plan allowance (No deductible) subject to a maximum payable of $400,000 per transplant (No catastrophic coverage) Out-of-network: 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.)	
- Marrow failure and related disorders (i.e., Fanconi's, PNH, Pure Red Cell Aplasia) - Myelodysplasia/Myelodysplastic syndromes - Paroxysmal Nocturnal Hemoglobinuria - Severe combined immunodeficiency - Severe or very severe aplastic anemia • Autologous transplants for: - Acute lymphocytic or nonlymphocytic (i.e., myelogenous) leukemia - Advanced Hodgkin's lymphoma with recurrence (relapsed) - Advanced non-Hodgkin's lymphoma with recurrence (relapsed) - Amyloidosis - Neuroblastoma 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: We cover donor screening test for up to four potential bone marrow/stem cell transplant donors per year from individuals unrelated to the patient, in addition to testing of family members. Note: The Plan has special arrangements with facilities to provide services for tissue and organ transplants only (see Section 5(h), *Special features, Institutes of Excellence*). The transplant 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 Institutes of Excellence. Your health care professional 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 facility for tissue and organ transplant (see Section 5(h) *Special features*, *Institutes of Excellence*): 10% of the Plan allowance (No deductible) In-network: 20% of the Plan allowance (No deductible) subject to a maximum payable of $400,000 per transplant (No catastrophic coverage) Out-of-network: 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 or as specified above* • *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 out-of-network 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). Note: We follow CMS guidelines for the determination of the Plan allowance for professional services for the administration of anesthesia.	In-network: 10% of the Plan allowance (No deductible) Out-of-network: 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: $250 per person for in-network providers and providers outside the 50 United States or $300 for out-of-network providers ($500 per family for in-network providers and providers outside the 50 United States or $600 per family for out-of-network providers).
- The out-of-network benefits are the standard benefits of this Plan. In-network benefits apply only when you use an in-network provider or when you use a provider outside the 50 United States. When no in-network provider is available in the network, out-of-network benefits apply.
- When you use an in-network facility, keep in mind that the healthcare professionals who provide services to you in the facility may not be in-network providers. We will pay up to the Plan allowance at the in-network provider percentage for services you receive from out-of-network anesthesiologists (including Certified Registered Nurse Anesthetists), radiologists, pathologists, emergency room physicians and neonatologists. This provision also applies when an out-of-network surgeon's immediate or emergency care is required. You will be responsible to pay the in-network coinsurance and any difference between the Plan allowance and billed amount for these out-of-network providers. When non-emergency care by out-of-network surgeons is provided, regular out-of-network benefits apply.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost-sharing works. Also, read Section 9 for information about how we pay if you have other coverage, or if you are age 65 or over.
- The amounts listed on the following pages 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).
- Note: Observation care is billed as outpatient facility care. As a result, benefits for observation care services are provided at the outpatient facility benefit levels (see Section 10, *Definitions*).
- **YOU MUST GET PRECERTIFICATION OR CONCURRENT REVIEW (FOR DAYS NEEDING CERTIFICATION BEYOND THE PLAN'S INITIAL APPROVAL) FOR HOSPITAL STAYS; FAILURE TO OBTAIN PRECERTIFICATION WILL RESULT IN A $500 PENALTY.** Please refer to the precertification information shown in Section 3 for additional details on precertification.
- **YOU ALSO MUST GET PREAUTHORIZATION OR CONCURRENT REVIEW FOR CARE YOU RECEIVE IN SKILLED NURSING FACILITIES, AND HOME HEALTH CARE.** Please refer to this Section, *Extended care benefits/Skilled nursing care facility benefits* and Section 5(a), *Home health services*, for details on how your benefits are affected if you do not preauthorize. Also, please refer to the preauthorization information shown in Section 3 for additional details on preauthorization.

Note: We do not require precertification, preauthorization or concurrent review in this section 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 before and/or during continued treatment.

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

Benefits Description	You pay
Note: The calendar year deductible applies ONLY when we say below: "(calendar year deductible applies)".	
Inpatient hospital	
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, then we will consider the private room rate. Note: Staying overnight in a hospital does not always mean you are an inpatient. You are considered an inpatient the day a physician formally admits you to a hospital with a physician's order. Confinement as an inpatient or an outpatient affects your out-of-pocket expenses. Always ask your physician or the hospital staff if you are an inpatient, outpatient, or observation care. Although you may stay overnight in a hospital room and receive meals and other hospital services, some hospital services including "observation care" are actually outpatient care. Since observation services are billed as outpatient care, outpatient facility benefit levels apply and your out-of-pocket expenses may be higher as a result. If you are admitted to the hospital as an inpatient after your observation care ends, you must precertify the inpatient admission per Section 3. Other services and supplies you receive while in a hospital, such as: • Use of operating, recovery, maternity, and other treatment rooms • Rehabilitative services • Prescribed drugs and medicines for use in the hospital • X-ray, laboratory, and pathology services and machine diagnostic tests • Blood or blood plasma, if not donated or replaced, and its administration • Dressings, splints, casts, and sterile tray services • Medical supplies and equipment, including oxygen • Anesthetics, including nurse anesthetist services • Drugs, medical supplies, medical equipment, prosthetic, and orthopedic devices and any covered items billed by a hospital for use at home (Note: We cover these items only under Section 5(a), *Medical services and supplies,* 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 or other health care professional, 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, physicians, or other health care professionals in connection with the dental treatment.	In-network: Nothing Out-of-network: $200 copayment per hospital stay and 20% of the Plan allowance and any difference between our allowance and the billed amount Providers outside the 50 United States: Nothing

Inpatient hospital - continued on next page

Benefits Description	You pay
Inpatient hospital (cont.)	
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 Section 10, Definitions)* • *Any part of a hospital admission that is not medically necessary (see Section 10, Definitions), such as when you do not need acute hospital inpatient (overnight) care, but could receive care in some other setting without adversely affecting your condition or the quality of your medical care. Note: In this event, we pay benefits for services and supplies other than room and board and in-hospital physician or other health care professional care at the inpatient level for other medically necessary services and supplies you receive while in the hospital.* • *Inpatient private duty nursing except as provided on the previous page* • *Personal comfort items, such as radio, television, beauty and barber services, identification tags, baby beads, footprints, guest cots and meals, newspapers, and similar items* • *Inpatient hospital services/supplies for surgery we do not cover except as noted on the previous page for non-covered dental procedures*	*All charges*
Outpatient hospital or ambulatory surgical center	
• 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), *Medical services and supplies,* 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, physicians or other health care professionals in connection with the dental treatment.	In-network: 10% of the Plan allowance (calendar year deductible applies) Out-of-network: 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/supplies for surgery we do not cover except as noted above for non-covered dental procedures*	*All charges*

Benefits Description	You pay
Extended care benefits/Skilled nursing care facility benefits	
If you preauthorize your admission, we cover semiprivate room, board, services, and supplies in a Skilled Nursing Facility (SNF) for up to 90 days per calendar year when the admission is: • medically necessary; and • under the supervision of a physician. **Note: Admissions rendered outside the 50 United States do not require preauthorization.** Note: When Medicare A is primary, the initial days paid in full by Medicare are considered part of the 90 day per calendar year benefit.	For preauthorized care: Nothing up to the Plan allowance for up to 90 days per calendar year and all charges after 90 days. Preauthorization not required for admissions outside the 50 United States.
If you do not preauthorize your admission, we cover semiprivate room, board, services, and supplies in a Skilled Nursing Facility (SNF) for up to 45 days per calendar year subject to the conditions above. Note: When Medicare A is primary, the initial days paid in full by Medicare are considered part of the 45 day per calendar year benefit. **Note: Admissions rendered outside the 50 United States do not require preauthorization. See benefit for preauthorized admission.** Note: Preauthorized and non-preauthorized days are combined. Day limit not to exceed 90 days per calendar year.	For non-preauthorized care: 20% up to the Plan allowance for up to 45 days per calendar year and all charges after 45 days. Preauthorization not required for admissions outside the 50 United States. See benefit for preauthorized admissions.
Not covered: • *Custodial care (see Section 10, Definitions)*	*All charges*
Hospice care	
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.	In-network: 10% of Plan allowance Out-of-network: 30% of Plan allowance and any difference between our allowance and the billed amount Providers outside the 50 United States: 10% of Plan allowance

Benefits Description	You pay
Ambulance	
• Professional ambulance service to the nearest facility equipped to handle your medical condition, including air ambulance, when medically necessary. Note: For air ambulance transport that initiates outside the 50 United States, we base our decision on the nearest facility to handle your medical condition and our Plan allowance for that transport on criteria provided to us by On Call International. See Section 10, *Definitions* for our Plan allowance. Note: If you are outside the 50 United States and need assistance arranging for air ambulance transportation to the nearest facility equipped to handle your medical condition, please call us at 1-800-593-2354, Monday-Friday from 6:00 a.m. to 5:00 p.m. Mountain Standard Time (MST) or after hours only you can call direct or collect at 603-952-2013. Note: We also cover medically necessary emergency care provided when transport services are not required.	In-network: 10% of the Plan allowance Out-of-network: 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: $250 per person for in-network providers and providers outside the 50 United States or $300 for out-of-network providers ($500 per family for in-network providers and providers outside the 50 United States or $600 per family for out-of-network providers). The calendar year deductible applies to some benefits in this Section. We added "(No deductible)" to show when the calendar year deductible does not apply.
- The out-of-network benefits are the standard benefits of this Plan. In-network benefits apply only when you use an in-network provider or when you use a provider outside the 50 United States. When no in-network provider is available in the network, out-of-network benefits apply.
- When you use an in-network facility, keep in mind that the healthcare professionals who provide services to you in the facility may not be in-network providers. We will pay up to the Plan allowance at the in-network provider percentage for services you receive from out-of-network anesthesiologists (including Certified Registered Nurse Anesthetists), radiologists, pathologists, emergency room physicians, neonatologists, and surgeons when immediate or emergency care is required. You will be responsible to pay the in-network coinsurance and any difference between the Plan allowance and billed amount for these out-of-network providers.
- Be sure to read Section 4, *Your costs for covered services,* for valuable information about how cost-sharing works. Also, read Section 9 for information about how we pay if you have other coverage, or if you are age 65 or over.
- Preauthorization of High End Radiology procedures is not required in the case of an accident or a medical emergency. See Section 3, *Other services*.

What is an accidental injury?

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

What is a medical emergency?

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

Benefits Description	You pay After the calendar year deductible…
Note: The calendar year deductible applies to some benefits in this Section. We say "(No deductible)" when it does not apply.	
Accidental injury	
We pay 100% of the Plan allowance for the following care you receive as a result of an accidental injury: • Emergency Room (ER) or urgent care facility charges, ER, urgent care physician's, or other health care professional's charges and ancillary services performed at the time of the initial ER visit or initial urgent care facility visit; **or** • Office visit and ancillary services performed at the time of the initial office visit for accidental injury.	In-network: Nothing (No deductible) Out-of-network: Only the difference between the Plan allowance and the billed amount (No deductible) Providers outside the 50 United States: Nothing (No deductible)

Accidental injury - continued on next page

Benefits Description	You pay After the calendar year deductible…
Accidental injury (cont.)	
Note: Regular Plan benefits apply after the initial ER, urgent care, physician, or other health care professional office visit. Note: We pay for services performed outside the ER or urgent care facility under the appropriate Plan benefit. Note: We pay Hospital benefits as specified in Section 5(c), *Services provided by a hospital or other facility* 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), *Medical services and supplies*. Note: We pay prescription medications for use at home under Sections 5 (a), 5(c) or 5(f) as appropriate.	In-network: Nothing (No deductible) Out-of-network: Only the difference between the Plan allowance and the billed amount (No deductible) Providers outside the 50 United States: Nothing (No deductible)
Medical emergency	
Initial services and items you receive in the outpatient Emergency Room (ER), physician's, or other health care professional's office because of a medical emergency (non-accident). Services and items covered include: • Medical services and supplies • Physician and professional services • X-ray, laboratory, pathology services, and machine diagnostic tests • Professional services for anesthesia Note: Regular Plan benefits apply after initial ER, physician's, or other health care professional's office visit.	In-network: 10% of the Plan allowance Out-of-network: 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
• Outpatient care in an urgent care facility because of a medical emergency Note: We pay medical supplies, medical equipment, prosthetic, and orthopedic devices for use at home under Section 5(a), *Medical services and supplies*. Note: Services received from an in-network provider for routine preventive care are paid under Section 5(a), *Preventive care, adult* or *Preventive care, children*.	In-network: $35 copayment per occurrence (No deductible) Out-of-network: $35 copayment per occurrence and any difference between our allowance and the billed amount (No deductible) Providers outside the 50 United States: $35 copayment per occurrence (No deductible)

Benefits Description	You pay After the calendar year deductible…
Ambulance	
• Professional ambulance service to the nearest facility equipped to handle your medical condition, including air ambulance, when medically necessary. Note: For air ambulance transport that initiates outside the 50 United States, we base our decision on the nearest facility to handle your medical condition and our Plan allowance for that transport on criteria provided to us by On Call International. See Section 10, *Definitions,* for our Plan allowance. Note: If you are outside the 50 United States and need assistance arranging for air ambulance transportation to the nearest facility equipped to handle your medical condition, please call us at 1-800-593-2354, Monday-Friday from 6:00 a.m. to 5:00 p.m. Mountain Standard Time (MST) or after hours only you can call direct or collect at 603-952-2013. Note: We also cover medically necessary emergency care provided when transport services are not required.	In-network: 10% of the Plan allowance (No deductible) Out-of-network: 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 an in-network or an out-of-network provider if you live in the United States. When you receive **any** care in the United States, you must get our prior approval for inpatient hospitalization and partial hospitalization. Cost-sharing and limitations for mental health and substance abuse benefits are no greater than for similar benefits for other illnesses and conditions.

