Foreign Service Benefit Plan

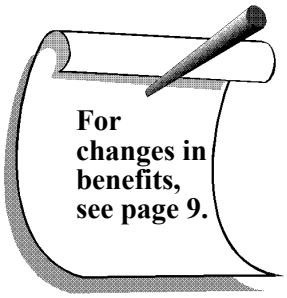
http://www.AFSPA.org/FSBP

AMERICAN FOREIGN SERVICE PROTECTIVE ASSOCIATION

FOREIGN SERVICE BENEFIT PLAN

2011

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



Sponsored and administered by: the American Foreign Service **Protective Association**

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

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

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

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

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

Enrollment codes for this Plan:

401 High Option - Self Only
402 High Option - Self and Family

The **Foreign Service Benefit Plan's** Health Utilization Review is accredited by the Utilization Review Accreditation Committee (URAC); and the Plan's Disease Management Program is accredited by URAC and the National Committee for Quality Assurance (NCQA). The Coventry Health Care National Network (the Plan's PPO network) is credentialed and recredentialed to NCQA's, URAC's and CMS's (Center for Medicare and Medicaid Services) standards. See the 2011 Guide for more information on accreditation.

The **Foreign Service Benefit Plan's** Pharmacy Benefit Manager (PBM), Medco Health Solutions, Inc., is accredited by URAC for PBM and Drug Therapy Management and the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) for Home Care Pharmacy Dispensing Services. See the 2011 Guide for more information on accreditation.

Authorized for distribution by the:

United States
Office of Personnel Management

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

Important Notice from the Foreign Service Benefit Plan About

Our Prescription Drug Coverage and Medicare

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

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

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

Please be advised

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

Medicare's Low Income Benefits

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

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

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

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Introduction

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

Foreign Service Benefit Plan

1716 N Street, NW

Washington, DC 20036-2902

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

Fax: 202-833-4918

E-mail:

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

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

If you are enrolled in this Plan, you are entitled to the benefits described in this brochure. If you are enrolled in Self and Family coverage, each eligible family member is also entitled to these benefits. You do not have a right to benefits that were available before January 1, 2011, unless those benefits are also shown in this brochure.

OPM negotiates benefits and rates with each plan annually. Benefit changes are effective January 1, 2011, and changes are summarized on page 9. Rates are shown on the back cover of this brochure.

Plain Language

All FEHB brochures are written in plain language to make them responsive, accessible, and understandable to the public. For instance,

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

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

Stop Health Care Fraud!

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

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

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

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

- Let only the appropriate medical professionals review your medical record or recommend services.
- Avoid using health care providers who say that an item or service is not usually covered, but they know how to bill us to get it paid.
- Carefully review explanations of benefits (EOBs) statements that you receive from us.
- Please review your claims history periodically for accuracy to ensure services are not being billed to your accounts that were never rendered.
- Do not ask your doctor to make false entries on certificates, bills or records in order to get us to pay for an item or service.
- If you suspect that a provider has charged you for services you did not receive, billed you twice for the same service, or misrepresented any information, do the following:

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

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

  If we do not resolve the issue:

CALL -- THE HEALTH CARE FRAUD HOTLINE

202-418-3300

OR WRITE TO:

United States Office of Personnel Management

Office of the Inspector General Fraud Hotline

1900 E Street, NW, Room 6400

Washington, DC 20415-1100

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

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

  Your child over age 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.
- You can be prosecuted for fraud and your agency may take action against you if you falsify a claim to obtain FEHB benefits or try to obtain services for someone who is not an eligible family member or if you are no longer enrolled in the Plan.
- 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.

Preventing Medical Mistakes

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

1. Ask questions if you have doubts or concerns.

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

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

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

3. Get the results of any test or procedure.

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

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

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

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

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

  "Exactly what will you be doing?"

  "About how long will it take?"

"What will happen after surgery?"

"How can I expect to feel during recovery?"

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

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 also to help choose quality health care providers and improve the quality of care you receive.
- www.npsf.org. The National Patient Safety Foundation has information on how to ensure safer health care for you and your family.
- www.talkaboutrx.org. The National Council on Patient Information and Education is dedicated to improving communication about the safe, appropriate use of medicines.
- www.leapfroggroup.org. The Leapfrog Group is active in promoting safe practices in hospital care.
- www.ahqa.org. The American Health Quality Association represents organizations and health care professionals working to improve patient safety.
- www.quic.gov/report/toc.htm. Find out what federal agencies are doing to identify threats to patient safety and help prevent mistakes in the nation's health care delivery system.

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

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

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

Questions regarding what protections apply and what protections do not apply to a grandfathered health plan, and what might cause a plan to change status from grandfathered to non-grandfathered may be directed to us at **Foreign Service Benefit Plan**, 1716 N Street, NW, Washington, DC 20036-2902, by phone at 202-833-4910, by fax at fax at 202 833-4918, or secure email at www.AFSPA.org/FSBP. You can also read additional information from the U.S. Department of Health and Human Services at www.healthcare.gov.

This plan is a "non-grandfathered health plan" under the Affordable Care Act. A non-grandfathered plan must meet immediate health care reforms legislated by the Act. Specifically, this plan must provide preventive services and screenings to you without any cost sharing; you may choose any available primary care provider for adult and pediatric care; visits for obstetrical or gynecological care do not require a referral; and emergency services, both in- and out-of-network, are essentially treated the same (i.e., the same cost sharing, no greater limits or requirements for one over the other; and no prior authorizations).

As a non-grandfathered health plan, this plan has also decided to follow the requirements that apply to grandfathered plans.

Questions regarding what protections apply may be directed to us at **Foreign Service Benefit Plan** using our contact information found in the Introduction section of this brochure. You can also read additional information from the U.S. Department of Health and Human Services at www.healthcare.gov.

General features of our High Option

We have a Preferred Provider Organization (PPO):

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

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

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

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

How we pay providers

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

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

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

We use InterQual criteria (a standardized, nationally recognized set of criteria, which are in common use among both hospital providers and insurance payors, that address criteria for appropriate levels of care and criteria for procedures, surgeries, and durable medical equipment) and other recognized clinical guidelines in making determinations regarding inpatient hospital, acute rehabilitation, residential treatment precertification, and also skilled nursing facility stays, extended stay reviews, observation stay reviews, and reviews of procedures and therapies that require preauthorization. (See *What you must do to get covered care* in Section 3.) 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, Foreign Claims), generally we will pay you.

Your Rights

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

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

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

Your medical and claims records are confidential

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

Section 2. How we change for 2011

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

Program-wide changes

- Several provisions of the Affordable Care Act (ACA) affect eligibility and benefits under the FEHB Program and FSAFEDS beginning January 1, 2011. For instance, children up to age 26 will be covered under a Self and Family enrollment. Please read the information in Sections 11 and 12 carefully.
- We have reorganized organ and tissue transplant benefit information to clarify coverage.
- The State of Oklahoma is a Medically Underserved Area.

Changes to this Plan

- Your share of the premium will increase for Self Only or increase for Self and Family. See back cover.
- The Plan has increased its catastrophic protection benefit maximum (see page 18).
- The Plan now includes coverage for facility and anesthesia charges at 100% (No deductible) for routine colonoscopy for PPO and providers outside the 50 United States (see page 27).
- The Plan has increased the Home health services benefit to 90% of the Plan allowance for PPO and providers outside the 50 United States and 70% of the Plan allowance for non-PPO providers for both preauthorized and non-preauthorized care (see page 36).
- The Plan has increased the Chiropractic benefit to $50 per visit (see page 37).
- The Plan has increased the Alternative benefit for acupuncture and massage therapy to $40 per visit (see page 38).
- The Plan has increased the Smoking cessation benefit (see page 38).
- The Plan has increased the Nutritional counseling benefit to $500 per person, per calendar year (see page 39).
- The Plan has increased the Diabetic Education or training benefit to $500 per person per calendar year (see page 39).
- The Plan has increased the Weight management benefit to $1,500 per person, per lifetime (see page 39).
- The Plan has expanded its list of covered transplants (see page 43).
- The Plan now includes testing for bone marrow/stem cell transplants for up to four donors (see page 46).
- The Plan has added categories of drugs to its list of prescriptions requiring prior authorization as a safety measure (see page 58).
- The Plan has enhanced its Diabetes Wellness Incentive and added a Coronary Artery Disease Incentive (see page 68).

Section 3. How you get care

Identification cards

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

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

Where you get covered care

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

- **Covered providers**

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

Medically underserved areas. Note: We cover any licensed medical practitioner for any covered service performed within the scope of that license in the states OPM determines are "medically underserved". For 2011, the states are: Alabama, Arizona, Idaho, Illinois, Kentucky, Louisiana, Mississippi, Missouri, Montana, New Mexico, North Dakota, Oklahoma, South Carolina, South Dakota, and Wyoming.

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

- **Nursing School Administered Clinic** — A clinic that is
  - Licensed or certified in the state where the services are performed; and
  - Provides ambulatory care in an outpatient setting – primarily in rural or inner city areas where there is a shortage of physicians. Services billed by these clinics are considered outpatient "office" services rather than facility charges.
- **Physician Assistant** — A person who is licensed, registered or certified in the state where services are performed.
- **Licensed Professional Counselor or Master's Level Counselor** — A person who is licensed, registered, or certified in the state where services are performed.
- **Licensed Physical Therapist** — A professional who is licensed or meets state requirements where the services are performed to provide physical therapy services.
- **Licensed Speech Therapist** — A professional who is licensed or meets state requirements where the services are performed to provide speech therapy services.
- **Licensed Occupational Therapist** — A professional who is licensed or meets state requirements where the services are performed to provide occupational therapy services.
- **Dietician —** A professional who, in states requiring licensure, certification or registration, is licensed, certified, or registered as a dietician where the services are performed.
- **Nutritionist —** A professional who, in states requiring licensure, certification or registration, is licensed, certified, or registered as a nutritionist where the services are performed.
- **Diabetic Educator** — A professional who, in states requiring licensure, certification or registration, is licensed, certified, or registered as a diabetic educator where the services are performed.
- **Audiologist** — A person who is licensed, certified, or registered in the state where services are performed.
- **Licensed Acupuncturist (L.Ac.)** — An individual who has completed the required schooling and licensure to perform acupuncture in the state where services are performed (see definition of acupuncture, page 38).
- **Massage Therapist** — An individual who has completed the required schooling and licensure or certification to perform massage therapy in the state where services are performed.

- **Covered facilities** Covered facilities include:
  - **Birthing Center** — A licensed facility that is equipped and operated solely to provide prenatal care, to perform uncomplicated spontaneous deliveries and to provide immediate postpartum care.
  - **Hospice Care Facility** — A facility providing hospice care services that is appropriately licensed or certified as such under the law of the jurisdiction in which it is located, and that:
    - Is certified (or is qualified and could be certified) under Medicare;
    - Is accredited by the Joint Commission on Accreditation of Healthcare Organizations;
    - Meets the standards established by the National Hospice Organization.
  - **Hospital**
    - An institution that is accredited as a hospital under the hospital accreditation program of the Joint Commission on Accreditation of Healthcare Organizations (JCAHO); or

- Any other institution that is operated pursuant to law, under the supervision of a staff of doctors and with 24-hour-a-day nursing services, and that is engaged primarily in providing: (a) General inpatient care and treatment of sick and injured persons through medical, diagnostic and major surgical facilities, all of which facilities must be provided on its premises or under its control; or (b) Specialized inpatient medical care and treatment of sick or injured persons through medical and diagnostic facilities (including X-ray and laboratory) on its premises, under its control, or through a written agreement with a hospital (as defined above) or with a specialized provider of those facilities.
- For inpatient and outpatient treatment of mental health and substance abuse, the term hospital also includes a free-standing residential treatment center facility approved by the JCAHO or the Commission for Accreditation of Rehabilitation Facilities (CARF).
- In no event shall the term hospital include a convalescent nursing home or institution or part thereof that: (a) Is used principally as a convalescent facility, rest facility, nursing facility or facility for the aged; (b) Furnishes primarily domiciliary or custodial care, including training in the routines of daily living; or (c) Is operated as a school.

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

What you must do to get covered care

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

- **Transitional care**

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

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

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

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

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

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

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

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

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

How to get approval for…

- **Your hospital stay**

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

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

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

- **How to precertify an admission**

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

- **Maternity care**

You do not need to precertify a maternity admission for a routine delivery. However, if your medical condition requires you to stay more than 48 hours after a vaginal delivery or 96 hours after a cesarean section, then your physician or the hospital must contact us for precertification of additional days. Further, if your baby stays after you are discharged, then your physician or the hospital must contact us within 2 business days for precertification of additional days for your baby.

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

If your hospital stay – including for maternity care – needs to be extended, you, your representative, your physician or the hospital must ask us to approve the additional days.

What happens when you do not follow the precertification rules

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

- If we determine that the stay was medically necessary, we will pay the inpatient charges, less the $500 penalty.
- If we determine that it was not medically necessary for you to be an inpatient, we will not pay inpatient hospital benefits. We will only pay for any covered medical supplies and services that are otherwise payable on an outpatient basis.

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

When we precertified the admission but you remained in the hospital beyond the number of days we approved and did not get the additional days precertified, then:

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

Exceptions: You do not need precertification in these cases:

- You are admitted to a hospital or residential treatment center outside the 50 United States. However, the Plan will review all services to establish medical necessity. We may request medical records in order to determine medical necessity.
- You have another group health insurance policy that is the primary 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. You, your representative, your doctor, or treating facility must call us at 1-800-593-2354 (except for prior authorization on prescription drugs – see below) before the admission or care, such as:

- High End Radiology procedures (CT Scan, PET Scan, MRI) (see page 26);
- Chemotherapy and radiation therapy (see page 31);
- Home health care (see page 36);
- Hospice care (see page 49);
- Organ/tissue transplants (see page 43);
- Skilled nursing facility admission (see page 49); and
- Mental health and substance abuse treatment (see page 53).
- Prescription drugs (see pages 56 and 60). Some medications are not covered unless you receive approval through a coverage review (prior authorization). This review uses Plan rules based on FDA-approved prescribing and safety information, clinical guidelines and uses that are considered reasonable, safe, and effective. To find out if your medication requires prior authorization, contact Medco Health Solutions, Inc. (Medco), the Plan's Pharmacy Benefit Manager at 1-800-818-6717 (TDD: 1-800-759-1089 for the hearing impaired).

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

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

Section 4. Your costs for covered services

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

Copayments

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

Example:

- When you purchase prescriptions from the Medco Pharmacy, you pay a copayment of $15 for generic, or $45 for single-source brand name, or $65 for multi-source brand name prescriptions.
- When you go in a non-PPO hospital, you pay $200 per person per hospital stay.

We do not reimburse you for copayments.

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

Cost-sharing

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

Deductible

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

The calendar year deductible is $300 per person. Under a family enrollment, the deductible is satisfied for all family members when the combined covered expenses applied to the calendar year deductible for family members reach $600. Expenses are "incurred" on the date on which the service or supply is received.

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

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

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

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

Coinsurance

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

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

If your provider routinely waives your cost

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

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

Waivers

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

Differences between our allowance and the bill

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

If you…

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

Then, for your inpatient hospital care,

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

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

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

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

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

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

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

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

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

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

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

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

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

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

High Option Benefits

See page 9 for how our benefits changed this year. Pages 101 - 103 are a benefits summary of our High Option.

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High Option Overview

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

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

The **High Option** offers unique features.

- Benefits available worldwide
- Providers' charges outside the 50 United States generally not subject to Plan allowance limitation
- Plan provides 100% coverage for covered inpatient hospital confinements in PPO network and outside the 50 United States
- Wellness and preventive care benefits for children and adults payable at 100% of Plan allowance with no deductible (PPO and outside the 50 United States)
- Special benefit (age and frequency limitations do not apply) available for colorectal cancer screenings and breast cancer screenings (mammogram) when familial or high risk factors indicate the need for them
- Maternity care benefit payable at 100% of Plan allowance with no deductible (PPO and outside the 50 United States)
- Alternative treatments benefits available for acupuncture, chiropractic and massage therapy
- Nutritional counseling and diabetic education benefits
- Diabetic wellness incentive
- Coronary Artery Disease wellness incentive
- Weight management program available under Educational classes and programs benefit
- Special overseas disease management benefit
- Special overseas second opinion benefit through e-Cleveland Clinic
- Orthodontic benefits available
- Plan provides translations and exchange rates
- Direct billing arrangements with hospitals in several foreign countries
- Web based customer service
  - *My Online Services* Web site allows members to view pending and finalized claims, print explanations of benefits (EOBs), search for providers participating in the Plan's PPO network, prepare a Personal Health Record and obtain quality information on providers and average costs of illnesses and procedures in the U.S.
  - Prescription management Web site allows members to refill and renew prescriptions, verify mail order status, review prescription histories, expenses and balances, locate participating Network pharmacies and compare Plan pricing and drug coverage information with lower cost, clinically appropriate alternatives.
- Secure method to submit claims to us via the Internet
  - Visit our Web site (www.AFSPA.org/FSBP), click on the "Ask AFSPA" tab and then click on "FSBP".
  - Attach a scanned copy (PDF) of your claim to an e-mail message you send to us.
  - Eliminate the lengthy mail time from your overseas post to our office.
  - Correspond with us via secure e-mail through this process.
  - Fax us your claims. Our special fax number is: 202-464-4508.

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

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- The calendar year deductible is: $300 per person ($600 per family). The calendar year deductible applies to almost all benefits in this Section. We added "(No deductible)" to show when the calendar year deductible does not apply.
- The non-PPO benefits are the standard benefits of this Plan. PPO benefits apply only when you use a PPO provider or when you use a provider outside the 50 United States. When no PPO provider is available in the PPO Network, non-PPO benefits apply.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost-sharing works, with special sections for members who are age 65 or over. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- **YOU MUST GET PREAUTHORIZATION FOR HIGH END RADIOLOGY PROCEDURES (CT SCAN, PET SCAN OR MRI).** Please refer to the preauthorization information shown in Section 3 for additional details on preauthorization and to this Section (*Lab, X-ray and other diagnostic tests*).
- **YOU MUST GET PREAUTHORIZATION FOR CHEMOTHERAPY AND RADIATION THERAPY.** Please refer to the preauthorization information shown in Section 3 for additional details on preauthorization and to this Section (*Treatment therapies*).

Benefits Description	You pay After the calendar year deductible...
Note: The calendar year deductible applies to almost all benefits in this Section. We say "(No deductible)" when it does not apply.	
Diagnostic and treatment Services	
• Professional services of physicians during a hospital stay, skilled nursing facility stay, in the physician's office, at home, or consultations (including video conferencing if performed when a member is hospitalized outside the United States) • Office consultation including second opinion • Psychological tests and pharmacological visits • Drugs and medical supplies billed by a physician	PPO: 10% of the Plan allowance Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount Providers outside the 50 United States: 10% of the Plan allowance
Not covered: • *Telephone consultations* • *Procedures, services, drugs, and supplies related to impotency, sex transformations, sexual dysfunction, or sexual inadequacy* • *Office visits by a dentist in relation to the removal of impacted teeth and other dental services. Office visits by a dentist in relation to covered oral and maxillofacial surgical procedures are covered.*	*All charges*

Benefits Description	You pay After the calendar year deductible...
Lab, X-ray and other diagnostic tests	
Tests, such as: • Blood tests • Urinalysis • Non-routine pap tests • Pathology • X-rays • Non-routine mammograms • CT Scan/PET Scan/MRI Note: Preauthorization is required for CT Scans, PET Scans and MRIs. See Section 3, *Other services*. • Ultrasound • Electrocardiogram and EEG • Hearing exam for non-auditory illness or disease • FDA recommended pharmacogenenetic testing to optimize prescription drug therapies used to treat certain conditions, such as: - For prevention of major adverse cardiovascular events (Plavix) - For breast cancer (Tamoxifen) - For prevention of blood clots (Warfarin) 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.	PPO: 10% of the Plan allowance Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount Providers outside the 50 United States: 10% of the Plan allowance
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, and EKG (electrocardiogram) per person, per calendar year Note: This includes a separate gynecological exam once per calendar year for women.	PPO: Nothing (No deductible) Providers outside the 50 United States: Nothing (No deductible)
One routine physical examination to include a history and physical, chest X-ray, urinalysis, blood tests such as general health panel basic or comprehensive metabolic panel test, CBC, and EKG (electrocardiogram) – limited to a maximum charge of $750 per person, per calendar year Note: This includes a separate gynecological exam once per calendar year for women.	Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount

Preventive care, adult - continued on next page

Benefits Description	You pay After the calendar year deductible...
Preventive care, adult (cont.)	
In addition Routine Cancer Screenings, limited to: • Colorectal Cancer Screening, limited to - Fecal occult blood test – one annually for members age 40 and older - Sigmoidoscopy, screening – one every five years for members age 50 and older - Colonoscopy, screening, including facility and anesthesia charges related to the colonoscopy exam – one every 10 years for members age 50 and older - Double Contrast Barium Enema (DCBE) – one every five years for members age 50 and older Note: Age and frequency limitations do not apply if there is a family history or high risk factor that indicates the need for screenings. • Breast Cancer Screening (Mammogram) – one annually for women age 35 and older Note: Age and frequency limitations do not apply if there is a family history or high risk factor that indicates the need for the screening. • Cervical Cancer Screening - Pap smear – once per calendar year for women • Prostate Cancer Screening - Prostate Specific Antigen (PSA) – one annually for men age 40 and older Other Routine Services, limited to: • Non-fasting total blood cholesterol test – once every three consecutive calendar years • One-time ultrasonography for abdominal aortic aneurysm screening for males between the ages of 65 to 75 who have smoked • Annual chlamydial screening • Fasting lipoprotein profile test – one every five years for members age 20 and older • Annual osteoporosis routine screening for members age 60 and older	PPO: Nothing (No deductible) Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount Providers outside the 50 United States: Nothing (No deductible)
Adult routine immunizations (including administration) endorsed by the Centers for Disease Control and Prevention (CDC) per their Recommended Adult Immunization Schedule by Vaccine and Age Group. Note: The Plan has no age limitations on Influenza, Pneumococcal, Human Papillomavirus (HPV) and Zostavax (Shingles) vaccines. Note: These benefits do not apply to children under age 22 (See *Preventive care, children*).	PPO: Nothing (No deductible) Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount Providers outside the 50 United States: Nothing (No deductible)

Benefits Description	You pay After the calendar year deductible...
Preventive care, children	
Immunizations for children (including administration) are limited to: • Childhood immunizations recommended by the American Academy of Pediatrics are covered for members under age 22.	PPO: Nothing (No deductible) Non-PPO: Only the difference between our allowance and the billed amount (No deductible) Providers outside the 50 United States: Nothing (No deductible)
Preventive care for children is limited to: • All healthy newborn visits including routine screening (inpatient or outpatient) • Retinal screening exam performed by an ophthalmologist for infants with low birth weight, less than 1 year of age and with an unstable clinical course • Screening, testing, diagnosis and treatment (including hearing aids) for hearing loss • Body Mass Index measurements beginning at age 24 months • The following routine services as recommended by the American Academy of Pediatrics for children up to the age of 22, including children living, traveling or adopted from outside the 50 United States: - Routine physical examinations - Routine hearing tests - Laboratory tests - Related office visits 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 over the age of 22 are covered under Preventive care, adult.	PPO: Nothing (No deductible) Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount (No deductible) Providers outside the 50 United States: Nothing (No deductible)
Maternity care	
Complete maternity (obstetrical) care, such as: • Prenatal care (including laboratory tests) • Delivery • Postnatal care • Sonograms Note: Here are some things to keep in mind: • You do not need to precertify your normal delivery; see *How you get care*, Section 3 for other circumstances when you must precertify, such as extended stays for you or your baby.	PPO: Nothing (No deductible) Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount (No deductible) Providers outside the 50 United States: Nothing (No deductible)

Maternity care - continued on next page

Benefits Description	You pay After the calendar year deductible...
Maternity care (cont.)	
• 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 *How you get care*, Section 3 for other circumstances.	PPO: Nothing (No deductible) Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount (No deductible) Providers outside the 50 United States: Nothing (No deductible)
• For facility care related to maternity, including care at birthing facilities, we pay at the inpatient hospital rate in accordance with Section 5(c) of the brochure. See *Inpatient hospital*, Section 5(c). • We consider bassinet or nursery charges during the covered portion of the mother's maternity stay to be the expenses of the mother and not expenses of the newborn child. We consider expenses of the child after the mother's discharge to be the expenses of the child. We cover these expenses only if the child is covered by a Self and Family enrollment. *Surgical benefits,* not *Maternity benefits,* apply to circumcision.	Note: If your child stays after your discharge and is covered under a Self and Family enrollment, you must pay a separate hospital copayment of $200 for non-PPO facilities. *If your child is not covered under a Self and Family enrollment, you pay all of your child's charges after your discharge.*
Not covered: • *Procedures, services, drugs, and supplies related to abortions except when the life of the mother would be endangered if the fetus were carried to term or when the pregnancy is the result of an act of rape or incest*	*All charges*
Family planning	
A range of voluntary family planning services, limited to surgery, medicine and IUDs. Surgery limited to (See *Surgical procedures* Section 5(c)): • Voluntary sterilization • Surgically implanted contraceptives to include fitting, inserting or removing intrauterine devices (IUDs) and diaphragms	PPO: 10% of the Plan allowance (No deductible) Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount (No deductible) Providers outside the 50 United States: 10% of the Plan allowance (No deductible)
Medicine and IUDs, limited to: • Injectable contraceptive drugs (such as Depo provera) • Intrauterine devices (IUDs) and diaphragms Note: We cover physician supplied FDA-approved drugs and devices for birth control not mentioned above under this benefit.	PPO: 10% of the Plan allowance (No deductible on surgery) Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount (No deductible on surgery) Providers outside the 50 United States: 10% of the Plan allowance (No deductible on surgery)
Injection of contraceptive drugs (such as Depo provera)	PPO: 10% of the Plan allowance Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount Providers outside the 50 United States: 10% of the Plan allowance

Family planning - continued on next page

Benefits Description	You pay After the calendar year deductible...
Family planning (cont.)	
Not covered: • *Reversal of voluntary surgical sterilization* • *Genetic counseling* • *Contraceptive management*	*All charges*
Infertility services	
Diagnosis and treatment of infertility, except as shown in *Not covered*, includes: • Initial diagnostic tests and procedures done only to identify the cause of infertility; • Fertility drugs, hormone therapy and related services; and • Medical or surgical procedures done to create or enhance fertility. Note: The Plan will pay up to $5,000 per person per lifetime for covered infertility services, including prescription drugs. Note: Prescription drugs may not be purchased through the Plan's Prescription drug benefit. You must file a claim for them under this benefit.	PPO: 10% of the Plan allowance until benefits stop at $5,000 and all charges after the Plan's maximum payment of $5,000 Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount until benefits stop at $5,000 and all charges after the Plan's maximum payment of $5,000 Providers outside the 50 United States: 10% of the Plan allowance until benefits stop at $5,000 and all charges after the Plan's maximum payment of $5,000
Not covered: • *Infertility services after voluntary sterilization* • *Assisted reproductive technology (ART) procedures, such as:* - *artificial insemination* - *in vitro fertilization* - *embryo transfer and gamete intrafallopian transfer (GIFT)* - *intravaginal insemination (IVI)* - *intracervical insemination (ICI)* - *intrauterine insemination (IUI)* • *Services and supplies related to ART procedures* • *Costs of donor sperm and donor egg*	*All charges*
Allergy care	
Testing, treatment and injections including materials (such as allergy serum)	PPO: 10% of the Plan allowance Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount Providers outside the 50 United States: 10% of the Plan allowance
Not covered: • *Provocative food testing, end point titration techniques, sublingual allergy desensitization, RAST tests and hair analysis*	*All charges*

Benefits Description	You pay After the calendar year deductible...
Treatment therapies	
• Chemotherapy and radiation therapy (includes radium and radioactive isotopes) Note: Chemotherapy and radiation therapy require preauthorization. See *How you get care*,Section 3. Note: High dose chemotherapy in association with autologous bone marrow transplants is limited to those transplants listed Section 5(c) *Organ/tissue transplants*. • 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	PPO: 10% of the Plan allowance Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount Providers outside the 50 United States: 10% of the Plan allowance
• Renal dialysis Note: This benefit includes only the actual charge for the dialysis treatment. Other covered charges associated with the dialysis treatment are payable under Section 5(a) *Lab, X-ray and other diagnostic tests*.	PPO: Nothing (No deductible) Non-PPO: Only the difference between our allowance and the billed amount (No deductible) Providers outside the 50 United States: Nothing (No deductible)