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- The calendar year deductible or, for facility care, the inpatient copayment applies to almost all benefits in this Section. We added "(No deductible)" to show when the calendar year deductible does not apply.
- The out-of-network benefits are the standard benefits of this Plan. In-network benefits apply only when you use an in-network provider or when you use a provider outside the 50 United States. When no in-network provider is available in the network, out-of-network benefits apply.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost-sharing works. Also, read Section 9 for information about how we pay if you have other coverage, or if you are age 65 or over.
- **YOU MUST GET PRECERTIFICATION/PREAUTHORIZATION/CONCURRENT REVIEW FOR INPATIENT HOSPITALIZATION AND PARTIAL HOSPITALIZATION.** If you fail to follow these procedures, the Plan may reduce your benefit. See the precertification and Other services information shown in Section 3, *How you get care,* and the instructions below.
  - **Precertification** establishes the medical necessity of your admission to a hospital, residential treatment center or other facility for you to receive full Plan benefits. **You must precertify any inpatient care before you receive it.** If you do not precertify, we will reduce the benefits payable by $500. You must report emergency admissions within two business days following the day of admission even if you have been discharged.
  - **Preauthorization** establishes the medical necessity for partial hospitalization. **You must preauthorize partial hospitalization before you receive it.** If you do not preauthorize, we will request information from your provider to review the services for medical necessity. This will delay your claim.
  - **Concurrent review (which means review of continuing treatment)** establishes the medical necessity for ongoing care in an inpatient or partial hospitalization setting. **You must obtain concurrent review for any inpatient or partial hospitalization care you receive before you receive continuing care.**
  - **To precertify or preauthorize care and obtain concurrent review for continuing care,** you, your representative, your health care professional, 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 in this Section 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 Part B or another group health insurance policy is the primary payor. However, precertification, preauthorization, and concurrent review for continuing care is required for inpatient and partial hospitalization when Medicare or the other group health insurance policy stops paying benefits for any reason.

Benefits Description	You pay After the calendar year deductible…
Note: The calendar year deductible applies to almost all benefits in this Section. We say "(No deductible)" when it does not apply.	
Mental health and substance abuse benefits	
All covered diagnostic and treatment services	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), *Diagnostic and treatment services,* no preauthorization required. • Diagnostic tests including psychological testing	In-network: 10% of the Plan allowance Out-of-network: 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
• Services provided by a hospital (including residential treatment center) or other facility	In-network inpatient facility: Nothing for room and board and other services (No deductible) Out-of-network inpatient facility: $200 copayment per person, per hospital stay and 20% of the Plan allowance and any difference between our allowance and the billed amount 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). 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.	In-network: 10% of the Plan allowance Out-of-network: 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: • *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*

Section 5(f). Prescription drug benefits

Important things you should keep in mind about these benefits:

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

Note: We do not require prior authorization in this section for medications you purchase from a retail pharmacy or Military Treatment Facility (MTF) outside the 50 United States. However, the Plan will review all services to establish medical necessity. We may request medical records in order to determine medical necessity before and/or during continued treatment.

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

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

Who can write your prescription.

- A U.S. licensed physician or dentist, and in states allowing it, licensed or certified Physician Assistant, Nurse Practitioner, and Psychologist must prescribe your medication.

When you have to purchase a prescription.

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

Where you can obtain your prescription.

- **Network pharmacies within the 50 United States**
  - *Your prescriber must be licensed in the United States.*
  - You must fill your prescription at a network pharmacy participating with Express Scripts (ESI). You may obtain the names of network phrmacies by calling 1-800-818-6717 or on the Internet as a link through the Plan's website at www.AFSPA.org/FSBP (click on the "Prescription Coverage and Programs" tab on the right). **You must present your Foreign Service Benefit Plan ID Card when filling your prescription in order to receive this benefit. See dispensing limitations on next page. *Prescriptions you purchase at network pharmacies without the use of your card are not covered.***
  - Note: Immunizations obtained from a participating retail network pharmacy have a $0 copay.

- **Out-of-network pharmacies in the 50 United States**
  - Prescriptions you purchase at out-of-network pharmacies in the 50 United States are not covered.
- **Home Delivery (the Express Scripts Pharmacy^{SM}) within the 50 United States**
  - *Your prescriber must be licensed in the United States.*
  - You will receive forms for refills and future prescription orders each time you receive drugs or supplies through the Express Scripts Pharmacy. You also may order refills on the Internet by visiting the Plan's website at www.AFSPA.org/FSBP (click on the "Prescription Coverage and Programs" tab on the right). Using the Internet saves you time and effort for refills. If you have any questions about a particular drug or a prescription, or to request order forms, you may call 1-800-818-6717 in the United States. ***Prescriptions you purchase through home delivery from a source other than the Express Scripts Pharmacy or Accredo Health Group (Accredo), the Plan's specialty pharmacy, are not covered.***
  - To order by mail: 1) Complete the initial home delivery form; 2) Enclose your prescription and copayment; 3) **Mail your order to Express Scripts, Home Delivery Service, P.O. Box 747000, Cincinnati, OH 45274-7000** (*do not mail your order to the Plan*); and 4) Allow approximately two weeks for delivery.
- **Retail pharmacies outside the 50 United States**
  - Fill your prescription as you normally do. **Mail claims for prescription drugs and supplies you purchased through a retail pharmacy outside the 50 United States to the Plan's address shown in Section 7, *Filing a claim for covered services*** (*do not mail foreign prescription claims to the Express Scripts Pharmacy).* Claims must include receipts that show the name of the patient, prescription number, name of drug(s), name of the prescriber, name of the pharmacy, date, and the charge. You may obtain claim forms by calling 202-833-4910 or from our website at www.AFSPA.org/FSBP.
- **Home Delivery (the Express Scripts Pharmacy) outside the 50 United States**
  - *Your prescriber must be licensed in the United States.*
  - Use the same forms as for home delivery within the 50 United States referenced above. If you have any questions about a particular drug or a prescription or to request order forms, you may call 1-800-497-4641 (available in over 140 countries) from outside the 50 United States. Also, you can call the Express Scripts Pharmacy collect at 412-829-5932 or 412-829-5933 if the toll-free number for outside the 50 United States does not work for you.
  - **Note: Per Federal regulations, the Express Scripts Pharmacy can mail only to addresses in the United States or to APO, FPO, DPO, and Pouch Mail addresses. Allow appropriate mailing time to reach them, for them to fill your prescription, and for the prescription to reach you.**
  - If you are posted, living, or traveling outside the 50 United States, you may request up to a 1-year supply of most medications. Ask your prescriber to write you a prescription for a 1-year supply with no refills. Contact the Plan or refer to our website if you need additional assistance. There are limitations to sending temperature sensitive medications outside the 50 United States. Please contact the Express Scripts Pharmacy if you have been prescribed a temperature sensitive medication.
  - **Use the Internet through the Plan's website at www.AFSPA.org/FSBP (click on the "Prescription Coverage and Programs" tab on the right) to refill home delivery medications via the Internet. Using the Internet saves you considerable time for refills compared to APO/FPO/DPO and Pouch Mail.**

These are the dispensing limitations.

- The Plan follows Food and Drug Administration (FDA) guidelines.
- You may purchase up to a 30-day supply of medication at a network pharmacy. Refills cannot be obtained until 50% of the drug has been used. You may not obtain more than a 30-day supply through the network pharmacy arrangement except in the following situations. If you do not contact us prior to purchasing your prescription when either of the following applies, the Plan will not supply more than a 30-day supply of medication and we will not reimburse you if you purchase more than a 30-day supply without the use of your Foreign Service Benefit Plan ID Card:
  - You are traveling to a foreign country, do not have time to use the Express Scripts Pharmacy (home delivery) and need to purchase more than a 30-day supply of prescriptions to take with you.
  - You are visiting the United States for a short time period, do not have time to use the Express Scripts Pharmacy and need to purchase more than a 30-day supply of prescriptions to take with you.

- You may purchase long-term (up to a 90-day supply) prescription needs through the Express Scripts Pharmacy (home delivery) to receive higher benefits. Per the home delivery reference on the previous page, if you are posted, living or traveling outside the 50 United states, you may request up to a 1-year supply of most medications.
  - We cover all drugs and supplies referenced on the following pages except for those that require constant temperature control (temperature sensitive), are too heavy to mail, or that must be administered by a prescriber.
- **As stated on the previous page, per Federal regulations, the Express Scripts Pharmacy (home delivery) can mail only to addresses in the United States or to APO, FPO, DPO, and Pouch Mail addresses.**
- You may not obtain hormone therapy treatment (for infertility) with your Foreign Service Benefit Plan ID Card or through the Express Scripts Pharmacy (home delivery).

Prescription Drug Utilization Management

The Plan's prescription drug utilization management programs help ensure that you receive the prescription drugs you need at a reasonable cost. The information below describes the features of these programs and explains 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).**
  - To find out if your prescription requires prior authorization or to learn more about our prescription drug utilization management programs, visit the Express Scripts Pharmacy online at www.express-scripts.com. If you are a first-time visitor to the site, register with your member ID and a recent prescription number, or call their Member Services at 1-800-818-6717. Members outside the U.S. who use Express Scripts home delivery may call 1-800-497-4641 (available in over 140 countries). Also, you can call the Express Scripts Pharmacy collect at 412-829-5932 or 412-829-5933 if the toll-free number for outside the 50 United States does not work for you.
  - **Prior authorization review** uses Plan rules based on FDA-approved prescribing and safety information, and clinical guidelines and uses that are considered reasonable, safe, and effective. There are other medications that may be covered with limits (for example, only for a certain amount or for certain uses) unless you receive approval through a coverage review. Examples of drug categories requiring prior authorization include, but are not limited to, growth hormones, certain hormone therapies, interferons, erythroid stimulants, anti-narcoleptics, sleep aids, migraine medication, weight loss medications, opioids, certain compound medications (medications that incorporate a powder or other medication that lacks clinical data to support the safety and efficacy of the product when incorporated into a compounded preparation), and oncologic agents. During this review, the Express Scripts Pharmacy asks your prescriber 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.*
- **Quantity Management**
  - The Drug Quantity Management program manages prescription costs by ensuring that the quantity of units supplied for each copayment are consistent with clinical dosing guidelines. The program is designed to support safe, effective, and economic use of drugs while giving patients access to quality care.
- **The Plan participates in other 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.**

Specialty Drugs

Specialty drugs, which can be given by any route of administration and are typically used to treat chronic, complex conditions, are defined as having one or more of several key characteristics, including:

- The requirement for frequent dosing adjustments and intensive clinical monitoring to decrease the potential for drug toxicity and increase the probability for beneficial treatment outcomes;
- The need for intensive patient training and compliance assistance to facilitate therapeutic goals;
- Limited or exclusive specialty pharmacy distribution;

- Specialized product handling and/or administration requirements;
- Exceptions may exist based on certain characteristics of the drug or therapy which will still require the drug to be classified as a specialty drug; and
- Some examples of the disease categories currently in the Plan's specialty pharmacy programs include cancer, cystic fibrosis, Gaucher disease, growth hormone deficiency, hemophilia, immune deficiency, Hepatitis C, infertility, multiple sclerosis, rheumatoid arthritis, and RSV prophylaxis.

You are required to obtain all specialty drugs used for long term therapy (chronic specialty drugs) from Accredo, your exclusive Specialty Pharmacy.

- Express Scripts customer service can advise you if your prescription is required to be obtained from Accredo and cannot be obtained from a retail pharmacy. Your prescriber can fax your prescription directly to Accredo at 1-800-391-9707 or you can mail your prescription to: Express Scripts, P.O. Box 747000, Cincinnati, OH 45274-7000.
- If you purchase your chronic specialty drugs from a retail pharmacy, you will be responsible for their full cost. Note: This does not apply to specialty medications you purchase from a retail pharmacy or Military Treatment Facility outside the 50 United States. You file a claim for them as you would for other medications purchased in this manner.
- Step Therapy (Specialty Drugs)
  - Within specific therapy classes, multiple drugs are available to treat the same condition. Step Therapy manages drug costs by ensuring that patients try frontline (first step), clinically effective, lower-cost medications before they “step up” to a higher-cost medication.
  - The Step Therapy program applies edits to drugs in specific therapeutic classes at the point of sale. Coverage for back-up therapies (second/third step) is determined at the patient level based on the presence or absence of front-line drugs

In addition, certain specialty drugs must be obtained from Accredo and not from your prescriber's office or outpatient facility.