Benefits Description	You pay After the calendar year deductible...
Physical, occupational and speech therapies	
100 total combined outpatient physical, occupational and speech therapy visits per calendar year for all three listed therapies provided by: • Licensed physical therapists; • Licensed physicians; • Licensed occupational therapists; and • Licensed speech therapists. Note: We only cover physical, occupational and speech therapy when a physician: • Orders the care; • Identifies the specific professional skills the patient requires and the medical necessity for skilled services; and • Indicates the frequency and length of time the services are needed. Note: We only cover physical and occupational therapy to restore bodily function when there has been a total or partial loss of bodily function due to illness or injury. Note: We cover physical, occupational and speech therapy for the diagnosis of autism. Note: Physical, occupational and speech therapies rendered in a home health care setting are included in this benefit and do not require preauthorization.	PPO: 10% of the Plan allowance Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount Providers outside the 50 United States: 10% of the Plan allowance
Hearing services (testing, treatment, and supplies)	
Limited to: • Initial hearing exam for auditory hearing loss Note: Non-auditory hearing loss exams are covered under *Lab, X-ray and other diagnostic tests*	PPO: 10% of the Plan allowance Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount Providers outside the 50 United States: 10% of the Plan allowance
Limited to: • Adult hearing aid exam and adult hearing aid – once every 5 consecutive years Note: Child hearing aid exams and child hearing aids are covered under Preventive care, children.	PPO, Non-PPO and Providers outside the 50 United States: Nothing (No deductible) up to the Plan maximum of $1,200 per aid per ear per person once every 5 years and all charges after the Plan maximum
Not covered: • *Hearing aids and examinations for them, except for the initial exam and except as provided in Preventive care, children*	*All charges*

Benefits Description	You pay After the calendar year deductible...
Vision services (testing, treatment, and supplies)	
One pair of eyeglasses or contact lenses per incident if required to correct an impairment directly caused by: • Accidental ocular injury or intraocular surgery for removal of cataracts or • Specifically ordered by the doctor in connection with a diagnosis of - Keratoconus - Glaucoma Note: Eye refractions are covered only for the diagnoses listed above. 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.	PPO: 10% of the Plan allowance Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount Providers outside the 50 United States: 10% of the Plan allowance
Not covered: • *Routine eye examinations, except when needed for covered eyeglasses or contact lenses above* • *Eyeglasses or contact lenses, except as shown above* • *Eye exercises and visual training (orthoptics)* • *Refractions (except as noted above)* • *All refractive surgeries*	*All charges*
Foot care	
Routine foot care when you are under active treatment for a metabolic or peripheral vascular disease, such as diabetes	PPO: 10% of the Plan allowance Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount Providers outside the 50 United States: 10% of the Plan allowance
Orthotic devices prescribed by a physician and custom fitted for the feet including necessary repair and adjustment Note: 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.	PPO, Non-PPO and Providers outside the 50 United States: Nothing (No deductible) up to $200 per person per calendar year and all charges after $200 per person per calendar year
Not covered: • *Cutting, trimming or removal of corns, calluses, or the free edge of toenails, and similar routine treatment of conditions of the foot, except as stated on the previous page* • *Treatment of flat feet*	*All charges*

Benefits Description	You pay After the calendar year deductible...
Orthopedic and prosthetic devices	
• Artificial limbs and eyes to replace natural limbs and eyes; stump hose • Externally worn breast prostheses and surgical bras, including necessary replacements following a mastectomy • Internal prosthetic devices, such as artificial joints, pacemakers, intraocular lenses, cochlear implants, and surgically implanted breast implant following mastectomy • Elastic stockings and support hose that require a physician's written prescription Note: A prosthetic device is surgically inserted or physically attached to the body to restore a bodily function or replace a physical portion of the body. Note: See Section 5(b) for coverage of the surgery to insert the device and Section 5(c) if billed by the facility.	PPO: 10% of the Plan allowance Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount Providers outside the 50 United States: 10% of the Plan allowance
• Wigs needed as a result of chemotherapy or radiation treatment for cancer	PPO, Non-PPO and Providers outside the 50 United States: Nothing (No deductible) up to $350 per person per calendar year and all charges after $350 per person per calendar year
Not covered: • *Orthopedic shoes, orthotics and other supportive devices for the feet (except as provided in Foot care), such as:* - *Arch supports* - *Heel pads and heel cups* • *Corsets* • *Elastic stockings and support hose that do not require a physician's written prescription*	*All charges*

Benefits Description	You pay After the calendar year deductible...
Durable medical equipment (DME)	
Durable medical equipment (DME) is equipment and supplies that: • Are prescribed by your attending physician (i.e., the physician who is treating your illness or injury); • Are medically necessary; • Are primarily and customarily used only for a medical purpose; • Are generally useful only to a person with an illness or injury; • Are designed for prolonged use; and • Serve a specific therapeutic purpose in the treatment of an illness or injury. We cover rental, up to the purchase price, or purchase (at our option), including necessary repair and adjustment, of durable medical equipment such as: • Wheelchairs • Hospital beds • Oxygen and equipment for its administration • Dialysis equipment • Crutches • Braces • Casts, splints, and trusses • Walkers Also included are: • Medical supplies, appliances, medical equipment, and any covered items billed by a hospital for use at home (Note: calendar year deductible applies).	PPO: 10% of the Plan allowance Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount Providers outside the 50 United States: 10% of the Plan allowance
Augmentative and alternative communications (AAC) devices such as: • Computer story boards • Light talkers • Enhanced vision systems • Speech aid prostheses for pediatrics • Speech aid prostheses for adults Note: For surgical insertion of speech aid prostheses, see *Surgical procedures* Section5(b).	PPO, Non-PPO and Providers outside the 50 United States: Nothing (No deductible) up to one device per person per calendar year up to the Plan allowance of $1,000 and all charges after $1,000
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.*	*All Charges*

Benefits Description	You pay After the calendar year deductible...
Home health services	
For services provided on a **part-time basis** (less than an 8-hour shift): **If you preauthorize your home health care**, 90 visits per calendar year when: A Registered Nurse (R.N.) or Licensed Practical Nurse (L.P.N.) provides the services; • A licensed social worker provides the services (limited to two visits per calendar year); • A home health aide provides services under the supervision of a Registered Nurse (R.N.) consisting of mainly medical care and therapy provided solely for the care of the insured person; • The attending physician orders the care; and • The physician identifies the specific professional skills required by the patient and the medical necessity for skilled services; and indicates the length of time the services are needed. • A home health agency (or visiting nurses where services of a home health agency are not available) must furnish the care in accord with a home health care plan (see definition below). The home health care plan must be certified by your physician and furnished in your home. Note: We define home health agency as a public or private agency or organization appropriately licensed, qualified and operated under the law of the state in which it is located. Note: We define home health care plan as a written plan, approved in writing by a physician, for continued care and treatment of a Plan member: • Who is under the care of a physician; and • Who would need a continued stay in a Hospital or Skilled Nursing Facility without the home health care. Note: Physical, occupational and/or speech therapy services performed in an outpatient setting and/or at home will count toward the 100-therapy visit limitation per calendar year, as listed under *Physical, occupational and speech therapy* in Section 5(a). Note: Home health services outside the 50 United States do not require preauthorization	For preauthorized home health care: PPO: 10% of Plan allowance and any visits above 90 visits per calendar year (No deductible); and all charges above one visit per day Non-PPO: 30% of Plan allowance and any difference between our allowance and the billed amount and any visits above 90 visits per calendar year (No deductible); and all charges above one visit per day 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

Home health services - continued on next page

Benefits Description	You pay After the calendar year deductible...
Home health services (cont.)	
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 above. Note: Preauthorized and Non-preauthorized visits are combined. Visit limit not to exceed 90 visits per calendar year. Note: Home health services outside the 50 United States do not require preauthorization.	For non-preauthorized home health care: PPO: 10% of Plan allowance and any visits above 40 visits per calendar year (No deductible); and all charges above one visit per day Non-PPO: 30% of Plan allowance and any difference between our allowance and the billed amount and any visits above 40 visits per calendar year (No deductible); and all charges above one visit per day Providers outside the 50 United States: 10% of Plan allowance and any visits above 40 visits per calendar year (No deductible); and all charges above one visit per day
For private duty nursing we pay $12 per hour when provided on a **full-time basis** (more than an 8-hour shift) by a Registered Nurse (R.N.) or Licensed Practical Nurse (L.P.N.) when: • The care is ordered by the attending physician; and • Your physician identifies the specific professional nursing skills that you require, as well as the length of time needed.	Nothing (No deductible) up to $12 per hour and all charges above $12 per hour; and all charges after 500 hours per calendar year
Not covered: • *Nursing care requested by, or for the convenience of, the patient or the patient's family* • *Home care primarily for personal assistance that does not include a medical component and is not diagnostic, therapeutic, or rehabilitative* • *Custodial care (see definition Section 10)*	*All charges*
Chiropractic	
Covered services are limited to 30 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.	PPO: Nothing (No deductible) up to the Plan maximum of $50 per visit and then all charges up to the Plan allowance; and all charges above 30 visits per person per calendar year Non-PPO and Providers outside the 50 United States: Nothing (No deductible) up to the Plan maximum of $50 per visit; and all charges above $50 per visit and/or 30 visits per person, per calendar year

Benefits Description	You pay After the calendar year deductible...
Alternative treatments	
Acupuncture only when performed by an M.D., D.O., O.M.D., or L.Ac., limited to 30 visits per calendar year Massage therapy only when performed by a Licensed Massage Therapist (LMT) or a Certified Massage Therapist (CMT) Note: The Plan defines acupuncture as the practice of insertion of needles into specific exterior body locations to relieve pain, to induce surgical anesthesia, or for therapeutic purposes. Note: Acupuncture and massage therapy visits have a separate calendar year maximum of 30 visits per person. Note: These providers are required to submit itemized bills and their Federal Tax I.D. Number (if a United States provider) as outlined in Section 7.	PPO: Nothing (No deductible) up to the Plan maximum of $40 per visit and then all charges up to the Plan allowance; and all charges above 30 visits per person, per calendar year Non-PPO and Providers outside the 50 United States: Nothing (No deductible) up to the Plan maximum of $40 per visit; and all charges above $40 per visit and/or 30 visits per person, per calendar year
Not covered: • *Chelation therapy except for acute arsenic, gold, mercury or lead poisoning; or use of Desferoxamine in iron poisoning* • *Naturopathic services and medicines* • *Homeopathic services and medicines* *(Note: Services of certain alternative treatment providers may be covered in medically underserved areas; How you get care Section 3.)*	*All charges*
Educational classes and programs	
Coverage is limited to: Smoking Cessation Program • Two quit attempts per calendar year as part of the Plan's Smoking Cessation Program. The quit attempts include proactive telephone counseling and up to four smoking 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 Smoking Cessation Program at no charge. - Prescription drugs approved by the FDA to treat tobacco dependence for smoking cessation only through the Plan's mail order Prescription benefits, Section 5(f) and only when enrolled in the Smoking Cessation Program at no charge. OTC medications approved by the FDA to treat tobacco dependence for smoking cessation are also available through the Plan's Prescription benefit at no charge. (See Section 5(f) for more details). Note: If you would like to contact the Plan for more information or to enroll in the Smoking Cessation Program, there are two ways to do this:	PPO, Non-PPO and Providers outside the 50 United States: Nothing (No deductible)

Educational classes and programs - continued on next page

Benefits Description	You pay After the calendar year deductible...
Educational classes and programs (cont.)	
• Online: Go to www.AFSPA.org/FSBP. Select "My Online Services" (middle of page). Log-in or register for "MyOnlineServices." Choose "Wellness Tools" and then "Smoking Cessation." After you view a description of the services, click the button to ENROLL ONLINE NOW. When prompted for an Authentication code, enter your 11 digit Coventry ID number. Proceed to the rest of the registration process. • Phone: Call 1-866-577-8210 or 419-329-4638. A representative will ask you for an Authentication code (your 11 digit Plan ID number) and will assist you in completing the registration process.	PPO, Non-PPO and Providers outside the 50 United States: Nothing (No deductible)
Coverage is limited to: • Nutritional counseling • Diabetic Education or training Note: We cover dieticians, nutritionists and diabetic educators who bill independently for nutritional counseling. Note: Nutritional counseling and diabetic education or training have separate Plan maximums of $500 each.	PPO, Non-PPO and Providers outside the 50 United States: Nothing (No deductible) up to $500 per person per calendar year and all charges after $500 per person per calendar year
Coverage is limited to: • Weight Management Program – Includes non-surgical outpatient treatment when diagnosed by a physician as having a Body Mass Index (BMI) of over 30. Benefits will be payable for the following medically necessary services: - Initial evaluation by your physician; - Follow-up visits to your physician; - Individual or group nutritional counseling; - Individual or group behavioral counseling; - Initial and follow-up lab tests; and - Maintenance counseling and follow-up visits for maintenance. Expense incurred for prescription drugs for weight loss and/or maintenance are payable only as shown under Section 5(f) *Prescription benefits* and are not applied to the maximum benefit limitation. Note: This benefit is limited to one program per person per lifetime. Note: We cover dieticians and nutritionists who bill independently for nutritional counseling. Note: If the member is seen for nutritional counseling, the Nutritional counseling benefit (above this benefit) will apply first.	PPO, Non-PPO and Providers outside the 50 United States: 50% of the Plan allowance (No deductible) until benefits stop at $1,500; and all charges after the Plan's maximum payment of $1,500
Not covered: • *Body composition analysis* • *Nutritional supplements or food* • *Non-prescription items* • *Exercise or weight loss programs or equipment* • *Services that are not considered medically necessary*	*All charges*

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

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- The calendar year deductible is: $300 per person ($600 per family). The calendar year deductible does not apply to any benefits in this Section. We added "(No deductible)" to show when the calendar year deductible does not apply.
- The non-PPO benefits are the standard benefits of this Plan. PPO benefits apply only when you use a PPO provider or when you use a provider outside the 50 United States. When no PPO provider is available in the PPO Network, non-PPO benefits apply.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost-sharing works, with special sections for members who are age 65 or over. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- The amounts listed below are for the charges billed by a physician or other health care professional for your surgical care. Look in Section 5(c) for charges associated with the facility (i.e., hospital, surgical center, etc.).