- You or your prescriber can contact Express Scripts at 1-800-922-8279 to speak to an Accredo representative to inquire if your drug should be obtained through Accredo. If you currently are using a specialty drug supplied by the prescriber’s office or an outpatient facility, you may be required to obtain the drug from Accredo.
- Nursing services are provided by Accredo when necessary.
- If you continue to purchase your drugs from your prescriber, outpatient facility, or another pharmacy, you will be responsible for their full cost. Note: This does not apply to specialty drugs you obtain from a provider or Military Treatment Facility outside the 50 United States. You file a claim for them as you would for other drugs purchased in this manner.

General specialty drug information:

- Accredo provides patient support and instructions on administering the drug.
- Most specialty drugs require special handling and cannot be shipped to APO/FPO/DPO and Pouch Mail addresses.
- Not all network retail pharmacies carry specialty drugs. Contact Accredo at 1-800-922-8279 for more information.
- Fertility drugs are covered only as specified under Section 5(a), Infertility services.

The Plan participates in a formulary.

The Plan’s Formulary includes a list of preferred drugs and non-preferred drugs. Preferred drugs are drugs that are either more effective at treating a particular condition than other drugs in the same class of drugs, or as effective as and less costly than similar medications. Non-preferred drugs also may be covered under the prescription drug benefit, but at a higher cost-sharing tier. The Plan’s Formulary is updated periodically and subject to change.

To get the most up-to-date list go online to www.express-scripts.com. Drugs that are excluded from the Plan's Formulary are **not** covered under the Plan unless approved in advance through a Formulary exception process managed by Express Scripts on the basis that the drug requested is (1) medically necessary and essential to your health and safety and/or (2) all Formulary drugs comparable to the excluded drug have been tried by you. If approved through that process, the non-preferred co-pay would apply for the approved drug based on the Plan's cost share structure. Absent such approval if you obtain drugs excluded from the Formulary you will pay the full cost of the drug without any reimbursement under the Plan. If your prescriber believes that an excluded drug meets the requirements described above, the prescriber may take the necessary steps to initiate a Formulary exception review.

The Formulary will continue to change from time to time.

Please be sure to check before the drug is purchased to make sure it is covered on the Formulary, as you may not have received notice that a drug has been removed from the Formulary. Certain drugs, even if covered on the Formulary, will require prior authorization in advance of receiving the drug. Other Formulary-covered drugs may not be covered under the Plan unless an established protocol is followed first; this is known as Step Therapy and described on the previous page. As with all aspects of the Formulary, these requirements may also change from time to time.

Four-tier drug benefit – We divide prescription drugs into four tiers. The four-tier drug benefit is not applicable to prescription drugs you purchase from a retail pharmacy or Military Treatment Facility (MTF) outside the 50 United States and file as a claim (see pages 62 and 69-70 for information on claims from outside the 50 United States).

- **Tier 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. Generic drugs are preferred by the Plan.
- **Tier II (Preferred Brand Name Drug):** Single-source brand name drugs are available from only one manufacturer and are patent-protected. No generic equivalent is available. Certain brands are preferred by the Plan.
- **Tier III (Non-Preferred Brand Name Drug):** Non-preferred drugs consist of multi-source brand drugs and single source brand drugs. 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 prescriber specifies that the prescription must be filled as written ("Dispense as Written – DAW"). **If an approved generic equivalent is available, but you or your prescriber specifies that the prescription must be filled as written, you will pay the Level III Non-Preferred copay.**
- **Tier IV (Specialty Drugs):** Specialty drugs are described on pages 63-64.

Personalized Medicine Program

- Your prescription drug coverage includes the Personalized Medicine Program, a program that incorporates pharmacogenetic testing to optimize prescription drug therapies for certain conditions such as those prescribed to determine the tolerance of anticoagulant medications or prevent major adverse cardiovascular events. The conditions, drugs, and testing covered by the program will change from time to time as new genetic tests become available that are recommended by the FDA and are included in the program. The most up-to-date information on the conditions and drugs covered by the program can be accessed online at the Plan's co-branded website at www.AFSPA.org/FSBP and clicking on the "Prescription Coverage and Programs" tab on the right or by calling an Express Scripts Pharmacy customer service representative at 1-800-818-6717.
- If you are a qualified participant, services are available to you through the Personalized Medicine Program at no additional cost. The Personalized Medicine Program includes: (i) access to certain specified pharmacogenetic tests administered and analyzed by one of several designated clinical laboratories; and (ii) a clinical program that includes consultation with the prescriber of your test by a representative of the Express Scripts Pharmacy trained specifically in pharmacogenetic testing. The Pharmacy also will offer on-going outreach and education to prescribers and patients when appropriate.

- When you qualify, the Express Scripts Pharmacy will contact you and/or your prescriber to enroll you in the program. With approval from your prescriber, the clinical laboratory will facilitate the processing of a pharmacogenetic test and share the results of the test with your prescriber and the Pharmacy. The results of the pharmacogenetic test are for informational purposes only. Any dosing or medication changes remain the sole discretion of your prescriber. Your participation is voluntary and, if you decide to participate, the Pharmacy will facilitate your coverage under the Program. **You pay nothing for this service.**

When you do have to file a claim.

- See **Where you can obtain your prescription** at the beginning of this Section for instructions when you purchase prescriptions from a retail pharmacy or Military Treatment Facility outside the 50 United States.
- When you must file a claim for a prescription medication you purchased without your Foreign Service Benefit Plan ID card (in the United States), please submit a letter explaining why you were unable to use your ID card and include the itemized pharmacy receipt from a network pharmacy. The submission must be itemized and show:
  - Patient's name, date of birth, and address
  - Patient's Plan identification number
  - Name and address of the pharmacy providing the medication
  - Dates that prescription drugs were furnished
  - Name, dose and strength of medication
  - Valid NDC number (your pharmacist will know what this is)
- **Compound medications purchased in the 50 United States require prior authorization.** Compound medications that incorporate a powder or other medication that lacks clinical data to support the safety and efficacy of the product when incorporated into a compounded preparation require prior authorization. See page 63 under Utilization Management. Contact Express Scripts Member Services at: 1-800-818-6717 before you fill your compound medication prescription to determine if it is covered by the Plan.
- If you are in a nursing home that requires unit dosing or the purchase of medication from an out-of-network pharmacy, contact the Plan for assistance.

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 Identification (ID) Card that also serves as a prescription ID card, a Health, Allergy & Medication Questionnaire, Express Scripts Pharmacy℠ home delivery forms, and envelopes. **You must present your Foreign Service Benefit Plan ID Card when filling your prescription at a Plan network pharmacy.** You may purchase the following medications and supplies prescribed for you by a United States licensed physician or other health care professional from either a Plan network pharmacy or by mail through the Express Scripts Pharmacy: • Drugs that by Federal law of the U.S. require a physician's or other health care professional's written prescription for their purchase except those listed as not covered • Insulin and diabetic supplies • Prescription drugs for weight management • Vitamins (including injectable B-12) and minerals that by Federal law of the United States require a physician's or other health care professional's prescription for their purchase • FDA approved women's oral contraceptives, including the "morning after pill" (non-preferred brand name drugs) that require a prescription (see page 69 for generic and single source brand name drug coverage) • Tobacco cessation drugs and medications (see page 69). See also *Educational classes and programs* in Section 5(a), *Medical services and supplies* for information about the Plan's Tobacco Cessation Program. • Needles and syringes for the administration of covered medications Prescription drugs you receive from a physician or other health care professional or facility are covered only as specified under Sections 5(a), *Medical services and supplies* and 5(c), *Services provided by a hospital and other facilities* 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 *Prescription Drug Utilization Management* in this Section for more information. To find out if your prescription requires prior authorization or more about your prescription drug benefits, visit the Express Scripts Pharmacy online at www.express-scripts.com. If you are a first-time visitor to the site register with your member ID and a recent prescription number, or call their Member Services at 1-800-818-6717. Members outside the United States may call the Pharmacy at 1-800-497-4641. Note: We do not require prior authorization for the purchase of certain prescription drugs when Medicare Part B or Part D is the primary payor or you are outside the 50 United States and purchase them from a retail pharmacy outside the 50 United States.	• Network retail (No deductible applies for all Levels): - Tier I (Generic Drug): $10 copay - Tier II (Preferred Brand Name Drug): 25% ($30 minimum) - Tier III (Non-Preferred Brand Name Drug): 30% ($50 minimum) - Tier IV (Specialty Drugs): 25% (Note: Chronic specialty drugs must be obtained from Accredo. If you continue to use retail and the Plan has instructed you to use Accredo, 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. • Out-of-network retail (in the 50 United States, including Medicare): 100% of cost • Out-of-network retail (outside the 50 United States, including Medicare): 10% of cost (No deductible) Note: If there is no generic equivalent available, you will still have to pay the Preferred Brand Name Drug or Non-Preferred Brand Name Drug coinsurance or copay. See next page for home delivery through the Express Scripts Pharmacy.

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 home delivery – the Express Scripts Pharmacy℠ (No deductible applies for all Levels): - Tier I (Generic Drug): $10 - Tier II (Preferred Brand Name Drug): $55 - Tier III (Non-Preferred Brand Name Drug): $70 - Tier IV (Specialty Drugs): 25% up to a maximum of $150 • Network home delivery – the Express Scripts Pharmacy (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 home delivery prescriptions to the Express Scripts Pharmacy. They will review the prescriptions to determine if they are eligible for Medicare Part B coverage. - When Medicare Part B is primary, contact Medicare at www.medicare.gov/supplier/home.asp or call Medicare at 1-800-633-4227 about your options for submitting claims for Medicare-covered medications and supplies, whether you use a Medicare-approved supplier or the Express Scripts Pharmacy. Prescriptions typically covered by Medicare Part B include diabetes supplies, specific medications used to aid tissue acceptance (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 home delivery prescriptions to your Medicare Part D Prescription Drug Plan (PDP). If your Medicare Part D PDP is the Express Scripts Pharmacy, they will submit a claim first to Medicare and then to the Plan for you. If your Medicare Part D PDP is not the Express Scripts Pharmacy, 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 Preferred Brand Name Drug or Non-Preferred Brand Name Drug coinsurance or 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 (MTF) 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)
• FDA-approved women's oral contraceptives, including the "morning after pill" (generic and single-source brand name drugs only) that require a prescription • Diaphragms • Cervical caps • Vaginal rings • Contraceptive hormonal patches • Injectable contraceptives	• Network retail, network home delivery, and out-of-network Retail (outside the 50 United States): Nothing (No deductible) • Out-of-network retail (in the 50 United States): 100% of the cost Note: If you are outside the 50 United States and purchase these prescriptions from a retail pharmacy on the economy or from a Military Treatment Facility you must include on your claim submission that the claim is for contraceptives and specify what contraceptive you purchased in order to receive benefits.
Tobacco cessation drugs and medications approved by the FDA to treat tobacco dependence for tobacco cessation purchased *in* the 50 United States Physician or other health care professional prescribed over-the-counter (OTC) medications and prescription drugs approved by the FDA to treat tobacco dependence for tobacco cessation are covered when you purchase them through: • A Plan network pharmacy (you must present your Foreign Service Benefit Plan ID card) • The Plan's home delivery pharmacy (the Express Scripts Pharmacy) Note: A U.S. licensed prescriber's written prescription is required at a Plan network pharmacy and the Express Scripts Pharmacy for OTC medications.	Nothing (No deductible)
Tobacco cessation drugs and medications approved by the FDA to treat tobacco dependence for tobacco cessation purchased *outside* the 50 United States are covered when you purchase them through: • A retail pharmacy outside the 50 United States • A Military Treatment Facility (MTF) outside the 50 United States (Note: A U.S. licensed prescriber's written prescription is required for prescription drugs purchased from an MTF.) Note: You must file a claim for drugs and medications purchased at a retail pharmacy or MTF outside the 50 United States. • The Plan's home delivery pharmacy (the Express Scripts Pharmacy) Note: A U.S. licensed prescriber's written prescription is required for OTC medications and prescription drugs purchased from the Plan's home delivery pharmacy.	Nothing (No deductible)

Covered medications and supplies - continued on next page

Benefits Description	You Pay
Covered medications and supplies (cont.)	
Medicines to promote better health recommended under the Patient Protection and Affordable Care Act (the Affordable Care Act), limited to: • Generic iron supplements for children age 6 months through 12 months • Generic oral fluoride supplements (less than or equal to 0.5 mg/day) for children age 6 months through age 5 • Generic folic acid supplements (0.4 to 0.8 mg) for women of child bearing age • Generic aspirin strength of less than or equal to 325 mg for men and woman age 45 and older • Generic vitamin D strength of less than or equal to 1,000 mg for adults age 65 and older • Generic prescription and OTC products used for bowel preparation before a colonoscopy up to two times per calendar year Note: To receive this benefit in the United States, you must use a network retail pharmacy and present a U.S. licensed prescriber's written prescription to the pharmacist. Note: Benefits not available for Tylenol, Ibuprofen, Aleve, etc.	• Network retail, network home delivery, and out-of-network retail (outside the 50 United States): Nothing (No deductible) • Out-of-network retail (in the 50 United States): 100% of the cost Note: If you are outside the 50 United States and purchase these medications from a retail pharmacy on the economy or from a Military Treatment Facility you must include on your claim submission what the claim is for and identify the specific medications in order to receive benefits.