Benefits Description	You pay
Note: The calendar year deductible does not apply to benefits in this Section. We say "(No deductible)" when it does not apply.	
Surgical procedures	
A comprehensive range of services, such as: • Operative procedures • Treatment of fractures, including casting • Normal post-operative care by the surgeon • Correction of amblyopia and strabismus • Endoscopy procedures • Biopsy procedures • Removal of tumors and cysts • Surgical treatment of morbid obesity (bariatric surgery) – a condition in which an individual has: 1) a Body Mass Index (BMI) equal to or greater than 40 or a BMI equal to or greater than 35 with comorbidities such as hypertension, heart disease, diabetes, sleep apnea, or hyperlipidemia which has persisted for a minimum of 5 years; and 2) has been under at least one physician supervised weight loss program for at least 6 months. The program should be multi-disciplinary by combining diet and nutritional counseling with an exercise program and a behavior modification program. Eligible members must be age 18 and older. • Insertion of internal prosthetic devices. See Section 5(a), *Orthopedic and prosthetic devices* for device coverage information. • Voluntary sterilization (e.g., tubal ligation, vasectomy) • Surgical implantation and removal of intrauterine devices (IUDs) • Surgical implantation and removal of contraceptive devices • Treatment of burns	PPO: 10% of the Plan allowance (No deductible) Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount (No deductible) Providers outside the 50 United States: 10% of the Plan allowance (No deductible)

Surgical procedures - continued on next page

Benefits Description	You pay
Surgical procedures (cont.)	
• Amniocentesis • Routine circumcision of a newborn child (only when the child is covered under a Self and Family enrollment) Note: Second opinion is covered under Section 5(a), *Diagnostic and treatment services.*	PPO: 10% of the Plan allowance (No deductible) Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount (No deductible) Providers outside the 50 United States: 10% of the Plan allowance (No deductible)
When multiple or bilateral surgical procedures performed during the same operative session add time or complexity to patient care, our benefits are: • For the primary procedure: - PPO: 90% of the Plan allowance - Non-PPO: 70% of the Plan allowance • For the secondary procedure(s): - PPO: 90% of one-half of the Plan allowance - Non-PPO: 70% of one-half of the Plan allowance Note: For certain surgical procedures, we may apply a value of less than 50% for subsequent procedures. Note: Multiple or bilateral surgical procedures performed through the same incision are "incidental" to the primary surgery. That is, the procedure would not add time or complexity to patient care. We do not pay extra for incidental procedures.	PPO: 10% of the Plan allowance for the primary procedure and 10% of one-half of the Plan allowance for the secondary procedure(s) (No deductible) Non-PPO: 30% of the Plan allowance for the primary procedure and 30% of one-half of the Plan allowance for the secondary procedure(s); and any difference between our allowance and the billed amount (No deductible) Providers outside the 50 United States: 10% of the Plan allowance for the primary procedure and 10% of one-half of the Plan allowance for the secondary procedure(s) (No deductible)
• Assistant Surgeon (inpatient/outpatient)	PPO: 20% of the Plan allowance (based on 20% of the Plan allowance allocated to the surgery charge) (No deductible) Non-PPO: 20% of the Plan allowance (based on 20% of the Plan allowance allocated to the surgery charge) and any difference between our allowance and the billed amount (No deductible) Providers outside the 50 United States: 20% of the Plan allowance (based on 20% of the Plan allowance allocated to the surgery charge) (No deductible)
• Co-surgeons (inpatient/outpatient) Note: When the surgery requires two surgeons (co-surgeons) with different skills to perform the surgery, the Plan's allowance for each surgeon is 100% of what it would allow for a single surgeon for the same procedure(s) and pay regular surgical benefits.	PPO: 10% of the Plan allowance for each co-surgeon (No deductible) Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount for each co-surgeon (No deductible) Providers outside the 50 United States: 10% of the Plan allowance for each co-surgeon (No deductible)

Surgical procedures - continued on next page

Benefits Description	You pay
Surgical procedures (cont.)	
Not covered: • *Cosmetic surgery except for the repair of accidental injuries; to correct a congenital anomaly; or for the reconstruction of a breast following a mastectomy* *Note: We define cosmetic surgery as any operative procedure or any portion of a procedure performed primarily to improve physical appearance and/or treat a mental condition through change in bodily form.* • *All refractive surgeries* • *Routine surgical treatment of conditions of the foot (see Foot care, Section 5(a))* • *Services of a standby surgeon* *Not covered (cont.)* • *Reversal of voluntary sterilization* • *Surgeries related to impotency, sex transformation, sexual dysfunction or sexual inadequacy*	*All charges*
Reconstructive surgery	
• Surgery to correct a functional defect • Surgery to correct a condition caused by injury or illness if: - The condition produced a major effect on the member's appearance and - The condition can reasonably be expected to be corrected by such surgery • Surgery to correct a condition that existed at or from birth and is a significant deviation from the common form or norm (congenital anomaly). Examples of congenital anomalies are: protruding ear deformities; cleft lip; cleft palate; birth marks; webbed fingers and toes; and other conditions that we may determine to be congenital anomalies. We will not consider the term congenital anomaly to include conditions relating to teeth or intra-oral structures supporting the teeth. • All stages of breast reconstruction surgery following a mastectomy, such as: - Surgery to produce a symmetrical appearance of breasts; - Treatment of any physical complications, such as lymphedemas; - Breast prostheses; and surgical bras and replacements (see *Orthopedic and prosthetic devices* for coverage) Note: If you need a mastectomy, you may choose to have the procedure performed on an inpatient basis and remain in the hospital up to 48 hours after the procedure.	PPO: 10% of the Plan allowance (No deductible) Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount (No deductible) Providers outside the 50 United States: 10% of the Plan allowance (No deductible)
Not covered: • *Cosmetic surgery except for the repair of accidental injuries; to correct a congenital anomaly; or for the reconstruction of a breast following a mastectomy*	*All charges*

Reconstructive surgery - continued on next page

Benefits Description	You pay
Reconstructive surgery (cont.)	
Note: We define cosmetic surgery as any operative procedure or any portion of a procedure performed primarily to improve physical appearance and/or treat a mental condition through change in bodily form. • *Surgeries related to impotency, sex transformation, sexual dysfunction or sexual inadequacy*	*All charges*
Oral and maxillofacial surgery	
Oral surgical procedures, limited to: • Reduction of fractures of the jaws or facial bones • Surgical correction of severe functional malocclusion only when we determine the correction of the malocclusion to be medically necessary • Removal of stones from salivary ducts • Excision of leukoplakia or malignancies • Excision of non-dentigerous cysts and incision of non-dentigerous abscesses • Surgical correction of temporomandibular joint (TMJ) dysfunction • Surgical removal of impacted teeth, including anesthesia charges • Other surgical procedures that do not involve the teeth or their supporting structures	PPO: 10% of the Plan allowance (No deductible) Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount (No deductible) Providers outside the 50 United States: 10% of the Plan allowance (No deductible)
Not covered: • *Oral implants and transplants and related services except for those required to treat accidental injuries as specifically 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* • *Pre- and post-operative medical examinations* • *Excision of non-impacted teeth*	*All charges*
Organ/tissue transplants	
Solid organ transplants are subject to medical necessity and experimental/investigational review. Refer to *Other services* in Section 3 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 - Small intestine - Small intestine with the liver - Small intestine with multiple organs, such as the liver, stomach, and pancreas	Plan-designated transplant network (see Centers of Excellence page 61) for organ/tissue transplant facility: 10% of the Plan allowance (No deductible) PPO: 20% of the Plan allowance (No deductible) subject to a maximum payable of $400,000 per transplant (no catastrophic coverage) Non-PPO: 100% of all charges (no catastrophic coverage) Providers outside the 50 United States: 10% of the Plan allowance (No deductible)

Organ/tissue transplants - continued on next page

Benefits Description	You pay
Organ/tissue transplants (cont.)	
• 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 These **tandem blood or marrow stem cell transplants for covered transplants** are subject to medical necessity review by the Plan. Refer to *Other services* in Section 3 for 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 reoccurrence (relapsed) - Advanced non-Hodgkin's lymphoma with reoccurrence (relapsed) - Acute myeloid leukemia - Advanced Myeloproliferative Disorders (MPDs) - Amyloidosis - Chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL) - Hemoglobinopathy - Marrow failure and related disorders (i.e., Fanconi's, PNH, Pure Red Cell Aplasia) - Myelodysplasia/Myelodysplastic syndromes - Paroxysmal Nocturnal Hemoglobinuria - Phagocytic/Hemophagocytic deficiency diseases (e.g., Wiskott-Aldrich syndrome) - Severe combined immunodeficiency - Severe or very severe aplastic anemia • Autologous transplants for: - Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia - Advanced Hodgkin's lymphoma with reoccurrence (relapsed) - Advanced non-Hodgkin's lymphoma with reoccurrence (relapsed) - Amyloidosis	Plan-designated transplant network (see Centers of Excellence page 61) for organ/tissue transplant facility: 10% of the Plan allowance (No deductible) PPO: 20% of the Plan allowance (No deductible) subject to a maximum payable of $400,000 per transplant (no catastrophic coverage) Non-PPO: 100% of all charges (no catastrophic coverage) Providers outside the 50 United States: 10% of the Plan allowance (No deductible)

Organ/tissue transplants - continued on next page

Benefits Description	You pay
Organ/tissue transplants (cont.)	
- Breast cancer - Epithelial ovarian cancer - 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 Other services in Section 3 for prior authorization procedures: • Allogeneic transplants for: - Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia - Acute myeloid leukemia - Advanced Myeloproliferative Disorders (MPDs - Advanced Hodgkin's lymphoma with reoccurrence (relapsed) - Advanced non-Hodgkin's lymphoma with reoccurrence (relapsed) - Amyloidosis - Chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL) - Hemoglobinopathy - Marrow failure and related disorders (i.e., Fanconi's, PNH, Pure Red Cell Aplasia) - Myelodysplasia/Myelodysplastic syndromes - Paroxysmal Nocturnal Hemoglobinuria - Severe combined immunodeficiency - Severe or very severe aplastic anemia • Autologous transplants for: - Acute lymphocytic or nonlymphocytic (i.e., myelogenous) leukemia - Advanced Hodgkin's lymphoma with reoccurrence (relapsed) - Advanced non-Hodgkin's lymphoma with reoccurrence (relapsed) - Amyloidosis - Neuroblastoma 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.	Plan-designated transplant network (see Centers of Excellence page 61) for organ/tissue transplant facility: 10% of the Plan allowance (No deductible) PPO: 20% of the Plan allowance (No deductible) subject to a maximum payable of $400,000 per transplant (no catastrophic coverage) Non-PPO: 100% of all charges (no catastrophic coverage) Providers outside the 50 United States: 10% of the Plan allowance (No deductible)

Organ/tissue transplants - continued on next page

Benefits Description	You pay
Organ/tissue transplants (cont.)	
Note: The Plan has special arrangements with facilities (Centers of Excellence) to provide services for tissue and organ transplants (see page 61). The network was designed to give you an opportunity to access providers that demonstrate high quality medical care for transplant patients. We also may assist you and one family member or caregiver with travel and lodging arrangements if you use one of our Centers of Excellence. Your physician can coordinate arrangements by calling a case manager in the Plan's Medical Management Department at 1-800-593-2354. For additional information regarding the transplant network, please call this number.	Plan-designated transplant network (see Centers of Excellence page 61) for organ/tissue transplant facility: 10% of the Plan allowance (No deductible) PPO: 20% of the Plan allowance (No deductible) subject to a maximum payable of $400,000 per transplant (no catastrophic coverage) Non-PPO: 100% of all charges (no catastrophic coverage) Providers outside the 50 United States: 10% of the Plan allowance (No deductible)
Not covered: • *Donor screening tests and donor search expenses, except those performed for the actual donor* • *Services or supplies for, or related to, surgical transplant procedures for artificial or human organ transplants not listed as covered* • *Transplants not listed as covered* • *Services or supplies for, or related to, surgical transplant procedures performed at non-PPO facilities*	*All charges*
Anesthesia	
Professional services provided in: • Hospital (inpatient) • Hospital outpatient department • Skilled nursing facility • Ambulatory surgical center • Office Note: Anesthesia rendered by a dentist only in relation to covered oral and maxillofacial surgery is also covered (see *Oral and maxillofacial surgery* this Section).	PPO: 10% of the Plan allowance (No deductible) Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount (No deductible) Providers outside the 50 United States: 10% of the Plan allowance (No deductible)

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

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- In this Section, unlike other subsections in Section 5, the calendar year deductible applies to only a few benefits. We added "(calendar year deductible applies)". The calendar year deductible is: $300 per person ($600 per family).
- The non-PPO benefits are the standard benefits of this Plan. PPO benefits apply only when you use a PPO provider or when you use a provider outside the 50 United States. When no PPO provider is available in the PPO Network, non-PPO benefits apply.
- When you use a PPO facility, some professionals who provide services to you in the facility may not be preferred providers. If they are not, they will be paid by this Plan as non-PPO providers. However, if the services are rendered at a PPO facility, we will pay up to the Plan allowance at the preferred provider percentage for services of radiologists, anesthesiologists, emergency room physicians, pathologists and neonatologists who are not preferred providers.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost-sharing works, with special sections for members who are age 65 or over. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- The amounts listed below are for the charges billed by the facility (i.e., hospital or surgical center) or ambulance service for your surgery or care. Any costs associated with the professional charge (i.e., physicians, etc.) are in Sections 5(a), (b), (d) or (e).
- **YOU MUST GET PRECERTIFICATION FOR HOSPITAL STAYS; FAILURE TO DO SO WILL RESULT IN A $500 PENALTY.** Please refer to the precertification information shown in Section 3 for additional details on precertification.
- **YOU ALSO MUST GET PREAUTHORIZATION FOR CARE YOU RECEIVE IN SKILLED NURSING FACILITIES, HOSPICE, and HOME HEALTH CARE.** Please refer to this Section (*Skilled nursing care facility* and *Hospice*) and Section 5(a) (*Home health services*) for details on how your benefits are affected if you do not preauthorize. Also, please refer to the preauthorization information shown in Section 3 for additional details on preauthorization.

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. 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	PPO: Nothing Non-PPO: $200 copayment per hospital stay and 20% of the covered charges Providers outside the 50 United States: Nothing

Inpatient hospital - continued on next page

Benefits Description	You pay
Inpatient hospital (cont.)	
• X-ray, laboratory and pathology services and machine diagnostic tests • Blood or blood plasma, if not donated or replaced, and its administration • Dressings, splints, casts and sterile tray services • Medical supplies and equipment, including oxygen • Anesthetics, including nurse anesthetist services • Medical supplies, medical equipment, prosthetic and orthopedic devices and any covered items billed by a hospital for use at home (Note: We cover these items only under Section 5(a) and the calendar year deductible and coinsurance apply.) • Special Overseas Benefit – Inpatient private duty nursing services by an R.N. or L.P.N. when the services are rendered outside of North America Note: We provide specified benefits for professional services of a physician, even when billed by the hospital. For example, when the hospital bills for such professional services as surgery, anesthesiology, medical or therapy services, etc., we pay the specific surgery, anesthesia, medical or therapy benefit. Note: We cover hospital services and supplies related to dental procedures when necessitated by a non-dental physical impairment to safeguard the health of the patient, even though we may not cover the services of dentists or physicians in connection with the dental treatment.	PPO: Nothing Non-PPO: $200 copayment per hospital stay and 20% of the covered charges Providers outside the 50 United States: Nothing
Not covered: • *Admission to nursing homes, rest homes, places for the aged, convalescent homes, or any place that is not a hospital, skilled nursing care facility, or hospice (see Section 3, Covered providers and Covered facilities)* • *Custodial care (see definition Section 10)* • *Any part of a hospital admission that is not medically necessary (see definition Section 10), such as when you do not need acute hospital inpatient (overnight) care, but could receive care in some other setting without adversely affecting your condition or the quality of your medical care. Note: In this event, we pay benefits for services and supplies other than room and board and in-hospital physician care at the level we would have covered if provided in an alternative setting.* • *Inpatient private duty nursing except as provided above* • *Personal comfort items, such as radio, television, beauty and barber services, identification tags, baby beads, footprints, guest cots and meals, newspapers and similar items* • *Inpatient hospital services and supplies for surgery that we do not cover except as noted above for non-covered dental procedures*	*All charges*

Benefits Description	You pay
Outpatient hospital or ambulatory surgical center	
• Operating, recovery, and other treatment rooms • Prescribed drugs and medicines for use in the facility • X-ray, laboratory and pathology services and machine diagnostic tests • Blood and blood plasma, if not donated or replaced, and its administration • Dressings, casts and sterile tray services • Medical supplies and equipment, including oxygen • Anesthetics and anesthesia service • Drugs, medical supplies, medical equipment, prosthetic and orthopedic devices and any covered items billed by a hospital for use at home (Note: We cover these items only under Section 5(a) and the calendar year deductible and coinsurance apply.) Note: We cover hospital services and supplies related to dental procedures when necessitated by a non-dental physical impairment to safeguard the health of the patient, even though we may not cover the services of dentists or physicians in connection with the dental treatment.	PPO: 10% of the Plan allowance (calendar year deductible applies) Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount (calendar year deductible applies) Providers outside the 50 United States: 10% of the Plan allowance (calendar year deductible applies)
Not covered: • *Outpatient hospital services and supplies for surgery that we do not cover except as noted above for non-covered dental procedures*	*All charges*
Extended care benefits/Skilled nursing care facility benefits	
If you 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: 1. Medically necessary; and 2. Under the supervision of a physician.	For preauthorized care: Nothing up to the Plan allowance for up to 90 days per calendar year and all charges after 90 days
If you do not preauthorize your admission, we cover semiprivate room, board, services and supplies in a Skilled Nursing Facility (SNF) for up to 45 days per calendar year subject to the above conditions. 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
Not covered: • *Custodial care (see definition Section 10)*	*All charges*
Hospice care	
If you preauthorize your Hospice care, we pay up to a lifetime maximum of $7,500. Note: This benefit does not apply to services covered under any other provisions of the Plan.	For preauthorized care: Nothing up to the Plan allowance until benefits stop at $7,500 and all charges after $7,500

Hospice care - continued on next page

Benefits Description	You pay
Hospice care (cont.)	
Note: We define Hospice Care Program as a coordinated program of home or inpatient pain control and supportive care for a terminally ill patient and the patient's family. Care must be provided by a medically supervised team under the direction of an independent hospice administration that we approve.	For preauthorized care: Nothing up to the Plan allowance until benefits stop at $7,500 and all charges after $7,500
If you do not preauthorize your Hospice care, we pay up to a lifetime maximum of $4,500. The note and definition above apply.	For non-preauthorized care: Nothing up to the Plan allowance until benefits stop at $4,500 and all charges after $4,500
Ambulance	
• Professional ambulance service when medically necessary Note: This benefit includes air ambulance service when medically necessary to transport you to the nearest facility equipped to handle your medical condition.	PPO: 10% of the Plan allowance Non-PPO: 10% of the Plan allowance and any difference between our allowance and the billed amount Providers outside the 50 United States: 10% of the Plan allowance
Not covered: • *Ambulance transport for you or your family's convenience*	*All charges*

Section 5(d). Emergency services/accidents

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- The calendar year deductible is: $300 per person ($600 per family). The calendar year deductible applies to some benefits in this Section. We added "(No deductible)" to show when the calendar year deductible does not apply.
- The non-PPO benefits are the standard benefits of this Plan. PPO benefits apply only when you use a PPO provider or when you use a provider outside the 50 United States. When no PPO provider is available in the PPO Network, non-PPO benefits apply.
- When you use a PPO facility, the professionals who provide services to you in the facility may not be preferred providers. If they are not, they will be paid by this Plan as non-PPO providers. However, if the services are rendered at a PPO facility, we will pay up to the Plan allowance at the preferred provider percentage for services of radiologists, anesthesiologists, emergency room physicians, pathologists and neonatologists who are not preferred providers.
- Be sure to read Section 4, *Your costs for covered services,* for valuable information about how cost-sharing works, with special sections for members who are age 65 or over. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

What is an accidental injury?

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

What is a medical emergency?

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) and urgent care facility charges, ER and urgent care physician's charges and ancillary services performed at the time of the ER or urgent care facility visit; **or** • Initial office visit and ancillary services performed at the time of the initial office visit for accidental injury. 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) 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).	PPO: Nothing (No deductible) Non-PPO: Only the difference between the Plan allowance and the billed amount (No deductible) Providers outside the 50 United States: Nothing (No deductible)

Accidental injury - continued on next page

Benefits Description	You pay After the calendar year deductible…
Accidental injury (cont.)	
Note: We pay prescription medications for use at home under Sections 5 (a), 5(c) or 5(f) as appropriate.	PPO: Nothing (No deductible) Non-PPO: Only the difference between the Plan allowance and the billed amount (No deductible) Providers outside the 50 United States: Nothing (No deductible)
Medical emergency	
Regular Plan benefits apply to care you receive in the outpatient Emergency Room (ER) or physician's office because of a medical emergency (non-accident). Items covered include: • Medical services and supplies • Physician services and supplies • X-ray, laboratory and pathology services and machine diagnostic tests	PPO: 10% of the Plan allowance Non-PPO: 10% of the Plan allowance and any difference between our allowance and the billed amount Providers outside the 50 United States: 10% of the Plan allowance
Outpatient care in an urgent care facility because of a medical emergency.	PPO: $50 copayment per occurrence (No deductible) Non-PPO: $50 copayment per occurrence and any difference between our allowance and the billed amount (No deductible) Providers outside the 50 United States: $50 copayment per occurrence (No deductible)
Ambulance	
• Professional ambulance service when medically necessary Note: This benefit includes air ambulance service when medically necessary to transport you to the nearest facility equipped to handle your medical condition.	PPO: 10% of the Plan allowance (No deductible) Non-PPO: 10% of the Plan allowance and any difference between our allowance and the billed amount (No deductible) Providers outside the 50 United States: 10% of the Plan allowance (No deductible)
Not covered: • *Ambulance transport for you or your family's convenience*	*All charges*

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

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

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- The calendar year deductible or, for facility care, the inpatient copayment applies to almost all benefits in this Section. We added "(No deductible)" to show when the calendar year deductible does not apply.
- The non-PPO benefits are the standard benefits of this Plan. PPO benefits apply only when you use a PPO provider or when you use a provider outside the 50 United States. When no PPO provider is available in the PPO Network, non-PPO benefits apply.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost-sharing works, with special sections for members who are age 65 or over. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- **YOU MUST GET PRECERTIFICATION/PREAUTHORIZATION/CONCURRENT REVIEW FOR THESE SERVICES.** If you fail to follow these procedures, the Plan may reduce your benefit. See the precertification and Other services information shown in Section 3 and the instructions below.
  - To be eligible to receive mental health and substance abuse benefits you must obtain and follow a treatment plan and follow all of our authorization processes. This applies to all inpatient and outpatient hospital care, and all inpatient, outpatient or office care you receive from doctors and other covered providers. **See Section 3 for more details**.
  - **Precertification** establishes the medical necessity of your admission to a hospital, residential treatment center or other facility for you to receive full Plan benefits. **You must precertify any inpatient care before you receive it.** If you do not precertify, we will reduce the benefits payable by $500. You must report emergency admissions within two business days following the day of admission even if you have been discharged.
  - **Preauthorization** establishes the medical necessity for all levels of outpatient or office care. **You must preauthorize any outpatient or office care before you receive it.** If you do not preauthorize, we will request information from your provider to review the services for medical necessity. This will delay your claim.
  - **Concurrent review (which means review of continuing treatment)** establishes the medical necessity for all levels of *continuing* outpatient or office care. **You must obtain concurrent review for any continuing outpatient or office care you receive before you receive continuing care.** If you do not obtain concurrent review or follow your treatment plan, we will request information from your provider to review the continued services for medical necessity. This will delay your claim.
  - **To precertify or preauthorize care and obtain concurrent review for continuing care,** you, your representative, your doctor or your hospital **must** call the Plan at 1-800-593-2354 prior to the admission or care.

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

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

Benefits Description	You pay After the calendar year deductible…
Note: The calendar year deductible applies to almost all benefits in this Section. We say "(No deductible)" when it does not apply.	
Mental health and substance abuse benefits	
All covered diagnostic and treatment services contained in a treatment plan that we approve. The treatment plan may include services, drugs, and supplies described elsewhere in this brochure. Note: Benefits are payable only when we determine the care is clinically appropriate to treat your condition and only when you receive the care as part of a treatment plan that we approve. **Note: If you receive care outside the 50 United States, we do not require precertification, preauthorization or concurrent review for continuing care. However, the Plan will review all services to establish medical necessity. We may request medical records in order to determine medical necessity. See Section 3 for details.**	Your cost-sharing responsibilities are no greater than for other illnesses or conditions.
Professional services including: • Individual or group therapy when rendered by covered providers • Medication management – Note: We cover this under Section 5(a) pharmacological visits, no preauthorization required. • Diagnostic tests including psychological testing	PPO: 10% of the Plan allowance Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount Providers outside the 50 United States: 10% of the Plan allowance
• Services provided by a hospital (including residential treatment center) or other facility	PPO inpatient facility: Nothing for room and board and other services (No deductible) Non-PPO inpatient facility: $200 copayment per person per hospital stay and 20% of covered charges for room and board and other services (No deductible) 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.	PPO: 10% of the Plan allowance Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount Providers outside the 50 United States: 10% of the Plan allowance

Mental health and substance abuse benefits - continued on next page

Benefits Description	You pay After the calendar year deductible…
Mental health and substance abuse benefits (cont.)	
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.
- In this Section, unlike other subsections in Section 5, the calendar year deductible applies to only a few benefits. The calendar year deductible is: $300 per person ($600 per family). We added "(No deductible)" to show when the calendar year deductible does not apply.
- Be sure to read Section 4, *Your costs for covered services,* for valuable information about how cost-sharing works, with special sections for members who are age 65 or over. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- **YOU MUST GET PRIOR AUTHORIZATION FOR CERTAIN DRUGS; AND PRIOR AUTHORIZATION MUST BE RENEWED PERIODICALLY.** Prior authorization uses Plan rules based on FDA-approved prescribing and safety information, clinical guidelines and uses that are considered reasonable, safe and effective. See the prior authorization information shown in *Other Services,* Section 3 and in *Coverage management*, this Section for more information about this important program.

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

Who can write your prescription.

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

When you have to purchase a prescription.

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

Where you can obtain your prescription.

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

Prescription drug benefits *(continued)*

Where you can obtain your prescription *(continued)***.**

- **Retail Pharmacies outside the 50 United States**
  - Fill your prescription as you normally do. **Mail claims for prescription drugs and supplies you purchased through a retail pharmacy outside the 50 United States to the Plan's address shown in Section 7** (*do not mail foreign prescription claims to Medco)*. Claims must include receipts that show the name of the patient, prescription number, name of drug(s), name of the prescribing physician, name of the pharmacy, date, and the charge. You may obtain claim forms by calling 202-833-4910 or from our Web site at www.AFSPA.org/FSBP.
- **Mail order (the Medco Pharmacy) outside the 50 United States -** *Your prescriber must be licensed in the United States.*
  - Use the same forms as for mail order within the 50 United States referenced on the previous page. If you have any questions about a particular drug or a prescription or to request order forms, you may call 1-800-497-4641 (available in over 140 countries) from outside the 50 United States. Also, you can call Medco collect at 412-829-5932 or 412-829-5933 if the toll-free number for outside the 50 United States does not work for you.
  - **Note: Per Federal regulations, the Medco Pharmacy can mail only to addresses in the United States or to APO, FPO, DPO and Pouch Mail addresses. Allow appropriate mailing time to reach Medco, for Medco to fill your prescription and for the prescription to reach you.**
  - If you are posted, living or traveling outside the 50 United States, you may request up to a 1-year supply of most medications. Ask your prescriber to write you a prescription for a 1-year supply with no refills. Contact the Plan or refer to our Web site if you need additional assistance. There are limitations to sending temperature sensitive medications outside the 50 United States. Please contact Medco if you have been prescribed a temperature sensitive medication.
  - **Use the Internet through the Plan's Web site at www.AFSPA.org/FSBP (click on "Manage RX Benefits") to refill mail order medications via the Internet. Using the Internet saves you considerable time for refills compared to APO/FPO/DPO and Pouch Mail.**

These are the dispensing limitations.