Covered medications and supplies - continued on next page

Benefits Description	You Pay
Covered medications and supplies (cont.)	
Not covered: • *Drugs purchased at a Network pharmacy in the United States that are not in the Plan Formulary* • *Drugs and supplies you purchase at an out-of-network pharmacy in the 50 United States except as covered under Sections 5(a) and 5(c) and except when Medicare Part B and Part D are primary* • *Chronic specialty drugs you purchase at a network pharmacy* • *All specialty drugs you purchase at an out-of-network pharmacy except when Medicare Part B and Part D are primary* • *Drugs and supplies you purchase without using your Foreign Service Benefit Plan ID Card at a network pharmacy except as covered under Section 5(a) and 5(c) and except when Medicare Part B and Part D are primary* • *Drugs and supplies (except colostomy, ostomy, or diabetic supplies) you purchase through home delivery from a source other than the Express Scripts Pharmacy℠, Accredo Health Group, the Plan's specialty pharmacy, Liberty Medical, or Arriva 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 drugs and over-the-counter (OTC) medications for tobacco cessation except those obtained with the use of your Foreign Service Benefit Plan ID Card at a Plan Retail Network Pharmacy, through the Express Scripts Pharmacy (home delivery), or when outside the 50 United States at a retail pharmacy or Military Treatment Facility* • *Non-prescription (OTC) medications* • *Prescription drug coinsurance* • *The Express Scripts Pharmacy (home delivery) copays* • *Drugs and supplies for cosmetic purposes* • *Medical foods and nutritional supplements except as described in Section 5 (a), Durable medical equipment* • *Vitamins and minerals except as described in Section 5(a) and this Section* • *Medication that under Federal law does not require a prescription, even if your physician or other health care professional prescribes it or State law requires it or for which there is a non-prescription equivalent available* • *You may not obtain hormone therapy treatment with your Foreign Service Benefit Plan ID Card or through the Express Scripts Pharmacy (home delivery).* • *Drugs and supplies related to impotency, 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 payor of any Benefit payments and your FEDVIP Plan is secondary to your FEHB Plan. See Section 9, *Coordinating benefits with other coverage*.
- The calendar year deductible is: $250 per person for in-network providers and providers outside the 50 United States or $300 for out-of-network providers ($500 per family for in-network providers and providers outside the 50 United States or $600 per family for out-of-network providers). The calendar year deductible does not apply to most benefits in this Section. We added "(calendar year deductible applies)" to show when the calendar year deductible does apply.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works. Also, read Section 9 for information about how we pay if you have other coverage, or if you are age 65 or over.
- Note: We cover hospital services and supplies related to dental procedures when necessitated by a non-dental physical impairment to safeguard the health of the patient, even though we may not pay benefits for services of dentists, physicians, or other health care professionals 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.	In-network: 20% of the Plan allowance (calendar year deductible applies) Out-of-network: 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		
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 define orthodontics as the realignment of natural teeth or correction of malocclusion.	50% of the Plan allowance up to $1,000 per course of treatment, per person Note: Courses of treatment are limited to one every five years.	50% of the Plan allowance until benefits stop at $1,000 per course of treatment, per person and all charges after $1,000 Note: Courses of treatment are limited to one every five years.

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 regular contract benefits as a less costly alternative. If we identify a less costly alternative, we will ask you to sign an alternative benefits agreement that will include all of the following terms in addition to other terms as necessary. Until you sign and return the agreement, regular contract benefits will continue. • Alternative benefits will be made available for a limited time period and are subject to our ongoing review. You must cooperate with the review process. • By approving an alternative benefit, we do not guarantee you will get it in the future. • The decision to offer an alternative benefit is solely ours, and except as expressly provided in the agreement, we may withdraw it at any time and resume regular contract benefits. • If you sign the agreement, we will provide the agreed-upon alternative benefits for the stated time period (unless circumstances change). You may request an extension of the time period, but regular contract benefits will resume if we do not approve your request. • Our decision to offer or withdraw alternative benefits is not subject to OPM review under the disputed claims process. However, if at the time we make a decision regarding alternative benefits, we also decide that regular contract benefits are not payable, then you may dispute our regular contract benefits decision under the OPM disputed claim process (see Section 8).
Electronic Funds Transfer (EFT) of claim reimbursements	You can elect to receive your benefit reimbursement via Electronic Funds Transfer (EFT) and have payments deposited directly into your U.S. bank account. Some important things to know about signing up for EFT service: • Enrolling for EFT service is easy. Simply complete the Authorization Form in full and return it to the address on the form with a voided check or savings withdrawal slip attached to it. • The Authorization Form can be found on the Plan's *My Online Services* (MOS): - Visit www.AFSPA.org/FSBP - Select "***My Online Services***" - Log on to **MOS** - Select **Member Info** - Select **Document Library** (under Plan Information) - Select **Electronic Funds Transfer(EFT)/Direct Deposit Authorization Form** • When you receive benefit reimbursement via EFT, your Explanation of Benefits (EOB) will be available to you on MOS and will no longer be mailed to you. Visit the Plan's website (www.AFSPA.org/FSBP) and select "*My Online Services*". Log on to MOS to view your EOB. • Only one bank account per family is permitted. • The Plan cannot retrieve funds from your bank account. The Electronic Funds Transfer (EFT)/Direct Deposit Authorization Form only allows the Plan to deposit funds into your bank account. • The Plan does not charge a fee for EFT service but your bank may charge a small transaction fee. We recommend that you verify with your bank if they will charge you any banking service fees. • You may opt to have a paper copy of your EOB mailed to you by checking the box at the bottom of the enrollment form indicating your desire to continue to receive a paper EOB. • You have the option to receive benefit reimbursement via check. There is nothing you need to do if you choose this option. See the next page for how to receive notification your EOB is ready for viewing.

Special feature	Description
Electronic Funds Transfer (EFT) (cont.)	• If you prefer to receive a notification when an EOB is available for viewing on MOS, look for the 'Member Info' section, choose 'Online & Mobile Settings', 'Communications & Document Delivery' and select the radial button for 'Send me an e-mail' under Document Delivery - Explanation of Benefits (EOBs). Once this option is selected, a notification will be sent to the e-mail address that is linked to the MOS account to tell you that an EOB is available for you to view in MOS.
Scanned claim submission via secure Internet connection	The Plan provides a secure method for you to submit claims to us via the Internet. Visit our website (www.myafspa.org), enter your username and password and click "Sign In". Once inside the portal, scroll down to the Foreign Service Benefit Plan section. Click on the "Secure Docs" tab on the right and select "Submit A Claim". Follow the screen prompts to upload your PDF claim documents. You have the options to include questions or comments and send your secure claims to a specific customer service representative. Although we designed this secure process to eliminate the lengthy mail time from your post outside the United States to our office, members in the United States use this also. In addition, you may correspond with us via secure e-mail through this process or you may fax your claims from overseas. Our secure fax number is 202-464-4508.
Electronic copies of Explanations of Benefits (EOBs)	Call the Plan's customer service department at 202-833-4910 and request to stop receiving a paper copy of your EOB. Follow these easy steps to view and print your EOB on the Plan's *My Online Services* (MOS): • Visit www.AFSPA.org/FSBP • Select "***My Online Services***" • Log on to **MOS** • Select **Claims and Explanation of Benefits** You will continue to receive your claim reimbursement checks unless you want to take advantage of our Electronic Funds Transfer (EFT) option (see above). If you would like to receive an e-mail notifying you that an EOB is available for viewing on MOS, look for the 'Member Info' section, choose 'Online & Mobile Settings', 'Communications & Document Delivery' and select the radial button for 'Send me an e-mail' under Document Delivery - Explanation of Benefits (EOBs). Once this option is selected, a notification will be sent to the e-mail address that is linked to the MOS account to tell you that an EOB is available for you to view in MOS.
FSBP 24-Hour Nurse Advice Line	You have access to a registered nurse, 24 hours a day, 7 days a week to discuss any health concerns by calling the FSBP 24-Hour Nurse Advice Line. The registered nurse will provide advice and answer health-related questions and concerns. The registered nurses are available by phone at 1-855-482-5750 or 704-834-6782. Select option 1 to speak to a nurse. In addition, you may contact a registered nurse by secure e-mail and secure e-mail chat. Visit the Plan's website (www.AFSPA.org/FSBP) and click on "My Online Services". Once you log on to My Online Services, select "Wellness Tools" and then "Nurse Advice Line". Then you may register or log on to the site. You also have access to the AudioHealth Library. This is a telephone information service consisting of an audio text information library of prerecorded health information, in English and Spanish, that can be accessed by member's touch-tone or rotary phone.
FSBP 24-Hour Translation Line	When you are overseas you have access to a translation service, 24 hours a day, 7 days a week to assist you in discussing your urgent health related conditions (such as accidents and medical emergencies that require immediate attention) with a foreign health care professional. You may call 1-855-482-5750 or 1-704-834-6782. Select option 2 to speak to an interpreter during an urgent or emergency visit to a foreign health care professional.
Healthy Pregnancy Program	You have access to the Plan's Healthy Pregnancy Program, which provides educational material and support to pregnant women during healthy and high risk pregnancies. Contact the Plan at 1-800-593-2354 for more information.

Special feature	Description
Mediterranean Wellness Program and Incentive	**Mediterranean Wellness Program and Incentive** You can receive up to 100% reimbursement for the Mediterranean Wellness Program once you complete at least 80% of the Program (see Section 5(a), *Medical services and supplies, Educational classes and programs, Nutritional counseling*). Once you complete at least 80% of the Program, the Plan will automatically reimburse you for the cost of the program under the Plan's Nutritional counseling benefit. The Mediterranean Wellness Program assists you in maintaining a desirable weight and keeping healthy by eating nutritious, appealing, and hearty food. The interactive, on-line, 8-week program provides you with the flexibility to enroll at any time. You will have access to an 80-page support manual and access to your own Registered Dietician. In addition, once you complete 100% of the Program, you will earn $50 to be deposited in a Wellness Incentive Coventry Fund Account to reimburse you for certain unreimbursed medical expenses ("Eligible Medical Expenses"). Eligible Medical Expenses, as defined by Internal Revenue Code Section 213(d), include your deductible, coinsurance, and copayments (e.g., prescription drug copayments) incurred by you or your covered dependents. Your and your dependents' medical claims and prescription claims submitted for non-network retail pharmacies outside the 50 United States will automatically transfer to the Wellness Incentive Coventry Fund after processing. Reimbursement of your deductible, coinsurance, and copayments will be sent to you if there are funds available. Other expenses, like dental, vision, and prescriptions purchased through the Plan's retail pharmacy network or home delivery program will not be reimbursed automatically. You will need to submit appropriate documentation (receipts, etc.) with a claim form that can be found on My Online Services^{SM} (MOS). • Visit www.AFSPA.org/FSBP • Select "My Online Services" (MOS) • Log on to MOS • Select "Benefits" • Select "Manage My HRA/FSA or Coventry Fund" Any unused funds in the Wellness Incentive Coventry Fund at the end of the calendar year will remain in the Wellness Incentive Coventry Fund Account for Eligible Medical Expenses in the next Plan year as long as you remain enrolled in the Plan. To learn more about the Mediterranean Wellness Program, visit www.AFSPA.org/FSBP and click on "My Online Services" (MOS). Once you log on to MOS, select the following: "Wellness Tools", then "WellBeing Solutions", then "Resources", and then "Mediterranean Wellness Program". If you would like to contact the Plan for more information about this Program, please call 202-833-4910. To monitor the availability of funds in your Wellness Incentive Coventry Fund Account, visit the Plan's website (www.AFSPA.org/FSBP) and click on "My Online Services" (MOS). Once you log on to MOS, select "Benefits" and then "Manage My HRA/FSA or Coventry Fund". If you would like to contact the Plan for more information about this Program, please call 202-833-4910. The **Foreign Service Benefit Plan (FSBP)** is committed to helping you achieve your best health. Rewards for participating in our wellness programs and incentives (Mediterranean Wellness Program, Health Risk Assessment, and Wellness Incentives) are available to all members. If you think you might be unable to meet a standard for a reward under these wellness programs, you might qualify for an opportunity to earn the same reward by different means. Contact us at 202-833-4910 and we will work with you (and, if you wish, with your physician or other health care professional) to find a suitable alternative with the same reward that is right for you in light of your health status.

Special feature	Description
Health Risk Assessment and Wellness Incentive	**Health Risk Assessment** A free Health Risk Assessment (HRA) is available on My Online Services (MOS). • Visit www.AFSPA.org/FSBP • Select "My Online Services" • Log on to MOS • Select "Wellness Tools" • Select "Well Being Solutions" • Select "Succeed Health Risk Assessment" The HRA will help you take an important first step toward improving your awareness of lifestyle behaviors and their effects on overall health risks. You will be provided a Personal Health Report that is generated automatically when the Assessment is completed. **Health Risk Assessment Wellness Incentive** Once you complete the HRA you will earn a $25 gift card. To redeem your $25 gift card, while in MOS, select "Rewards" and "Redeem Rewards" and choose a gift card from over 30 merchants/retailers. Once you order your gift card, please allow 4-6 weeks for it to be delivered. You can obtain this reward once per year. In addition, if you complete the additional criteria below, you can earn an additional $25 incentive, once per year, to be deposited in a Wellness Incentive Coventry Fund Account to reimburse you for certain unreimbursed medical expenses ("Eligible Medical Expenses"). You are not eligible for this additional $25 wellness incentive unless you have first completed the HRA. The criteria to earn the additional $25 wellness incentive are obtaining the following services: • Routine physical examination; and • One Living Well Together program (as described in this Section). Eligible Medical Expenses, as defined by Internal Revenue Code Section 213(d), include your deductible, coinsurance, and copayments (e.g., prescription drug copayments) incurred by you or your covered dependents. Your and your dependents' medical claims and prescription claims submitted for non-network retail pharmacies outside the 50 United States will automatically transfer to the Wellness Incentive Coventry Fund after processing. Reimbursement of your deductible, coinsurance, and non-prescription drug copayments will be sent to you if there are funds available. Other expenses, like dental, vision, and prescriptions purchased through the Plan's retail pharmacy network or home delivery program will not be reimbursed automatically. You will need to submit appropriate documentation (receipts, etc.) with a claim form that can be found on My Online Services^{SM} (MOS). • Visit www.AFSPA.org/FSBP • Select "My Online Services" (MOS) • Log on to MOS • Select "Benefits" • Select "Manage My HRA/FSA or Coventry Fund" Any unused funds in the Wellness Incentive Coventry Fund at the end of the calendar year will remain in the Wellness Incentive Coventry Fund Account for Eligible Medical Expenses in the next Plan year as long as you remain enrolled in the Plan. To monitor the availability of funds in your Wellness Incentive Coventry Fund Account, visit the Plan's website (www.AFSPA.org/FSBP) and click on "My Online Services" (MOS). Once you log on to MOS, select "Benefits" and then "Manage My HRA/FSA or Coventry Fund". If you would like to contact the Plan for more information about this Program, please call 202-833-4910.

Special feature	Description
Wellness Incentives	The Plan offers Wellness Incentives to help you maintain good health when you are diagnosed with Diabetes, Coronary Artery Disease, or Asthma. Through this program, you can earn $50 per condition to be deposited in a Wellness Incentive Coventry Fund Account to reimburse you for certain unreimbursed medical expenses ("Eligible Medical Expenses"). Eligible Medical Expenses, as defined by Internal Revenue Code Section 213 (d), include your deductible, coinsurance, and copayments (e.g., prescription drug copayments) incurred by you or your covered dependents. Your and your dependents' medical claims and prescription claims submitted for non-network retail pharmacies outside the 50 United States will automatically transfer to the Wellness Incentive Coventry Fund after processing. Reimbursement of your deductible, coinsurance, and non-prescription drug copayments will be sent to you if there are funds available. Other expenses, like dental, vision, and prescriptions purchased through the Plan's retail pharmacy network or home delivery programs will not be reimbursed automatically. You will need to submit appropriate documentation (receipts, etc.) with a claim form that can be found on My Online Services^{SM} (MOS). • Visit www.AFSPA.org/FSBP • Select "My Online Services" (MOS) • Log on to MOS • Select "Benefits" • Select "Manage My HRA/FSA or Coventry Fund" Any unused funds in the Wellness Incentive Coventry Fund at the end of the calendar year will remain in the Wellness Incentive Coventry Fund Account for Eligible Medical Expenses in the next Plan year as long as you remain enrolled in the Plan. To monitor the availability of funds in your Wellness Incentive Coventry Fund Account, visit the Plan's website (www.AFSPA.org/FSBP) and click on "My Online Services" (MOS). Once you log on to MOS, select "Benefits" and then "Manage My HRA/FSA or Coventry Fund". If you would like to contact the Plan for more information about this Program, please call 202-833-4910. **Asthma Wellness Incentive -** The criteria to earn the $50 Wellness Incentive Coventry Fund Account for Asthma are participating in the Asthma Disease Management Program (see *Disease Management Programs*, this Section) and obtaining the following services: • Annual physician visit related to Asthma • Using appropriate medication (or submit a letter from your physician stating no medication is required) • Spirometry test within the past 24 months **Coronary Artery Disease Wellness Incentive -** The criteria to earn the $50 Wellness Incentive Coventry Fund Account for Coronary Artery Disease are participating in the Coronary Artery Disease Management Program (see *Disease Management Programs*, this Section) and obtaining the following services: • Annual physician visit related to Coronary Artery Disease • Prescription for ACE Inhibitor or ARB per your physician's orders • Prescription for Beta Blocker per your physician's orders • LDL test **Diabetes Wellness Incentive -** The criteria to earn the $50 Wellness Incentive Coventry Fund Account for Diabetes are participating in the Diabetes Disease Management Program (see *Disease Management Programs*, this Section) and obtaining the following services: • Annual physician visit related to Diabetes • LDL and Micro albumin tests • Hemoglobin A1C blood test • Dilated Retinal Eye Exam

Special feature	Description
Living Well Together (health coaching program)	The Living Well Together Program provides you and your covered dependents the opportunity to work one-on-one with a Health Coach to improve your health. A Health Coach is a healthcare professional who partners with you to transform your health goals into action. Your Health Coach will provide guidance, support, and resources to help you overcome obstacles that may be keeping you from realizing optimal health. You can talk to a Health Coach about the following health-related matters: • Tobacco Cessation • Weight Management • Exercise • Nutrition • Stress Management How does health coaching work? • You talk with your Health Coach over the telephone through conveniently scheduled appointments and create a plan that is right for you to meet your health goals. Everything in the program is tailored to you. • You explore ways to make changes in your behavior that will last. • You receive written materials from your Health Coach that can help you decide where you want to go with your health and how to get there. • Appointments can range from 15 minutes to an hour. How long and how often you meet with your Health Coach depends on your individual needs. To enroll in a program, contact a Health Coach at 1-855-406-5122 or 1-479-973-7168. Coaches are available Monday through Thursday from 8:00 a.m. – 10:00 p.m. ET and Friday from 8:00 a.m. – 6:00 p.m. ET. You may also enroll online at http://enroll.trestletree.com (passcode: FSBP). Note: See Section 5(a), *Educational classes and programs* for more information. Note: In addition, see the Plan's *Health Risk Assessment and Wellness Incentive*, in this Section for information on how to earn a Wellness Incentive for completing a Living Well Together program.
Virtual Lifestyle Management	The Virtual Lifestyle Management Program is a year-long internet-enabled program that includes online self-management education, tools and the involvement of a trained coach to assist you with nutrition and weight management. The program includes 16 weekly and eight monthly lessons with audio narration, workbook pages, and action plans that encourage you to track your diet and your physical activity. You are assigned a trained coach who monitors your progress and offers guidance and support throughout the program. You have access to a calorie counter tool online to help with food tracking and meal planning and you will receive a calorie counter booklet for reference. We will contact candidates and invite them to participate in the program. Participation is voluntary. If you would like to participate in the program and have a Body Mass Index (BMI) of 30 or higher, you may enroll in the program by telephone at 1-866-312-8144, by e-mail at afspa@vlmservice.com or by visiting http://afspa.vlmservice.com. Note: See Section 5(a), *Educational classes and programs* for more information.
Case Management Program	We administer several components of your medical health plan. One of these components is case management. This program is a voluntary program provided to you and your dependents at no additional cost. Case management services are designed to assist and support you, your family, and your physicians or other health care professionals to address acute, complex, and/or long term medical needs. They provide: nurse support; education about disease, injury, illness, and how they affect the body; and proper medical management that can help lead to a healthier lifestyle. If you feel you would benefit from case management services or would like more information, please call us at 1-800-593-2354. We are available to assist you Monday-Friday from 6:00 a.m. to 5:00 p.m. Mountain Standard Time (MST).

Special feature	Description
Disease Management Programs	The Plan offers Disease Management Programs for members and covered dependents with asthma, chronic obstructive pulmonary disease (COPD), coronary artery disease (CAD), diabetes, congestive heart failure (CHF) or chronic kidney disease (CKD). Disease Management Programs are provided at no additional cost to participants. **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. Non-Medicare primary insured members are automatically enrolled in the Program. However, participation is voluntary. If you are enrolled in the Program and do not want to participate, please call 1-800-579-5755. The participant and his/her physician or other health care professional 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 1-800-579-5755. We are available to assist you Monday-Friday from 10:00 a.m. to 8:00 p.m. ET. **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 nurse support to you via secure e-mail; and • Educational materials and notifications about your condition. While overseas, members have the option of personal interaction with their case management nurse through the use of video conferencing technology. Members are automatically enrolled in the Program. However, participation is voluntary. If you are enrolled in the Program and do not want to participate, please e-mail us at FSBPhealth@cvty.com or call us at 1-800-593-2354 (if available from your overseas location). If you would like to contact the Plan for more information about this program, please e-mail us at FSBPhealth@cvty.com or call the number listed above. We are available to assist you Monday-Friday from 6:00 a.m. to 5:00 p.m. Mountain Standard Time (MST).
Pre-Diabetic Alert Program	The Pre-Diabetic Alert Program is focused to provide education and support for members "at risk" for developing diabetes. We will contact those individuals identified at risk and offer them the opportunity to participate in the Program. Participation is voluntary. The participant and his/her physician or other health care professional remain in charge of the participant's treatment plan. Refer to Section 5(a), *Medical services and supplies* for the Plan's Diabetic Education or training benefit. If you would like to contact the Plan for more information about this Program, please call 1-800-593-2354.
Cancer Management Program	Cancer Management Program is designed to provide education and support to members. We will contact candidates and ask them to participate in the Program. Participation is voluntary. The participant and his/her physician or other health care professional remain in charge of the treatment plan. If you would like to contact the Plan for more information about this Program, please call 1-800-593-2354. We are available to assist you Monday-Friday from 6:00 a.m. to 5:00 p.m. Mountain Standard Time (MST). See Section 5(a), *Treatment therapies* for our benefits for chemotherapy and radiation therapy. See the next page for information on TherapEase Cuisine, the Plan's cancer nutrition benefit.

Special feature	Description
TherapEase Cuisine	TherapEase Cuisine, a nutritional program through the Express Scripts Pharmacy℠, the Plan's home delivery pharmacy, offers an easy-to-use online program providing cancer patients access to nutritional information that follows the American Dietetic Association guidelines for cancer nutrition. TherapEase Cuisine helps answer the question, **"What should I be eating?"** for those diagnosed with cancer. Simply visit https://www.therapeasecuisine.com/medcomembers.aspx, complete the registration form and an access code will be sent to you via e-mail. You may use this code to access and use the system. Note: See Section 5(a), *Medical services and supplies, Educational classes and programs* for more information on how you can take advantage of the Plan's Cancer Management Program that provides education and nursing support for cancer patients.
My Online Services (Web based customer service)	Access the Plan's website tool **My Online Services (MOS)** through our link at www.AFSPA.org/FSBP. Click on "My Online Services". This provides you secure access to a broad range of your personal health information after you register. **My Online Services** provides tools to become an optimal health care consumer. Services such as the following are available: • **Interactive Personal Health Record** — The Plan will build your health record with information from your claims. You also can add other personal health information such as blood pressure, weight, vital statistics, immunization records, and more. • **Robust claims information** — You can view and organize your claims the way you want: sort by date of service, health care provider, procedure, etc. • **Explanation of Benefits (EOBs)** — You can access and print your EOBs. • **Authorization notices** — You can view and print your certification for medical services, such as a precertification of a planned hospital admission. • **Decision support tools** — You can check the average cost of medical procedures or view hospital quality information before you receive care. • **Health information** — You can obtain health information and news that is relevant to you. • **Interactive health tools** — You can assess, understand, and manage conditions and health risks. Easy to use content helps members navigate common, but sometimes complex conditions. • **Digital coaching programs** — These include nine base programs for weight management, smoking cessation, stress management, nutrition, physical activity, cholesterol management, blood pressure, depression management, and sleep improvement. Programs are prioritized based on a member's health risk assessment to help create a personalized plan for successful behavior change. Members can engage and participate through personalized messaging with tools and resources to help track their progress and stay on the path to wellness. • **KidsHealth Library** — Nemours, one of the nation's largest nonprofit pediatric health systems, offers KidsHealth, an online resource that educates families and helps them make informed decisions about children's health. KidsHealth is an engaging way to encourage preventive behaviors and motivate kids and teens to become more involved in their health. KidsHealth has physician-approved content for parents, kids, teens and families.