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

Prescription drug benefits *(continued)*

These are the dispensing limitations *(continued)***.**

- **Coverage Management**
  - The Plan utilizes coverage management programs to help ensure that you receive the prescription drugs you need at a reasonable cost. The information below describes a feature of your prescription drug Plan known as coverage management. This program determines how the Plan will cover certain medications.
    - **Prior authorization review may be required: Some medications are not covered unless you receive approval through a coverage review (prior authorization).**
    - **Prior authorization review** uses Plan rules based on FDA-approved prescribing and safety information, clinical guidelines and uses that are considered reasonable, safe and effective. There are other medications that may be covered with limits (for example, only for a certain amount or for certain uses) unless you receive approval through a coverage review. Examples of drug categories requiring prior authorization include, but are not limited to, growth hormones, certain hormone therapies, interferons, erythroid stimulants, anti-narcoleptics, sleep aids, migraine medication, and oncologic agents. During this review, Medco asks your doctor for more information than what is on the prescription before the medication may be covered under the Plan. If coverage is approved, you simply pay your normal copayment for the medication. *If coverage is not approved, you will be responsible for the full cost of the medication.*
  - The Plan will participate in other approved managed care programs, as deemed necessary, to insure patient safety and appropriate quantities in accordance with the Plan rules based on FDA-approved guidelines referenced above.
  - To find out if your prescription requires prior authorization or more about our coverage management program visit Medco online at www.medco.com. If you are a first-time visitor to the site, register with your member ID and a recent prescription number, or call Medco Member Services at 1-800-818-6717. Members outside the U. S. may call Medco at 1-800-497-4641.
- **"Specialty Drugs" means those covered drugs that typically cost $500 or more per dose or $6,000 or more per year and have one or more of the following characteristics:** 1) complex therapy for complex disease; 2) specialized patient training and coordination of care (services, supplies, or devices) required prior to therapy initiation and/or during therapy; 3) unique patient compliance and safety monitoring requirements; 4) unique requirements for handling, shipping and storage; and 5) potential for significant waste due to the high cost of the drug. In addition, a follow-on-biologic or generic product will be considered a Specialty Drug if the innovator drug is a Specialty Drug.
  - Exceptions to the price threshold may exist based on certain characteristics of the drug or therapy which will still require the drug to be classified as a Specialty Drug.
  - Some examples of the disease categories currently in Medco's specialty pharmacy programs include cancer, cystic fibrosis, Gaucher disease, growth hormone deficiency hemophilia, immune deficiency, Hepatitis C, infertility, multiple sclerosis, rheumatoid arthritis and RSV prophylaxis.
  - **For drugs that are classified as Specialty Drugs, you may obtain only an initial 30-day supply and one refill of that medication at a Plan network retail pharmacy. All future refills of that medication must be purchased through the Plan's mail service benefit, Accredo Health Group, Medco's specialty pharmacy.** The Plan will provide you instructions on purchasing future refills. Purchases of Specialty Drugs made after the first refill at a network pharmacy are not covered by the Plan. For inquiries about this special program, please call 1-800-803-2523 Monday – Friday 8 a.m. to 9 p.m. Eastern Time and Saturday 8 a.m. to 5 p.m. Eastern Time. Also, please note the following items:
    - Accredo provides patient support and instructions on administering the medication.
    - Most Specialty Drugs require special handling and cannot be shipped to APO/FPO/DPO and Pouch Mail addresses.
    - Not all network retail pharmacies carry Specialty Drugs. Contact Accredo at 1-800-803-2523 for more information.
    - Fertility drugs are covered only as specified under Section 5(a), *Infertility services.*
- **Four-tier drug benefit** - we divide prescription drugs into four levels:
  - **Level I (generic drug):** Generic drugs are chemically and therapeutically equivalent to their corresponding brand name drugs, but cost less. The FDA must approve all generic versions of a drug and assure that they meet strict standards for quality, strength and purity. The FDA requires that generic equivalent medications contain the same active ingredients and be equivalent in strength and dosage to brand name drugs. The main difference between a generic and its brand name drug is the cost of the product.

Prescription drug benefits*(continued)*

- **Four-tier drug benefit** *(continued)*
  - **Level II (single-source brand name drug):** Single-source brand name drugs are available from only one manufacturer and are patent-protected. No generic equivalent is available.
  - **Level III (multi-source brand name drug):** Multi-source brand name drugs are brand name drugs for which the patent protection has expired. As a result, generic equivalent drugs are available. When an approved generic equivalent is available, that is the drug you will receive, unless you or your physician specifies that the prescription must be filled as written ("Dispense as Written – DAW"). When an approved generic equivalent is not available, you will pay the single-source brand name coinsurance/copayment. **If an approved generic equivalent is available, but you or your physician specifies that the prescription must be filled as written, you will pay the multi-source brand name coinsurance/copayment.**
  - **Level IV (Specialty Drugs):** Specialty Drugs are described on the previous page.
  - **The four level drug benefit is not applicable to prescription drugs you purchase from a retail pharmacy outside the 50 United States and file as a claim.**
- **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 treat breast cancer, determine the tolerance of anticoagulant medications or prevent major adverse cardiovascular events. The conditions, drugs and testing covered by the program will change from time to time as new genetic tests become available that are recommended by the FDA and are included in the program. The most up-to-date information on the conditions and drugs covered by the program can be accessed online at the Plan's co-branded Web site at www.AFSPA.org/FSBP and clicking "Manage RX Benefits" or by calling a Medco customer service representative at 1-800-818-6717.
  - If you are a qualified participant, services are available to you through the Personalized Medicine Program at no additional cost. The Personalized Medicine Program includes: (i) access to certain specified pharmacogenetic tests administered and analyzed by one of several designated clinical laboratories; and (ii) a clinical program that includes consultation with your prescriber of your test result by a representative of Medco trained specifically in pharmacogenetic testing. Medco also will offer on-going outreach and education to physicians and patients when appropriate.
  - When you qualify, Medco will contact you and/or your physician to enroll you in the program. With approval from your physician, the clinical laboratory will facilitate the processing of a pharmacogenetic test and share the results of the test with your physician and Medco. The results of the pharmacogenetic test are for informational purposes only. Any dosing or medication changes remain in the sole discretion of your physician. Your participation is voluntary and, if you decide to participate, Medco will facilitate your coverage under the Program. **You pay nothing for this service.**

When you do have to file a claim.

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

Benefits Description	You Pay
Note: The calendar year deductible does not apply to benefits in this Section. We say "(No deductible)" when it does not apply.	
Covered medications and supplies	
We will send each new enrollee a Foreign Service Benefit Plan/Medco Prescription Drug Identification Card, a description of our prescription drug program, a Health, Allergy & Medication Questionnaire and several mail order forms and envelopes. **You must present your Foreign Service Benefit Plan/Medco Prescription Drug ID Card when filling your prescription at a network pharmacy.** You may purchase the following medications and supplies prescribed by a physician from either a network pharmacy or by mail through the Medco Pharmacy: • Drugs that by Federal law of the United States require a physician's prescription for their purchase except those listed as not covered • Insulin and diabetic supplies • FDA-approved drugs, prescriptions, and devices for birth control • Prescription drugs for weight management • Prescription drugs approved by the FDA to treat tobacco dependence for smoking cessation only when enrolled in the Plan's Smoking Cessation Program (See *Educational classes and programs,* Section 5(a)) and only through mail order (except you may purchase prescription drugs through a retail pharmacy or Military Treatment Facility only when outside the 50 United States) (See page 62.) • Over-the-counter (OTC) medications approved by the FDA to treat tobacco dependence for smoking cessation (See page 62.) • Folic acid only when a physician's written prescription is required and only when medically necessary for women of childbearing age • Needles and syringes for the administration of covered medications Prescription drugs you receive from a physician or facility are covered only as specified under Section 5(a) and 5(c) and below. Note: **The Plan requires a coverage review (prior authorization) of certain prescription drugs based on FDA-approved prescribing and safety information, clinical guidelines and uses that are considered reasonable, safe and effective.** See *Coverage management* in this Section for more information. To find out if your prescription requires prior authorization or more about your prescription drug Plan, visit Medco online at www.medco.com. If you are a first-time visitor to the site register with your member ID and a recent prescription number, or call Medco Member Services at 1-800-818-6717. Members outside the United States may call Medco at 1-800-497-4641. Note: We do not require prior authorization for the purchase of certain prescription drugs when Medicare Part B or Part D is the primary payor or you are outside the 50 United States and purchase them from a retail pharmacy outside the 50 United States.	• Network Retail (non-Medicare) (No deductible applies for all Levels): - Level I (generic drug): $10 copay - Level II (single-source brand name drug): 25% ($30 minimum) - Level III (multi-source brand name drug): 30% ($50 minimum) - Level IV (Specialty Drugs): 25% (Note: After your first refill, you must use Accredo (see previous pages) if the Plan instructs you to do so. If you continue to use retail and the Plan has instructed you to use the Medco Pharmacy, you pay 100% of the cost.) • Network Retail (Medicare): - The Plan coordinates benefits with Medicare Part B and Part D coverage. - Be sure to present your Medicare ID card whenever using a retail pharmacy. If your medication or supplies are eligible for Medicare B or D, the retail pharmacy will submit your claim first to Medicare and then to the Plan for you. Most independent pharmacies and national chains are Medicare providers. To find a retail pharmacy near you that is a Medicare B- or D-participating pharmacy, please visit the Medicare website at www.medicare.gov/supplier/home.asp or call Medicare Customer Service at 1-800-633-4227. • Non-Network Retail (in the 50 United States, including Medicare): 100% of cost • Non-Network Retail (outside the 50 United States, including Medicare): 10% of cost (No deductible) See next page for Mail Order (the Medco 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 Mail Order – the Medco Pharmacy (non-Medicare) (No deductible applies for all Levels): - Level I (generic drug): $15 - Level II (single-source brand name drug): $45 - Level III (multi-source brand name drug): $65 - Level IV (Specialty Drugs): 25% up to a maximum of $150 • Network Mail Order – the Medco 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 mail order prescriptions to the Medco Pharmacy. Medco will review the prescriptions to determine if they could be eligible for Medicare Part B coverage. - When Medicare Part B is primary, contact Medicare at www.medicare.gov/supplier/home.asp or call Medicare Customer Service at 1-800-633-4227 about your options for submitting claims for Medicare-covered medications and supplies, whether you use a Medicare-approved supplier or the Medco Pharmacy. Prescriptions typically covered by Medicare Part B include diabetes supplies (test strips and meters), specific medications used to aid tissue acceptance (such as with organ transplants), certain oral medications used to treat cancer, and ostomy supplies. - Once Medicare Part B pays the claim, it will submit the claim to the Plan for you. - To receive your Medicare Part D-eligible medications and supplies by mail, send your mail order prescriptions to your Medicare Part D Prescription Drug Plan (PDP). If your Medicare Part D PDP is Medco, they will submit a claim first to Medicare and then to the Plan for you. If your Medicare Part D PDP is not Medco, you will need to submit a paper claim to the Plan. Note: If there is no generic equivalent available, you will still have to pay the single-source brand name coinsurance/copay. Note: A separate copay applies per prescription fill.

Covered medications and supplies - continued on next page

Benefits Description	You Pay
Covered medications and supplies (cont.)	
The following are covered: • If you are outside the 50 United States and purchase prescriptions only from a retail pharmacy outside the 50 United States or a Military Treatment Facility outside the 50 United States • If you do not use your prescription card to purchase colostomy, ostomy or diabetic supplies	• 10% of the cost (including Medicare) (No deductible)
The following are covered prescription drugs approved by the FDA to treat tobacco dependence for smoking cessation: • Prescription drugs you purchase only through mail order (except retail outside the 50 United States - see below) and only when enrolled in the Plan's Smoking Cessation Program	• Network Mail Order - the Medco Pharmacy (non-Medicare and Medicare) - Levels I, II, III: $0 copay (No deductible) only available through mail order
• Prescription drugs you purchase only from a retail pharmacy or a Military Treatment Facility outside the 50 United States and only when enrolled in the Smoking Cessation Program. You must file a claim for them.	Outside the 50 United States • Nothing (No deductible)
The following are covered OTC medications approved by the FDA to treat tobacco dependence for smoking cessation whether or not you are enrolled in the Plan's Smoking Cessation Program: • OTC medications you purchase at a Plan Network pharmacy Note: You must present your Foreign Service Benefit Plan/Medco Prescription ID card. Note: A physician's written prescription is required at a Plan Network pharmacy.	• Network Retail - (non-Medicare and Medicare) - Levels I, II, III: $0 copay (No deductible)
• OTC medications you purchase through mail order Note: A physician's written prescription is required to purchase through the Medco Pharmacy.	• The Medco Pharmacy - mail order (non-Medicare and non-Medicare): - Levels I, II, III: $0 copay (No deductible) only available through mail order
• OTC medications you purchase only from a retail pharmacy or a Military Treatment Facility outside the 50 United States. You must file a claim for them.	Outside the 50 United States • Nothing (No deductible)
Not covered: • *Drugs and supplies you purchase at a non-network pharmacy in the 50 United States except as covered under Section 5(a) and 5(c) and except when Medicare Part B and Part D are primary* • *Specialty Drugs you purchase at a non-network pharmacy except when Medicare Part B and Part D are primary* • *Specialty Drugs you purchase at a network pharmacy after your first refill and/or you purchase from a source other than through Accredo Health Group, Medco's specialty pharmacy, except when Medicare Part B and Part D are primaryDrugs and supplies you purchase without using your Foreign Service Benefit Plan/Medco Prescription Drug ID Card at a network pharmacy except as covered under Section 5(a) and 5(c) and except when Medicare Part B and Part D are primary*	*All charges*

Covered medications and supplies - continued on next page

Benefits Description	You Pay
Covered medications and supplies (cont.)	
Not covered (cont.) • *Drugs and supplies (except colostomy, ostomy, or diabetic supplies) you purchase by mail order from a source other than the Plan's Medco Pharmacy, Accredo Health Group, Medco's specialty pharmacy, or Liberty Medical, and except when Medicare Part B and Part D are primary* • *Medications for which you did not obtain prior authorization and which require prior authorization* • *Prescription drugs for smoking cessation except those obtained through the Medco Pharmacy (mail order) or when outside the 50 United States at a retail pharmacy or Military Treatment Facility as part of the Plan's Smoking Cessation Program* • *Non-prescription medicines (over-the-counter [OTC] medications)* • *OTC smoking cessation products purchased without the use of your Foreign Service Benefit Plan/Medco Prescription Drug ID Card at a Plan network pharmacy or purchased through mail order from a source other than the Plan's Medco Pharmacy except when outside the 50 United States* • *Prescription drug coinsurance* • *The Plan's Medco Pharmacy (mail order) copays* • *Drugs and supplies for cosmetic purposes* • *Nutritional supplements and vitamins except for folic acid when a physician's written prescription is required and when medically necessary for women of childbearing age* • *Medication that under Federal law does not require a prescription, even if your physician prescribes it or State law requires it or for which there is a non-prescription equivalent available* • *Hormone therapy to diagnose or treat infertility except that limited to the $5,000 lifetime maximum as part of the diagnosis and treatment of infertility (see Section 5(a), Infertility services). You may not obtain hormone therapy treatment with your Foreign Service Benefit Plan/Medco Prescription Drug ID Card or through the Medco Pharmacy (mail order).* • *Drugs and supplies related to impotency, sex transformations, sexual dysfunction, or sexual inadequacy*	*All charges*

Section 5(g). Dental benefits

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- If you are enrolled in a Federal Employees Dental/Vision Insurance Program (FEDVIP) Dental Plan, your FEHB Plan will be First/Primary 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: $300 per person ($600 per family). The calendar year deductible does not apply to most benefits in this Section. We added "(calendar year deductible applies)" to show when the calendar year deductible does apply.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works, with special sections for members who are age 65 or over. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- Note: We cover hospital services and supplies related to dental procedures when necessitated by a non-dental physical impairment to safeguard the health of the patient, even though we may not pay benefits for services of dentists or physicians in connection with the dental treatment. See Section 5 (c) for inpatient hospital benefits.