Special feature	Description
Express Scripts (ESI) - Prescription benefits (Web based customer service)	Access the Plan's website tool for managing your Prescription benefits (see Section 5(f), *Prescription drug benefits*) through our link at www.AFSPA.org/FSBP. Click on the "Prescription Coverage and Programs" tab on the right. This provides you secure access to the Express Scripts Pharmacy and a broad range of prescription management tools. Services such as the following are available: • Refill and renew home delivery prescriptions; • Verify home delivery prescription status; • View retail and home delivery prescription claim histories, expenses, and balances; • Locate participating network pharmacies; • Compare plan-specific pricing and drug coverage information with all lower cost, clinically appropriate alternatives identified; • Review drug information (interactions, side effects, precautions, guidelines for use, etc.); • Review benefit highlights, including days supply and copayments; • Prepare for a physician or other health care professional visit; • Transfer retail prescriptions to mail; and • Receive automated e-mail refill and renewal reminders to help ensure continuous therapy and late-to-fill messages that indicate when you are late to fill an important medication.
Institutes of Excellence (formerly known as Centers of Excellence) for tissue and organ transplants	The Plan has special arrangements with facilities to provide services for tissue and organ transplants only. The transplant 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 one of the transplant network facilities, 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. See Section 5(b), *Organ/tissue transplants* for the Plan's Organ/Tissue transplants benefit. Contact the Plan at 1-800-593-2354 for more information. We are available to assist you Monday-Friday from 6:00 a.m. to 5:00 p.m. Mountain Standard Time (MST).
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 physician 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 online at a secure website. 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.

Non-FEHB benefits available to Plan members

The benefits in this Section are not part of the FEHB contract or premium **and you cannot file an FEHB disputed claim about them**. Fees you pay for these services do not count toward FEHB deductibles, copayments or catastrophic protection out-of-pocket maximums. These programs and materials are the responsibility of the American Foreign Service **Protective Association (AFSPA)** and all appeals must follow their guidelines.

Group Dental Insurance	**AFSPA** offers four dental plans to meet our members' needs. Two are Dental Health Maintenance Organizations (DHMO's) available for our stateside members. One plan is exclusively for the Mid-Atlantic area and the other offers nationwide coverage. The Mid-Atlantic area plan offers a separate orthodontic benefit to members who need that specific coverage. These DHMO's do not require claim forms and the member pays reduced fees for procedures without waiting periods. Members must use a participating dentist in the network for these services to be covered. We also offer a Dental Preferred Provider Organization (DPPO) plan that can be used anywhere in the world. Waiting periods apply only for Major Restorative Care. Coinsurance rates are the same, whether you use an in-network or an out-of-network provider. Our international dental plan provides worldwide coverage. However, it pays at a higher coinsurance rate when services are rendered outside the U.S. than in the U.S. Overseas services are not subject to a fee schedule or out-of-network penalties.
Members of Household Health Insurance	**AFSPA** offers several medical plans for Members of Household, which include domestic partners, parents and dependent children over age 26 who do not qualify for coverage under the Federal Employees Health Benefits Program. These policies offer a choice of deductibles and medical coverages. Separate coverage applies for treatment received inside the U.S. and Canada**.**
Group Disability Income Protection Insurance	Our Disability Plan fills in a particular gap in coverage when you are unable to work for a long period of time due to an illness or an injury, but are not permanently disabled. Consider buying this Plan if you are a newly hired employee, do not have a substantial amount of sick leave, or just want some extra protection.
Group Term Life Insurance	Coverage is available up to $600,000. This policy can be purchased as your main source of protection or to supplement any existing coverage. It includes benefits for loss due to acts of war or terrorism. There are no exclusions. Members can keep this policy in the event they leave government service. Family coverage is available also.
Group Accidental Death & Dismemberment Insurance	This plan provides protection up to $600,000 against accidental injuries or death anywhere in the world. It includes a Home Alteration and Vehicle Modification Benefit of 10% of the principal amount or $10,000. The policy includes benefits for loss due to acts of terrorism.
Immediate Benefit Plan	**AFSPA** offers a term life insurance plan that is available to employees of selected agencies to cover immediate expenses, such as mortgage payments, funeral expenses and final medical costs upon the death of a loved one. • A benefit of $15,000 ($7,500 at age 70) paid to the beneficiary, generally within two business days upon **AFSPA's** receipt of notification of employee's death. • No medical questions to answer when enrolling during a qualifying event (new hire, open enrollment period, or first overseas assignment).

Non-FEHB benefits - continued on next page

Long Term Care Planning	**AFSPA** has been sponsoring long term care plans since 1990 as we believe strongly that this coverage can be a very important part of an individual's portfolio. One plan does not fit all, so as long term care products have evolved, we enhanced our long term care offerings. Our broker, Signature Financial Partners LLC, assists members with finding a long term care plan that best suits their needs.
Tax Consultation Services	Beers, Hamerman & Company, P.C., offers services from a group of five CPA tax accountants with at least 10 years of accounting experience. They offer: • A complimentary 20-minute consultation to **AFSPA** members and retirees who have tax questions. • A 10% discount on standard hourly rates. • A dedicated secure e-mail address for members to ask their questions. Prior to services being rendered, they will issue a letter of understanding.
Financial Planning	**AFSPA** recognizes the importance of financial planning for the future. There is not a magic formula or set of criteria that works for all members. We offer several financial planning options with knowledgeable advisors to help navigate the overwhelming amount of information pertaining to planning for the future. Knowledge/education is the key to financial planning.
Travel Insurance	This plan offers emergency medical evacuation, on-the-spot emergency medical payments, worldwide medical referrals, medical monitoring, prescription replacement assistance and repatriation of remains benefits. Annual and per trip coverage is available. As a member of **AFSPA**, you will receive a 10% discount.
Legal Services	To help our members find the appropriate representation and advice, **AFSPA** has arranged for several Washington, D.C. metropolitan area law firms to provide advice on wills, power of attorney, family law, real estate transactions, taxes, personal injury and business planning at a discounted rate.
Discount on Non-Covered Prescription Drugs	You may purchase non-covered (off-plan) prescription drugs at a discount directly from the Express Scripts Pharmacy^{SM} such as: • Dermatologicals (Renova) • Rx vitamins • Erectile dysfunction agents • Drugs labeled for cosmetic indications (Propecia) You pay 100% of the discounted price. You cannot file a claim for off-plan prescriptions. • Call the Pharmacy first at 1-800-818-6717 to find out the price of off-plan prescriptions. • Obtain a prescription from your prescriber, complete a home delivery form and enclose the prescription with your check or credit card number. Include full payment with your order. Note: This program is available only to members of the **Foreign Service Benefit Plan**.

Non-FEHB benefits - continued on next page

Weight Watchers Online Discount Program	Plan members can receive $10 off a 3-month subscription to Weight Watchers Online. Members will get Weight Watchers Online for only $55.00 (less than $5 per week). To learn more, visit www.AFSPA.org/FSBP and select "My Online Services" (MOS). Once you log on to MOS, select "Wellness Tools" and then "Discount Programs" to locate the Weight Watchers Program information. Click on the link to sign up using the online form. Click “Enter Promotion Code” and enter code 8-334-791-17805 in the promotion code box and click “Apply Code”. Follow the remaining steps for setting up your account. Note: This program is available only to members of the **Foreign Service Benefit Plan**.
EyeMed Vision Care Program	Save up to 40% with your EyeMed Vision Care discount program on exams, glasses and contact lenses. Members have access to over 33,000 providers nationwide, including optometrists, ophthalmologists, opticians and leading optical retailers such as LensCrafters, participating Pearle Vision and Sears Optical locations, Target Optical, JCPenney Optical and many independents. For more information concerning the program or to locate a participating provider, visit the Plan's website at www.AFSPA.org/FSBP and select "My Online Services" (MOS). Once you log on to MOS, select "Wellness Tools" and then "Discount Programs" or call us at 202-833-4910. Note: For members who reside overseas, plan to take advantage of this program when you are in the United States. Note: This program is available only to members of the **Foreign Service Benefit Plan**.
QualSight LASIK	QualSight LASIK brings members savings of 40% to 50% off the overall national average price for Traditional LASIK. QualSight's network of the nation's most experienced LASIK surgeons has collectively performed over 2.5 million procedures. Choose from over 800 locations nationwide for your free LASIK consultation to find out if you are a candidate for this procedure. Flexible financing options and Lifetime Assurance plans are available. To locate a provider near you, call 1-877-213-3937 or visit www.QualSight.com/-Coventry. To learn more, visit www.AFSPA.org/FSBP and select "My Online Services" (MOS). Once you log on to MOS, select "Wellness Tools" and then "Discount Programs" or call us at 202-833-4910. Note: For members who reside overseas, plan to take advantage of this program when you are in the United States. Note: This program is available only to members of the **Foreign Service Benefit Plan**.

Non FEHB benefits - continued on next page

GlobalFit®

GlobalFit®

You can save on gym memberships and brand-name home fitness and nutrition products with services provided by GlobalFit®, a comprehensive provider of gyms and programs supporting members' healthy lifestyles.

When you join a gym in the GlobalFit network you get:

- Access to thousands of gyms in the United States including national chains and independent local facilities
- Free guest passes* to try gyms before you join
- Guaranteed lowest rates** on gym memberships
- Flexible membership options
- Convenient billing options through your major credit card or bank account
- Use of gyms for your spouse or domestic partner and your dependent children
- Guest privileges*** at participating network gyms when you travel
- Transfer of your membership*** to another participating gym or another person

You can also get discounts on the following through GlobalFit:

- At-home weight loss programs
- Home exercise products and equipment
- One-on-one health coaching services**** to quit smoking, lower stress, lose weight and more

For more information concerning the GlobalFit offering, details about any gym, gym rates, and to join a gym online, visit the Plan's web site at www.AFSPA.org/FSBP and select "My Online Services" (MOS). Once you log on to MOS, select "Wellness tools" and then "Discount Programs". You can also call GlobalFit toll free at **1-800-298-7800.** A GlobalFit representative can answer your questions, send you a free guest pass*, or help you join the gym of your choice. You may pay a one-time activation fee. Check with GlobalFit for details.

* Not available at all gyms

** Participation in GlobalFit is for new gym members only. If you belong to a gym now or belonged recently, you should call GlobalFit to see if a discount applies.

*** Call GlobalFit for more information.

**** Provided by HealthAdvocate, through GlobalFit.

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

FSAFEDS Paperless Reimbursement Option

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

FSAFEDS Paperless Reimbursement Option continued on next page

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

Note: You must enroll in paperless reimbursement with FSAFEDS to take advantage of this option.

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

American Foreign Service **Protective Association**

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

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

For the **Protective Association**
E-mail: AFSPA@AFSPA.org website: www.AFSPA.org

For the **FOREIGN SERVICE BENEFIT PLAN**
E-mail: Health@AFSPA.org website: www.AFSPA.org/FSBP

Section 6. General exclusions – services, drugs and supplies we do not cover

The exclusions in this Section apply to all benefits. There may be other exclusions and limitations listed in Section 5 of this brochure. **Although we may list a specific service as a benefit, we will not cover it unless we determine it is medically necessary to prevent, diagnose, or treat your illness, disease, injury, or condition.** The fact that a covered provider has prescribed, recommended or approved a service or supply does not make it medically necessary or eligible for coverage under this Plan. For information on obtaining prior approval for high end radiology procedures, chemotherapy/radiation therapies, home health care, transgender surgical services (gender reassignment surgery), transplants, skilled nursing facility admissions, mental health and substance abuse treatment, and certain prescription drugs see Section 3, *You need prior Plan approval for certain services*.

We do not cover the following:

- Services, drugs, or supplies you receive while you are not enrolled in this Plan.
- Services, drugs, or supplies that are not medically necessary.
- Services, drugs, or supplies not required according to accepted standards of medical, dental, or psychiatric practice.
- Experimental or investigational procedures, treatments, drugs or devices.
- Services, drugs, or supplies related to clinical trials as follows: Extra care costs related to taking part in a clinical trial such as additional tests that a patient may need as part of the trial, but not as part of the patient's routine care. This Plan does not cover these costs; and research costs related to conducting the clinical trial such as research physician and nurse time, analysis of results, and clinical tests performed only for research purposes. These costs are generally covered by the clinical trials. This Plan does not cover these costs.
- Services, drugs, or supplies related to abortions, except when the life of the mother would be endangered if the fetus were carried to term, or when the pregnancy is the result of an act of rape or incest.
- Services, drugs, or supplies related to impotency, sexual dysfunction or sexual inadequacy.
- Services, drugs, or supplies you receive from a provider or facility barred from the FEHB Program.
- Any part of a provider's fee or charge ordinarily due from you that has been waived. If a provider routinely waives (does not require you to pay) a deductible, copayment or coinsurance, we will calculate the actual provider fee or charge by reducing the fee or charge by the amount waived.
- Charges which the enrollee or the Plan have no legal obligation to pay, such as excess charges for an annuitant 65 or older who is not covered by Medicare Parts A and/or B (see Section 9), doctor's charges exceeding the amount specified by the Department of Health and Human Services when benefits are payable under Medicare (limiting charge, see Section 9), preventable medical errors ("Never Events") as defined by Medicare that Medicare states you are not liable for, or State premium taxes however applied.
- Services, drugs, or supplies you receive without charge while in active military service.
- Services, drugs, or supplies for which no charge would be made if the covered individual had no health insurance coverage.
- Services and supplies not recommended or approved by a covered provider.
- Services for cosmetic purposes.
- Services, drugs, or supplies related to weight control or any treatment of obesity except as described in Sections 5(a), *Medical services and supplies* and 5(f), *Prescription drug benefits* and except surgery for morbid obesity as described in Section 5(b), *Surgical and anesthesia services*.
- Services, drugs, or supplies furnished or billed by a noncovered facility, except that medically necessary prescription drugs and physical, speech, and occupational therapy rendered by a qualified professional therapist on an outpatient basis are covered, subject to Plan limits.
- Services, drugs, or supplies furnished by yourself, immediate relatives, or household members, such as spouse, parents, children, brothers, or sisters by blood, marriage, or adoption.
- Services, drugs, or supplies not specifically listed as covered.
- Charges that we determine are over our Plan allowance.