Accidental injury benefit	You pay
Accidental injury benefit	
We cover dental work (including dental X-rays) to repair or initially replace sound natural teeth under the following condition: • You must receive these services as a result of an accidental injury to the jaw or sound natural teeth. Note: We cover dental care required as a result of accidental injury from an external force such as a blow or fall to sound natural teeth (not from biting or chewing) that requires immediate attention. Note: We define a sound natural tooth as a tooth which: • Is whole or properly restored; • Is without impairment, periodontal or other conditions; and • Does not need treatment for any reason other than an accidental injury. Note: The Plan will ask for information from your dentist that documents the teeth involved in the accident were sound natural teeth prior to the accident if such information is not submitted with the claim.	PPO: 20% of the Plan allowance (calendar year deductible applies) Non-PPO: 20% of the Plan allowance and any difference between our allowance and the billed amount (calendar year deductible applies) Providers outside the 50 United States: 20% of the Plan allowance (calendar year deductible applies)

Dental benefits - continued on next page

Dental benefits		
Only those services listed below are covered		
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 a lifetime maximum of $1,000 per person	50% of the Plan allowance until benefits stop at $1,000 and all charges after $1,000

Section 5(h). Special features

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

Special feature	Description
Healthy Pregnancy Program	You have access to the Plan's Healthy Pregnancy Program, which provides educational material and support to pregnant women. Contact the Plan at 1-800-593-2354 for more information.
Disease management programs	Disease Management programs for members and covered dependents with asthma, chronic obstructive pulmonary disease (COPD), coronary artery disease (CAD), diabetes, heart failure (HF) 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. Members are automatically enrolled in the program. However, participation is voluntary. If you are enrolled in the program and do not want to participate, please call 1-800-579-5755. The participant and his/her physician remain in charge of the participant's treatment plan. If you would like to contact the Plan for more information about this program, please call 1-800-579-5755. We are available to assist you Monday- Friday from 10:00 AM to 8:00 PM ET. **Overseas Disease Management Program** This program is tailored specifically to meet the needs of members who reside in a foreign country. This is an exclusive arrangement that the Plan has with Coventry. The program provides: • Information and support to you via secure e-mail; • Educational materials and notifications about your condition; and • Direct consultations with case managers. We will contact candidates and ask them to participate voluntarily. If you are posted back to the United States, you will remain enrolled in the program and will continue to receive information. If you would like to contact the Plan for more information about this program, please e-mail FSBPhealth@cvty.com.
ITA (Cancer Management Program)	Cancer Management Program for members and covered dependents, which provides education and support to cancer patients. We will contact candidates and ask them to participate in the Program. Participation is voluntary. The participant and his/her physician remain in charge of the participant's treatment plan. If you would like to contact the Plan for more information about this Program, please call 1-800-938-2220

Special feature	Description
Wellness incentives	**Diabetes Wellness Incentive** Members diagnosed with diabetes can earn a $50 reward when they enroll in the Diabetes Disease Management Program and meet all of the following criteria: physician visit, hemoglobin A1C blood test and lipid panel blood test once per calendar year. The reward will be sent to members completing all criteria and may be used for out-of-pocket health expenses or non-covered health expenses you might incur. **Coronary Artery Disease Wellness Incentive** Members diagnosed with coronary artery disease (CAD) can earn a $50 reward when they enroll in the CAD Disease Management Program and meet all of the following criteria: physician visit and lipid panel blood test once per calendar year. The reward will be sent to members completing all criteria and may be used for out-of-pocket health expenses or non-covered health expenses you might incur.
Scanned claim submission via secure Internet connection	The Plan provides a secure method for you to submit claims to us via the Internet from overseas locations. Visit our Web site (www.AFSPA.org/FSBP), click on the "Ask AFSPA" tab and then "FSBP". You can attach a scanned copy of your claim (as a PDF) to an e-mail message you send to us. We designed this secure process to eliminate the lengthy mail time from your post outside the United States to our office. Also, you may correspond with us via secure e-mail through this process. In addition, you may fax us your claims from overseas. Our special fax number is 202-464-4508.
My Online Services **(Web based customer service)**	Access the Plan's Web site tool ***My Online Services*** 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 pre-certification 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.

Special feature	Description
Medco Health - Prescription benefits (Web based customer service)	Access the Plan's Web site tool for managing your prescription benefits through our link at www.AFSPA.org/FSBP. Click on "Manage RX Benefits". This provides you secure access to a broad range of prescription management and tools. Services such as the following are available: • Refill and renew mail order prescriptions; • Verify mail order prescription status; • View retail and mail order prescription claim histories, expenses, and balances; • Locate participating network pharmacies; • Compare plan-specific pricing and drug coverage information with all lower cost, clinically appropriate alternatives identified; • Review drug information (interactions, side effects, precautions, guidelines for use, etc.); • Review benefit highlights, including days supply and copayments; • Prepare for a doctor visit; • Transfer retail prescriptions to mail; and • Receive automated e-mail refill and renewal reminders to help ensure continuous therapy and late-to-fill messages that indicate when you are late to fill an important medication.

Non-FEHB benefits available to Plan members

The benefits on this page are not part of the FEHB contract or premium **and you cannot file an FEHB disputed claim about them**. Fees you pay for these services do not count toward FEHB deductibles, copayments or catastrophic protection out-of-pocket maximums. These programs and materials are the responsibility of the **AMERICAN FOREIGN SERVICE PROTECTIVE ASSOCIATION (AFSPA)** and all appeals must follow their guidelines.

Long Term Care

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

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

Term Life Insurance

You can obtain up to $300,000 of term life coverage with this plan. Family coverage is also available.

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

Accidental Death & Dismemberment Insurance

This plan helps to protect against accidents anywhere in the world. You can obtain up to $300,000 of coverage, which includes:

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

Total Disability

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

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

Immediate Benefit Plan

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

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

Dental Insurance

We offer several plans to suit your needs, whether you reside in the United States or overseas. The following is a brief description of each plan.

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

- $25 calendar year deductible per person ($75 maximum for family)
- Calendar year maximum of $2,000 per covered person
- No waiting periods
- No claim forms to file
- Optional Orthodontia benefit is available

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

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

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

- No calendar year deductible for preventive and diagnostic care services
- In-network benefits are 100%/80%/50%
- Calendar year maximum is $3,000 per person for in-network services (starting January 1, 2011)
- Dependent child coverage to age 26 (starting January 1, 2011)

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

- Calendar year maximum of $3,000 per person for services rendered outside the U.S. (starting January 1, 2011)
- Coinsurance amount of 100%/80%/50% for services rendered outside the U.S.
- Coverage available in the U.S. at reduced coinsurance amounts and calendar year maximums
- Multilingual customer service available 24/7
- Direct payment to foreign providers
- Direct deposit/EFT is available

Members of Household Insurance

Worldwide medical insurance plans for domestic partners, parents and dependent children who do not qualify for coverage under the FEHB Program.

- Applicants must reside outside the U.S. at time of application or must depart the U.S. within 30 days of the Certificate's Effective Date.
- Both plans cover hospital expenses, preventive care, laboratory tests, X-rays and other medical scans, prescription medication, chiropractic, ambulance and more.

Travel Assistance Services

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

Discount on Non-Covered Prescription Drugs

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

- dermatologicals (Renova)
- anorexiants
- Rx vitamins, erectile dysfunction agents
- drugs labeled for cosmetic indications (Propecia)

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

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

Discount on Over-the-Counter (OTC) Nonprescription Products through the Medco Health Store

You may purchase OTC products directly from the Medco Health Store.

- To search for nonprescription items on Medco's Web site, log on to www.medco.com and click on "Nonprescription items" (left menu or tab at top).
- If you are a first-time visitor to the site, take a moment to register. Please have your member ID and a recent prescription number available.

You will find a wide selection of products including such items as nonprescription medications, vitamins, herbal products and personal care products.

- Follow the on-screen instructions to search for items and add them to your shopping cart.
- If you plan to purchase products on a regular basis, you can create an online shopping list that will simplify future shopping.
- Interaction Checker can detect certain combinations of medicines that may result in side effects or inhibit your medicines from working.

Legal Services

A number of firms located in the Washington, DC metropolitan area provide advice on wills, immigration, estate planning, real estate, family law and adoptions at a discounted rate to AFSPA members.

EyeMed Vision Care Program

Save up to 40% with your EyeMed Vision Care discount program. Members are eligible for discounts on exams, glasses and contact lenses at thousands of providers nationwide. Members have access to over 33,000 providers including optometrists, ophthalmologists, opticians and leading optical retailers such as: LensCrafters, participating Pearle Vision and Sears Optical locations, Target Optical, JCPenney Optical and many independents. For more information concerning the program or to locate a participating provider, visit the Plan's Web site at www.AFSPA.org/FSBP and select My Online Services (MOS). Once you have signed into MOS, select "Wellness Tools" and then "Discount Programs" or call 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 life changing 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 for more information.

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**.

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

AMERICAN FOREIGN SERVICE PROTECTIVE ASSOCIATION

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

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

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

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

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

We do not cover the following:

- Services, drugs, or supplies you receive while you are not enrolled in this Plan;
- Services, drugs, or supplies that are not medically necessary;
- Services, drugs, or supplies not required according to accepted standards of medical, dental, or psychiatric practice;
- Experimental or investigational procedures, treatments, drugs or devices;
- Services, drugs, or supplies related to 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, sex transformations, sexual dysfunction or sexual inadequacy;
- Services, drugs, or supplies you receive from a provider or facility barred from the FEHB Program;
- Any part of a provider's fee or charge ordinarily due from you that has been waived. If a provider routinely waives (does not require you to pay) a deductible, copayment or coinsurance, we will calculate the actual provider fee or charge by reducing the fee or charge by the amount waived;
- Charges which the enrollee or the Plan have no legal obligation to pay, such as excess charges for an annuitant 65 or older who is not covered by Medicare Parts A and/or B (see Section 4), 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 4), 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) and 5 (f) and except surgery for morbid obesity as described in Section 5(b);
- Services, drugs, or supplies furnished or billed by a noncovered facility, except that medically necessary prescription drugs and physical, speech and occupational therapy rendered by a qualified professional therapist on an outpatient basis are covered, subject to Plan limits;
- Services, drugs, or supplies furnished by immediate relatives or household members, such as spouse, parents, children, brothers or sisters by blood, marriage, or adoption;
- Services, drugs, or supplies not specifically listed as covered; or
- Charges that we determine are over our Plan allowance.

Listed below are examples of some of our exclusions:

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

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

Section 7. Filing a claim for covered services

How to claim benefits

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

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

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

- Name of patient, date of birth and relationship to enrollee;
- Plan identification number of the enrollee;
- Name and address of person or firm providing the service or supply;
- Dates that services or supplies were furnished;
- Diagnosis;
- Valid medical or dental code and/or description of each service or supply; and
- The charge for each service or supply.

Note: Canceled checks, cash register receipts, or balance due statements are not acceptable substitutes for itemized bills. The Plan cannot accept a claim as an e-mail attachment, except as described above (and also in detail on the next page under *Foreign claims*) using our secure electronic method.

In addition:

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

Foreign Claims

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

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

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

You may include an English translation (not required) and a currency exchange rate (recommended). We will translate claims and convert them to U.S. Dollars using the exchange rate applicable at the time the expense was incurred if you do not supply us with a currency conversion rate. You do not need to file foreign claims on CMS-1500 or UB-04 forms.

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

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

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

Foreign Service Benefit Plan

1716 N Street, NW

Washington, DC 20036-2902

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

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

Urgent care claims procedures

If you have an urgent care claim, please contact our Customer Service Department at **Foreign Service Benefit Plan,** 1716 N Street, NW, Washington, DC 20036-2902, by phone at 202-833-4910 (members), fax at 202-833-4918, or secure e-mail through our Web site at www.AFSPA.org/FSBP (click on the "Ask AFSPA" tab and then "FSBP"). Urgent care claims must meet the definition found in Section 10 of this brochure, and most urgent care claims will be claims for access to care rather than claims for care already received. We will notify you of our decision not later than 72 hours after we receive the claim as long as you provide us with sufficient information to decide the claim. If you or your authorized representative fails to provide sufficient information to allow us to make a decision, we will inform you or your authorized representative of the specific information necessary to complete the claim not later than 72 hours after we receive the claim and a time frame for our receipt of this information. We will decide the claim within 48 hours of (i) receiving the information or (ii) the end of the time frame, whichever is earlier.

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

Concurrent care claims procedures

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 as an appealable decision. 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.

Pre-service claims procedures

As indicated in Section 3, certain care requires Plan approval in advance. We will notify you of our decision within 15 days after the 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 before the expiration 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.

If you fail to follow these pre-service claim procedures, then we will notify you of your failure to follow these procedures as long as (1) your request is made to our customer service department and (2) your request names you, your medical condition or symptom, and the specific treatment, service, procedure, or product requested. We will provide this notice within five days following the failure or 24 hours if your pre-service claim is for urgent care. Notification may be oral, unless you request written correspondence.

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.

Records

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

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

Deadline for filing your claim

Send us all of the documents for your claim as soon as possible. You must submit the claim within 2 years from the date you incur the expense. We can extend this deadline if you were prevented from filing your claim timely by administrative operations of Government or legal incapacity, provided you file the claim as soon as reasonably possible. Once we pay benefits, there is a three-year limitation on the reissuance of uncashed checks.