Listed below are examples of some of our exclusions:

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

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

Section 7. Filing a claim for covered services

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

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

How to claim benefits

To obtain claim forms, visit our website at www.AFSPA.org/FSBP. To obtain claims filing advice or answers about our benefits, contact us by e-mail through our secure Member Portal at www.myafspa.org. You may submit your claims through the Member Portal also. Login to the Member Portal with your username and password. In addition, you may contact us by phone at 202-833-4910 (members) or 202-833-5751 (health care providers), by fax at 202-833-4918, or by mail at the **Foreign Service Benefit Plan**, 1716 N Street, NW, Washington, DC 20036-2902.

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

When you must file a claim – such as for out-of-network providers or when another group health plan is primary – submit it on the CMS-1500 or a claim form that includes the information shown below. Claims from foreign providers do not need to be filed on a CMS-1500 (see *Overseas Claims* on next page). Bills and receipts should be itemized and show:

- Patient's name, date of birth, address, phone number and relationship to enrollee
- Patient's Plan identification number
- Name, address, and tax identification number of the person or company providing the services or supplies. We do not need the tax identification number for providers outside the United States.
- Dates that services or supplies were furnished
- Diagnosis
- Type of each service or supply
- Charge for each service or supply
- Valid medical or ADA dental code or description of each service or supply

Note: If you paid for the services, we may ask you for proof of payment in the form of your receipt of payment or provider proof of payment stamp.

Note: Canceled checks, cash register receipts, or balance due statements are not acceptable substitutes for itemized bills. In addition, the Plan cannot accept a claim from you as an e-mail attachment. You may submit claims as described above through our secure Member Portal.

In addition:

- Generally, you need to fill out only one claim form per year. You should fill out a claim form if you submit a claim due to accidental injury, you have changed your address, or if the member's other insurance/Medicare status has changed.
- If another health plan is your primary payor, you must send a copy of the explanation of benefits (EOB) form you received from your primary payor (such as the Medicare Summary Notice (MSN)) with your claim.
- Bills for private duty nursing care must show that the nurse is a Registered Nurse (R.N.) or Licensed Practical Nurse (L.P.N.). You also should include the initial history and physical, treatment plan indicating expected duration and frequency from your attending physician or other health care professional 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 dental services must include a copy of the dentist's itemized bill (including the information required on the previous page) and the dentist's Federal Tax ID Number. We do not have separate dental claim forms.
- We will provide translation and currency conversion services for claims for overseas (foreign) services. See *Overseas Claims* below.

Post-service claims procedures

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

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

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

Records

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

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

Deadline for filing your claim

Send us all of the documents for your claim as soon as possible. You must submit the claim within 2 years from the date you incur the expense. If you could not file on time because of Government administrative operations or legal incapacity, you must submit your claim as soon as reasonably possible. Once we pay benefits, there is a three-year limitation on the reissuance of uncashed checks.

Overseas Claims

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

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

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

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

We use the following methods to process your foreign claims:

- We will translate your claim, if you do not provide a translation.
- We will use the U.S. dollar exchange rate applicable on the date the claim was processed, if you do not supply us with a currency exchange rate. There are exceptions, such as:
  - If you provide us with only one currency exchange rate and your claim covers multiple dates of service, the currency exchange rate you provided will be applied for all dates of service. For the most accurate currency conversion, please provide us a receipt with the date the bill was paid, the amount you paid, and the exchange rate used if available.
  - If you receive services from a provider who is part of our Direct Billing Arrangements, we will use the exchange rate on the date the claim is processed or pay according to our Direct Billing Arrangements.
  - Generally, you do not pay a provider in our Direct Billing Arrangement. We must reimburse the provider directly for any covered expenses. You are responsible, however, for any deductible and coinsurance, which we do not reimburse.

- If you have paid a direct billing provider prior to your claim submission, we request that you provide us with a copy of your receipt along with the exchange rate you used to convert the currency.

We have **special direct billing arrangements** with hospitals in several countries, including China, Colombia, France, Germany, Great Britain, Italy, Japan, Korea, Panama, Russia, Switzerland and Turkey. In addition, overseas Seventh-day Adventist Hospitals and Clinics participate in our special billing arrangement. Please see our website (www.AFSPA.org/FSBP) for the most up-to-date information.

The Plan provides a secure electronic method for you to submit claims to us via the Internet. Visit our secure Member Portal (www.myafspa.org), enter your username and password and click "Sign In". Once inside the portal, scroll down to the Foreign Service Benefit Plan section. Click on the "Secure Docs" tab on the right and select "Submit A Claim". Follow the screen prompts to upload your PDF claim documents. You have the options to include questions or comments and send your secure claims to a specific customer service representative. Although we designed this secure process to eliminate the lengthy mail time from your post outside the United States to our office, members in the United States use this process also. In addition, you may correspond with us via secure e-mail through this process or you may fax your claims from overseas. Our secure fax number is 202-464-4508.

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

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

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

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

When we need more information

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

Authorized Representative

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

Notice Requirements

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

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

Section 8. The disputed claims process

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

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

To help you prepare your appeal, you may arrange with us to review and copy, free of charge, all relevant materials and Plan documents under our control relating to your claim, including those that involve any expert review(s) of your claim. To make your request, please contact our Customer Service Department by writing Foreign Service Benefit Plan, 1716 N Street, NW, Washington, DC 20036 or calling (202) 833-4910.

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

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

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

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

Step	Description
1	Ask us in writing to reconsider our initial decision. You must: a) Write to us within 6 months from the date of our decision; and b) Send your request to us at: **Foreign Service Benefit Plan**, 1716 N Street, NW, Washington, DC 20036-2902; and c) Include a statement about why you believe our initial decision was wrong, based on specific benefit provisions in this brochure; and d) Include copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms. e) Include your email address (optional for member), if you would like to receive our decision via email. Please note that by giving us your email, we may be able to provide our decision more quickly. We will provide you, free of charge and in a timely manner, with any new or additional evidence considered, relied upon, or generated by us or at our direction in connection with your claim and any new rationale for our claim decision. We will provide you with this information sufficiently in advance of the date that we are required to provide you with our reconsideration decision to allow you a reasonable opportunity to respond to us before that date. However, our failure to provide you with new evidence or rationale in sufficient time to allow you to timely respond shall not invalidate our decision on reconsideration. You may respond to that new evidence or rationale at the OPM review stage described in step 4.

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

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

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

Section 9. Coordinating benefits with Medicare and other coverage

When you have other health coverage

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

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

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

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

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

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

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

- **TRICARE and CHAMPVA**

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

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

- **Workers' Compensation**

We do not cover services that:

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

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

- **Medicaid**

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

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

When other Government agencies are responsible for your care

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

When others are responsible for injuries

Our subrogation and reimbursement rights are both a condition of, and a limitation on, the payments that you (the enrollee or any covered family member) are eligible to receive for benefits.

If you receive (or are entitled to) a monetary recovery from any source as the result of an accidental injury or illness, you are required to reimburse us out of that recovery for any and all of our benefits paid to diagnose and treat that illness or injury. Additionally, if your representatives (heirs, estate, administrators, legal representatives, successors, or assignees) receive (or are entitled to) a monetary recovery from any source as a result of an accidental injury or illness to you, they are required to reimburse us out of that recovery. This is known as our reimbursement right.

We may also, at our option, pursue recovery on your behalf, which includes the right to file suit and make claims in your name, and to obtain reimbursement directly from the responsible party, liability insurer, first party insurer, or benefit program. This is known as our subrogation right.

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

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

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

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

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

We enforce our reimbursement right by asserting a first priority lien against any and all recoveries you receive by court order or out-of-court settlement, insurance or benefit program claims, or otherwise, regardless of whether medical benefits are specifically designated in the recovery and without regard to how it is characterized, for example as "pain and suffering."

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

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

You further agree to cooperate fully with us in the event we exercise our subrogation right.

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

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

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

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

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

Clinical trials

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

If you are a participant in a clinical trial, this health plan will cover related care costs only as follows, if they are not provided by the clinical trial:

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

When you have Medicare

- **What is Medicare?**

Medicare is a health insurance program for:

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

Medicare has four parts:

- Part A (Hospital Insurance). Most people do not have to pay for Part A. If you or your spouse worked for at least 10 years in Medicare-covered employment, you should be able to qualify for premium-free Part A insurance. (If you were a Federal employee at any time both before and during January 1983, you will receive credit for your Federal employment before January 1983.) Otherwise, if you are age 65 or older, you may be able to buy it. Contact 1-800-MEDICARE (1-800-633-4227), (TTY: 1-877-486-2048) for more information.
- Part B (Medical Insurance). Most people pay monthly for Part B. Generally, Part B premiums are withheld from your monthly Social Security check or your retirement check.
- Part C (Medicare Advantage). You can enroll in a Medicare Advantage plan to get your Medicare benefits. Please review the information on coordinating benefits with Medicare Advantage plans on page 102.
- Part D (Medicare prescription drug coverage). There is a monthly premium for Part D coverage. 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. For people with limited income and resources, extra help in paying for a Medicare prescription drug plan is available. For more information about this extra help, visit the Social Security Administration online at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY: 1-800-325-0778).

- **Should I enroll in Medicare?**

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

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

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

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

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

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

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

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

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

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

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

Claims process when you have the Original Medicare Plan – Send us a copy of your Medicare Card when we are secondary to Medicare. We need this information in order to start electronic crossover of your claims. Electronic crossover is a process that assures, in most cases, you do not have to file a claim when Medicare is primary. Call us at 202-833-4910 or contact us through our secure Member Portal at www.myafspa.org. Login to the Member Portal with your username and password to find out if your claims are being electronically filed or you have questions about the process described on the next page. You probably will not need to file a claim form when you have both our Plan and the Original Medicare Plan.

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

When Original Medicare is the primary payor, Medicare processes your claim first. In most cases, we will coordinate your claim automatically and provide secondary benefits for covered charges. There are exceptions:

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

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

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

- **Tell us about your Medicare coverage**

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

- **Private contract with your physician**

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

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

- **Medicare Advantage (Part C)**

  If you are eligible for Medicare, you may choose to enroll in and get your Medicare benefits from a Medicare Advantage plan. These are private health care choices (like HMOs and regional PPOs) in some areas of the country.

  To learn more about Medicare Advantage plans, contact Medicare at 1-800-MEDICARE (1-800-633-4227), (TTY: 1-877-486-2048) or at their website, www.medicare.gov.

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

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

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

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

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

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

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

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

Generally, this Plan is primary if you receive services or incur charges outside the 50 United States. However, in certain limited situations, Medicare may be primary for certain types of healthcare services you receive.

See Medicare publication 11037 found at: http://www.medicare.gov/Pubs/pdf/11037.pdf for details.

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

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

If you:

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

Then, for your inpatient hospital care:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Section 10. Definitions of terms we use in this brochure

Admission

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

Assignment

You authorize us to issue payment of benefits directly to the provider of services. The Plan reserves the right to pay the member directly for all covered services.

Calendar year

January 1 through December 31 of the same year. For new enrollees, the calendar year begins on the effective date of their enrollment and ends on December 31 of the same year.

Cardiac rehabilitation

A comprehensive exercise, education, and behavioral modification program designed to improve the physical and emotional condition of patients with heart disease. Heart attack survivors, bypass and angioplasty patients, cardiac valvular surgery patients, and individuals with angina, congestive heart failure, and heart transplants are all candidates for a cardiac rehabilitation program. Cardiac rehabilitation is prescribed to control symptoms, improve exercise tolerance, and improve the overall quality of life in these patients.

Clinical trials cost categories

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

If you are a participant in a clinical trial, this health Plan will cover related care costs as follows, if they are not provided by the clinical trial:

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

Coinsurance

The percentage of our allowance that you must pay for your care. You also may be responsible for additional amounts. See Section 4, *Coinsurance*.

Copayment

A fixed amount of money you pay to the provider when you receive covered services. See Section 4, *Copayment*.

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 Section 4, *Deductible*.

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.

Health care professional

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

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.

Medical Foods

The term medical food, as defined in Section 5(b) of the Orphan Drug Act (21 U.S.C. 360ee (b)(3)), is "a food which is formulated to be consumed or administered enterally under the supervision of a physician and which is intended for the specific dietary management of a disease or condition for which distinctive nutritional requirements, based on recognized scientific principles, are established by medical evaluation." In general, to be considered a medical food, a product must, at a minimum, meet the following criteria: the product must be a food for oral or tube feeding; the product must be labeled for the dietary management of a specific medical disorder, disease, or condition for which there are distinctive nutritional requirements; and the product must be intended to be used under medical supervision.