When we need more information

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

Section 8. The disputed claims process

Please follow this Federal Employees Health Benefits Program disputed claims process if you disagree with our decision on your claim or request for services, drugs, or supplies – including a request for preauthorization/concurrent review/prior approval required by Section 3. You may be able to appeal to the U.S. Office of Personnel Management (OPM) immediately if we do not follow the particular requirements of this disputed claims process. For more information about situations in which you are entitled to immediately appeal and how to do so, please visit www.AFSPA.org/FSBP.

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.

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;

d) Include copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms; and

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.

2 We have 30 days from the date we receive your request to:

a) Pay the claim (or, if applicable, arrange for the health care provider to give you the care or precertify your hospital stay or grant your request for prior approval for a service, drug, or supply); or

b) Write to you and maintain our denial – go to step 4; or

c) Ask you or your provider for more information. If we ask your provider, we will send you a copy of our request – go to step 3.

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

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

We will write to you with our decision.

In the case of an appeal of an urgent care claim, we will notify you of our decision not later than 72 hours after receipt of your reconsideration request. We will hasten the review process, which allows oral or written requests for appeals and the exchange of information by telephone, electronic mail, facsimile, or other expeditious methods.

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

You must write to OPM within:

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

Write to OPM at: United States Office of Personnel Management, Insurance Operations, Health Insurance 2, 1900 E Street, NW, Washington, DC 20415-3620.

Send OPM the following information:

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

5 OPM will review your disputed claim request and will use the information it collects from you and us to decide whether our decision is correct. OPM will send you a final decision within 60 days. There are no other administrative appeals.

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

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

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

Note: **If you have a serious or life threatening condition** (one that may cause permanent loss of bodily functions or death if not treated as soon as possible), and you did not indicate that your claim was a claim for urgent care, then call us at (202) 833-4910. We will hasten our review (if we have not yet responded to your claim); or we will inform OPM so they can quickly review your claim on appeal. You may call OPM's Health Insurance 2 at (202) 606-3818 between 8 a.m. and 5 p.m. eastern time.

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) 606-3818. We will hasten our review (if we have not yet responded to your claim); or we will inform OPM so they can quickly review your claim on appeal. You may call OPM's Health Insurance 2 at (202) 606-3818 between 8 a.m. and 5 p.m. eastern time.

Section 9. Coordinating benefits with other coverage

When you have other health coverage

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

When you have double coverage, one plan normally pays its benefits in full as the primary 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' guidelines.

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.

What is Medicare?

Medicare is a health insurance program for:

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

Medicare has four parts:

- Part A (Hospital Insurance). Most people do not have to pay for Part A. If you or your spouse worked for at least 10 years in Medicare-covered employment, you should be able to qualify for premium-free Part A insurance. (If you were a Federal employee at any time both before and during January 1983, you will receive credit for your Federal employment before January 1983.) Otherwise, if you are age 65 or older, you may be able to buy it. Contact 1-800-MEDICARE (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 pages 83 and 86.

- Part D (Medicare prescription drug coverage). There is a monthly premium for Part D coverage. If you have limited savings and a low income, you may be eligible for Medicare's Low-Income Benefits. For people with limited income and resources, extra help in paying for a Medicare prescription drug plan is available. Information regarding this program is available through the Social Security Administration (SSA). For more information about this extra help, visit SSA online at www.socialsecurity.gov, or call them at 1-800-772-1213, (TTY 1-800-325-0778). Before enrolling in Medicare Part D, please review the important disclosure notice from us about the FEHB prescription drug coverage and Medicare. The notice is on the first inside page of this brochure. The notice will give you guidance on enrolling in Medicare Part D.

- **Should I enroll in Medicare?**

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

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

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

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

Please refer to *When you are age 65 or over and do not have Medicare* in Section 4 for information about how we provide benefits when you are age 65 or older and do not have Medicare.

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

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

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

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

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

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

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

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

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

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

- **Medical services and supplies provided by physicians and other health care professionals in Section 5(a).**
  - If you are enrolled in Medicare Part B, we will waive your calendar year deductible and coinsurance.
- **Surgical and anesthesia services provided by physicians and other health care professionals in Section 5(b).**
  - If you are enrolled in Medicare Part B, we will waive your coinsurance.
- **Services provided by a hospital or other facility, and ambulance services in Section 5(c).**
  - If you are enrolled in Medicare Part A, we will waive your inpatient hospital copayment and coinsurance for inpatient stays.

- If you are enrolled in Medicare Part B, we will waive the deductible and coinsurance for outpatient hospital, ambulatory surgical center and ambulance.

- **Services provided by facilities and providers covered under Emergency services/ accidents in Section 5(d).**
  - If you are enrolled in Medicare Part B, we will waive the deductible and coinsurance.
- **Services provided by mental health and substance abuse facilities and providers in Section 5(e).**
  - If you are enrolled in Medicare Part A, we will waive the inpatient hospital copayment and coinsurance for inpatient stays.
  - If you are enrolled in Medicare Part B, we will waive the deductible and coinsurance.
- **Services provided under Prescription benefits in Section 5(f).**
  - If you are enrolled in Medicare Part B, the Plan will coordinate benefits and waive the deductible, coinsurance and/or copayment for prescription drugs you purchase only at Network pharmacies.
  - If you are enrolled in Medicare Part B, the Plan will coordinate benefits and waive the deductible, coinsurance and/or copayment for colostomy, ostomy and diabetic supplies you purchase from any Medicare Part B provider.
- **Services provided under Dental benefits in Section 5(h).**
  - We do **not** waive the coinsurance under Dental benefits.

- **Tell us about your Medicare coverage**

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

- **Private contract with your physician**

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

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

- **Medicare Advantage (Part C)**

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

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

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

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

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

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

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

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

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

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

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

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

TRICARE and CHAMPVA

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

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

Workers' Compensation

We do not cover services that:

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

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

Medicaid

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

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

When other Government agencies are responsible for your care

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

When others are responsible for injuries

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

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

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

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

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

If we invoke this provision:

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

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

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

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

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

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

Clinical trials

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

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

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

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

Coinsurance

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

Copayment

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

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 *Deductible*, Section 4.

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.

Medically necessary

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

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

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

Mental conditions/ substance abuse

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

Plan allowance

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

PPO Providers – Our Plan allowance is a negotiated amount between 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.

Non-PPO Providers – Our Plan allowance is the lesser of: (1) the provider's billed charge; or (2) the Plan's out-of-network (OON) fee schedule amount. The Plan's OON fee schedule amount is equal to the 90th percentile amount for the charges listed in the Prevailing Healthcare Charges System, administered by Fair Health, Inc. The OON fee schedule amounts vary by geographic area in which services are furnished. We base our coinsurance of this OON fee schedule amount. This applies to all benefits in Section 5 of this brochure.

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

Providers outside the 50 United States – We generally do not reduce claims from providers outside the 50 United States to a Plan allowance. However, we reserve the right to request information that will enable us to determine an allowance on charges that we deem to be excessive.

We determine what is reasonable and thus what is within our Plan allowance.

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

Post-service claims

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

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

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

Urgent care claims 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 **Foreign Service Benefit Plan**, 1716 N Street, NW, Washington, DC 20036-2902, by phone at 202-833-4910, fax at 202-833-4918, or secure e-mail through our our Web site at www.AFSPA.org/FSBP (click on the “Ask AFSPA” tab and then "FSBP"). 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. FEHB Facts

Coverage information

- **No pre-existing condition limitation**

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

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

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

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

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

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

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

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

Several provisions of the Affordable Care Act (ACA) affect the eligibility of family members under the FEHB Program effective January 1, 2011.

Children	Coverage
Between ages 22 and 26	Children between the ages of 22 and 26 are covered under their parent's Self and Family enrollment up to age 26.
Married Children	Married children (but **NOT** their spouse or their own children) are covered up to age 26. This is true even if the child is currently under age 22.
Children with or eligible for employer-provided health insurance	Children who are eligible for or have their own employer-provided health insurance are eligible for coverage up to age 26.
Stepchildren	Stepchildren do not need to live with the enrollee in a parent–child relationship to be eligible for coverage up to age 26.
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.
Foster Children	Foster children are eligible for coverage up to age 26.

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

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 or stepchildren your employing or retirement office authorizes coverage for. Under certain circumstances, you may also continue coverage for a disabled child 26 years of age or older who is incapable of self-support.

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

Your employing or retirement office will **not** notify you when a family member is no longer eligible to receive benefits, nor will we. Please tell us immediately when you add or remove family members from your coverage for any reason, including family members are added or lose coverage for any reason, including your marriage, divorce, annulment, or when your child under age 26 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.

- **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 2011 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 2010 benefits until the effective date of your coverage with your new plan. Annuitants' coverage and premiums begin on January 1. If you joined at any other time during the year, your employing office will tell you the effective date of coverage.

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

- **When you retire**

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

When you lose benefits

- **When FEHB coverage ends**

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

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

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

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

- **Upon divorce**

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

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

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

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

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

- **Converting to individual coverage**

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

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

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

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

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

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

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

Section 12. Three Federal Programs complement FEHB benefits

Important information

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

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

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

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

The Federal Flexible Spending Account Program – *FSAFEDS*

What is an FSA?

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

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

- **Health Care FSA (HCFSA)** – Reimburses you for eligible health care expenses (such as copayments, deductibles, insulin, products, physician prescribed over-the-counter drugs and medications, vision and dental expenses, and much more) for you and your tax dependents including adult children (through the end of the calendar year in which they turn 26) who are not covered or reimbursed by FEHBP or FEDVIP coverage or any other insurance.
- **Limited Expense Health Care FSA (LEX HCFSA)** – Designed for employees enrolled in or covered by a High Deductible Health Plan with a Health Savings Account. Eligible expenses are limited to dental and vision care expenses for you and your dependents which are not covered or reimbursed by FEHBP or FEDVIP coverage or any other insurance.
- **Dependent Care FSA (DCFSA)** – Reimburses you for eligible **non-medical** day care expenses for your child(ren) under age 13 and/or for any person you claim as a dependent on your Federal Income Tax return who is mentally or physically incapable of self-care. You (and your spouse if married) must be working, looking for work (income must be earned during the year), or attending school full-time to be eligible for a DCFSA.
- 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 and was established by the Federal Employee Dental and Vision Benefits Enhancement Act of 2004. This Program provides comprehensive dental and vision insurance at competitive group rates with no pre-existing condition limitations.

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

Dental Insurance

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

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

Vision Insurance

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

Additional information

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

How do I enroll?

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

The Federal Long Term Care Insurance Program – *FLTCIP*

It's important protection

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

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Do not rely on this page; it is for your convenience and may not show all pages where the terms appear. **This index references both covered and non-covered services and supplies.**

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Summary of benefits for the High Option of the Foreign Service Benefit Plan - 2011

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

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

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

High Option Benefits	You pay	Page
Medical services provided by physicians:		
• Diagnostic and treatment services provided in the hospital and office	PPO: 10% of our allowance* Non-PPO: 30% of our allowance and any difference between our allowance and the billed amount* Providers outside the 50 United States: 10% of our allowance*	25
Services provided by a hospital:		
• Inpatient	PPO: Nothing Non-PPO: $200 per hospital stay and 20% of charges Providers outside the 50 United States: Nothing	47
• Outpatient	Surgical: PPO: 10% of our allowance* Non-PPO: 30% of our allowance and any difference between our allowance and the billed amount* Providers outside the 50 United States: 10% of our allowance* Medical: PPO: 10% of our allowance* Non-PPO: 30% of our allowance and any difference between our allowance and the billed amount* Providers outside the 50 United States: 10% of our allowance*	49
Emergency benefits:		
• Accidental injury: emergency room charges (ER) and urgent care facility charges, ER and urgent care physicians' charges and ancillary services (performed at the time of the ER or urgent care facility visit) **or** initial office visit and ancillary services (performed at the time of the initial office visit)	PPO: Nothing Non-PPO: Only the difference between our allowance and the billed amount Providers outside the 50 United States: Nothing	51

High Option Benefits	You pay	Page
• Medical emergency	PPO: 10% of our allowance* Non-PPO: 10% of our allowance and any difference between our allowance and the billed amount* Providers outside the 50 United States: 10% of our allowance*	52
• Outpatient care in an urgent care facility because of a medical emergency	PPO: $50 copayment per occurrence Non-PPO: $50 copayment per occurrence and any difference between our allowance and the billed amount Providers outside the 50 United States: $50 copayment per occurrence	52
Mental health and substance abuse treatment:	PPO: Regular cost-sharing* Non-PPO: Regular cost-sharing* Providers outside the 50 United States: Regular cost-sharing*	53
Prescription drugs:		
• Retail pharmacy	Network Pharmacies in the 50 United States: Note – You must show your Plan ID card: • Level I (generic): $10 copay for up to a 30-day supply • Level II (single-source brand name): 25% ($30 minimum) for up to a 30-day supply • Level III (multi-source brand name): 30% ($50 minimum) for up to a 30-day supply • Level IV (Specialty Drugs): 25% for up to a 30-day supply (Note: Restrictions apply on refills.) Non-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)	60
• Mail order	Mail Order (the Medco Pharmacy): • Level I (generic): $15 for up to a 90-day supply • Level II (single-source brand name): $45 for up to a 90-day supply • Level III (multi-source brand name): $65 for up to a 90-day supply • Level IV (Specialty drugs): 25% up to maximum of $150 for up to a 90-day supply	61

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	65
• Orthodontics	50% of our allowance up to our maximum payment of $1,000 and 100% after our maximum payment of $1,000	65
Special features:		
• The Plan offers the following Special features: - Flexible benefits option - Centers of Excellence for tissue and organ transplants - Overseas second opinion - Healthy Pregnancy Program - Disease management program (domestic and overseas) - ITA (Cancer Management Program) - Wellness incentives (Diabetes and Coronary Artery Disease) - Scanned claim submission via secure Internet connection - *My Online Services* (Web based customer service) - Medco Health - Prescription benefits (Web based customer service)		66
Protection against catastrophic costs (out-of-pocket maximum):	PPO: Nothing after $4,000/Self Only or $4,500/Self and Family enrollment per year Non-PPO: Nothing after $6,000/Self Only or $6,500/Self and Family enrollment per year Providers outside the 50 United States: Nothing after $4,000/Self Only or $4,500/Self and Family enrollment per year Note: Benefit maximums still apply and some costs do not count toward this protection.	18

Notes

Notes

2011 Rate Information for the Foreign Service Benefit Plan

2011 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	$170.99	$ 56.99	$370.47	$123.49
High Option Self and Family	402	$403.98	$141.31	$875.29	$306.17