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.

Observation Care

Observation care is a well-defined set of specific, clinically appropriate services, which include ongoing short term treatment, assessment, and reassessment, that are provided while a decision is being made regarding whether a patient will require further treatment as a hospital inpatient or whether a patient will be able to be discharged from the hospital. Observation services are commonly ordered for a patient who presents to the emergency room department and who then requires a significant period of treatment or monitoring in order to make a decision regarding their inpatient admission or discharge. Some hospitals will bill for observation room status (hourly) and hospital incidental services. See page 52 for more information.

This Plan uses National Standardized Criteria Sets and other recognized clinical guidelines in making determinations to evaluate the appropriateness of observation care services.

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:

In-network Providers – Our Plan allowance is a negotiated amount between the Plan and the provider. We base our coinsurance on this negotiated amount, and the provider has agreed to accept the negotiated amount as full payment for any covered services rendered. This applies to all benefits in Section 5 of this brochure.

Out-of-network Providers – Our Plan allowance is the lesser of: (1) the provider's billed charge; or (2) the Plan's out-of-network fee schedule amount. The Plan's out-of-network fee schedule amount is equal to the 90th percentile amount for the charges listed in the Prevailing Healthcare Charges System, or the Medicare Data Resources System administered by Fair Health, Inc., if such a charge does not exist for the service or supply. The out-of-network fee schedule amounts vary by geographic area in which services are furnished. We base our coinsurance on this out-of-network fee schedule amount. This applies to all benefits in Section 5 of this brochure. For urine drug testing services, the out-of-network allowance is the maximum Medicare allowance for such services.

For certain services, exceptions may exist to the use of the out-of-network fee schedule to determine the Plan's allowance for out-of-network providers, including, but not limited to, the use of Medicare fee schedule amounts. For claims governed by the Omnibus Budget Reconciliation Act (OBRA) of 1990 and 1993, the Plan allowance will be based on Medicare allowable amounts as is required by law. For claims where the Plan is the secondary payer to Medicare (Medicare COB situations), the Plan allowance is the Medicare allowable charge.

Other Participating Providers – Our Plan allowance is the amount that the provider has negotiated and agreed to accept for the services and/or supplies. Benefits will be paid at out-of-network benefit levels, subject to any applicable deductibles, coinsurance, and copayments. This applies to all benefits in Section 5 of this brochure.

Providers outside the 50 United States – We generally do not reduce claims from providers outside the 50 United States to a Plan allowance, that is, our Plan allowance is the amount billed by the provider or as part of our Direct Billing Arrangements. However, we reserve the right to request information from you or your provider that will enable us to determine medical necessity or an allowance on charges that we deem to be excessive. Our Plan allowance for air ambulance transport that initiates outside the 50 United States to the nearest medical facility equipped to handle your medical condition will be based on criteria provided to us from On Call International.

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

Post-service claims

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

Pre-service claims

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

Providers outside the 50 United States

We consider treatment or services rendered by providers not located in the 50 United States including the District of Columbia to be outside the 50 United States.

Routine preventive services/ immunizations

Preventive services:

- We cover preventive services that have a rating of "A" or "B" from the United States Preventive Services Task Force (USPSTF) under the appropriate benefit without cost sharing when delivered by an in-network provider or provider outside the 50 United States. For a complete list, see http://www.uspreventiveservicestaskforce.org/uspstf/uspsabrecs.htm.

Immunizations:

- We cover routine adult immunizations. See: http://www.cdc.gov/vaccines/schedules/index.html.
- We cover routine childhood and adolescent immunizations. See: http://www2.aap.org/immunization/IZSchedule.html.

Routine testing/ screening

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

Urgent care claims

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

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

Urgent care claims usually involve pre-service claims and not post-service claims. We will judge whether a claim is an urgent care claim by applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine. If you believe your claim qualifies as an urgent care claim, please contact the Plan through our Customer Service Department at the **Foreign Service Benefit Plan**, 1716 N Street, NW, Washington, DC 20036-2902, by phone at 202-833-4910, fax at 202-833-4918, or e-mail through our secure Member Portal at www.myafspa.org. Login to the Member Portal with your username and password. You may also prove that your claim is an urgent care claim by providing evidence that a physician with knowledge of your medical condition has determined that your claim involves urgent care.

Us/We

Us and We refer to the **Foreign Service Benefit Plan**.

You

You refers to the enrollee and each covered family member.

Section 11. Other Federal Programs

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

Important information about three Federal programs that complement the FEHB Program

First, the **Federal Flexible Spending Account Program**, also known as FSAFEDS, lets you set aside pre-tax money from your salary to reimburse you for eligible dependent care and/or health care expenses. You pay less in taxes so you save money. Participating employees save an average of about 30% on products and services they 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 $100. The maximum annual election for a health care flexible spending account (HCFSA) or a limited expense health care spending account (LEX HCFSA) is $2,500 per person. The maximum annual election for a dependent care flexible spending account (DCFSA) is $5,000 per household.

- Health Care FSA (HCFSA) – Reimburses you for eligible out-of-pocket health care expenses (such as copayments, deductibles, **physician prescribed** over-the-counter drugs and medications, vision and dental expenses, and much more) for you and your tax dependents, including adult children (through the end of the calendar year in which they turn 26).

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

- 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 out-of-pocket dental and vision care expenses for you and your tax dependents including adult children (through the end of the calendar year in which they turn 26).
- Dependent Care FSA (DCFSA) – Reimburses you for eligible non-medical day care expenses for your children under age 13 and/or for any person you claim as a dependent on your Federal Income Tax return who is mentally or physically incapable of self-care. You (and your spouse if married) must be working, looking for work (income must be earned during the year), or attending school full-time to be eligible for a DCFSA.
- If you are a new or newly eligible employee you have 60 days from your hire date to enroll in an HCFSA or LEX HCFSA and/or DCFSA, but you must enroll before October 1. If you are hired or become eligible on or after October 1 you must wait and enroll during the Federal Benefits Open Season held each fall.

Where can I get more information about FSAFEDS?	Visit www.FSAFEDS.com or call an FSAFEDS Benefits Counselor toll-free at 1-877-FSAFEDS (1-877-372-3337), Monday through Friday 9 a.m. until 9 p.m., Eastern Time. TTY: 1-800-952-0450.

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

Important Information	The Federal Employees Dental and Vision Insurance Program (FEDVIP) is separate and different from the FEHB Program. **This Program provides comprehensive dental and vision insurance at competitive group rates with no pre-existing condition limitations for enrollment.** FEDVIP is available to eligible Federal and Postal Service employees, retirees, and their eligible family members on an enrollee-pay-all basis. Employee premiums are withheld from salary on a pre-tax basis.
Dental Insurance	All dental plans provide a comprehensive range of services, including: • Class A (Basic) services, which include oral examinations, prophylaxis, diagnostic evaluations, sealants, and x-rays. • Class B (Intermediate) services, which include restorative procedures such as fillings, prefabricated stainless steel crowns, periodontal scaling, tooth extractions, and denture adjustments. • Class C (Major) services, which include endodontic services such as root canals, periodontal services such as gingivectomy, major restorative services such as crowns, oral surgery, bridges, and prosthodontic services such as complete dentures. • Class D (Orthodontic) services with up to a 12-month waiting period. **Most FEDVIP dental plans cover adult orthodontia. Review your FEDVIP dental plan's brochure for information on this benefit.**
Vision Insurance	All vision plans provide comprehensive eye examinations and coverage for lenses, frames and contact lenses. Other benefits such as discounts on LASIK surgery also may be available.
Additional information	You can find a comparison of the plans available and their premiums on the OPM website at www.opm.gov/dental and www.opm.gov/vision. These sites also provide links to each plan's website, where you can view detailed information about benefits and preferred providers.
How do I enroll?	You enroll on the Internet at www.BENEFEDS.com. For those without access to a computer, call 1-877-888-3337 (TTY: 1-877-889-5680).

The Federal Long Term Care Insurance Program – *FLTCIP*

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

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 - 2015

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

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

Below, an asterisk (*) means the item is subject to the $250 calendar year deductible for in-network providers and providers outside the 50 United States or $300 for out-of-network providers. And, after we pay, you generally pay any difference between our allowance and the billed amount if you use an out-of-network 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	In-network: 10% of our allowance* Out-of-network: 30% of our allowance and any difference between our allowance and the billed amount* Providers outside the 50 United States: 10% of our allowance*	27-28
Surgical and Anesthesia Services provided by physicians:	In-network: 10% of the Plan allowance Out-of-network: 30% of the Plan allowance Providers outside the 50 United States: 10% of the Plan allowance	43-50
Services provided by a hospital:		
• Inpatient	In-network: Nothing Out-of-network: $200 per hospital stay and 20% of charges Providers outside the 50 United States: Nothing	52-53
• Outpatient	Surgical: In-network: 10% of our allowance* Out-of-network: 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: In-network: 10% of our allowance* Out-of-network: 30% of our allowance and any difference between our allowance and the billed amount* Providers outside the 50 United States: 10% of our allowance*	53

High Option Benefits	You pay	Page
Emergency benefits:		
• Accidental injury: emergency room charges (ER) or urgent care facility charges, ER, urgent care physicians' or other health care professional charges and ancillary services performed at the time of the initial ER visit or initial urgent care facility visit; **or** office visit and ancillary services performed at the time of the initial office visit	In-network: Nothing Out-of-network: Only the difference between our allowance and the billed amount Providers outside the 50 United States: Nothing	56-57
• Medical emergency	In-network: 10% of our allowance* Out-of-network: 10% of our allowance and any difference between our allowance and the billed amount* Providers outside the 50 United States: 10% of our allowance*	57
• Outpatient care in an urgent care facility because of a medical emergency	In-network: $35 copayment per occurrence Out-of-network: $35 copayment per occurrence and any difference between our allowance and the billed amount Providers outside the 50 United States: $35 copayment per occurrence	57
Mental health and substance abuse treatment:	In-network: Regular cost-sharing* Out-of-network: Regular cost-sharing* Providers outside the 50 United States: Regular cost-sharing*	59-60
Prescription drugs:		
• Retail pharmacy	Network pharmacies in the 50 United States: Note – You must show your Plan ID card: • Tier I (Generic Drug): $10 copay for up to a 30-day supply • Tier II (Preferred Brand Name Drug): 25% ($30 minimum) for up to a 30-day supply • Tier III (Non-Preferred Brand Name Drug): 30% ($50 minimum) for up to a 30-day supply • Tier IV (Specialty Drugs): 25% for up to a 30-day supply **(NOTE: See Section 5(f) for restrictions.)** Out-of-network pharmacies in the 50 United States: 100% and cannot claim reimbursement from the Plan (no coverage) Retail pharmacies outside of the 50 United States: 10% (claim reimbursement from the Plan)	67
• Network home delivery	Network home delivery through the Express Scripts Pharmacy℠: • Tier I (Generic Drug): $10 for up to a 90-day supply • Tier II (Preferred Brand Name Drug): $55 for up to a 90-day supply • Tier III (Non-Preferred Brand Name Drug): $70 for up to a 90-day supply • Tier IV (Specialty Drugs): 25% up to maximum of $150 for up to a 90-day supply	68

High Option Benefits	You pay	Page
Dental care:		
• Routine preventive care and surgical procedures	The difference between our scheduled allowances and the actual billed amounts	73
• Orthodontics	50% of our allowance up to $1,000 per course of treatment, per person and 100% after our maximum payment of $1,000	73
Special features:		
• Flexible benefits option • Electronic Funds Transfer (EFT) of claim reimbursements • Scanned claim submission via secure Internet connection • Electronic copies of Explanations of Benefits • 24-Hour Nurse Advice Line • 24-Hour Translation Line • Healthy Pregnancy Program • Mediterranean Wellness Program and Incentive • Health Risk Assessment and Wellness Incentive • Wellness Incentives	• Living Well Together (health coaching program) • Virtual Lifestyle Management • Case Management Program • Disease Management Programs • Pre-Diabetic Alert Program • Cancer Management Program • TherapEase Cuisine • My Online Services (Web based customer service) • Express Scripts (ESI) Prescription benefits (Web based customer service) • Institutes of Excellence for tissue and organ transplants • Overseas Second Opinion	74-82
Protection against catastrophic costs (out-of-pocket maximum):	In-network only: Nothing after $4,500/Self Only or $5,000/Self and Family enrollment per year (includes prescriptions purchased at a network retail pharmacy and through network home delivery) In- and out-of-network: Nothing after $6,000/Self Only or $6,500/Self and Family enrollment per year (includes prescriptions purchased at a network retail pharmacy and through network home delivery) Providers outside the 50 United States: Nothing after $4,500/Self Only or $5,000/Self and Family enrollment per year (includes prescriptions purchased outside the 50 United States and through network home delivery) Note: Benefit maximums still apply and some costs do not count toward this protection.	23

Notes

2015 Rate Information for the Foreign Service Benefit Plan

2015 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	$180.50	$ 60.17	$391.09	$130.36
High Option Self and Family	402	$444.75	$148.25	$963.62	$321.21