Foreign Service Benefit Plan

www.AFSPA.org/FSBP

Customer Service: 202-833-4910

afspa
FOREIGN SERVICE BENEFIT PLAN
Caring For Your Health Worldwide®

2021

A Fee-for-Service Plan (High Option) with Network Providers

This Plan's health coverage qualifies as minimum essential coverage and meets the minimum value standard for the benefits it provides. See page 8 for details. This Plan is accredited. See page 12.

IMPORTANT
- Rates: Back Cover
- Changes for 2021: Page 15
- Summary of Benefits: Page 128

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

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

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

(1) Department of State (Foreign Service and Civil Service);
(2) Department of Defense;
(3) Department of Homeland Security;
(4) USAID (Foreign Service and Civil Service);
(5) Foreign Commercial Service (Foreign Service and Civil Service);
(6) Foreign Agricultural Service (Foreign Service and Civil Service);
(7) CIA, NSA and other intelligence organizations; and to
(8) Executive Branch civilian employees assigned overseas or to U.S. possessions and territories; and the direct hire domestic employees assigned to support those activities.

Direct hire employees and Executive Branch civilian employees must enroll in the **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 systems 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
403 High Option - Self Plus One
402 High Option - Self and Family

FEHB
Federal Employees Health Benefits Program

Authorized for distribution by the:

United States Office of Personnel Management

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

Important Notice from the Foreign Service Benefit Plan About

Our Prescription Drug Coverage and Medicare

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

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

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

Please be advised

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

Medicare's Low Income Benefits

For people with limited income and resources, extra help paying for a Medicare prescription drug plan is available. Information regarding this program is available through the Social Security Administration (SSA) online at www.socialsecurity.gov*, or call the SSA at 800-772-1213, TTY 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 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 (FSBP)** under the American Foreign Service Protection Association contract (CS 1062) with the United States Office of Personnel Management, as authorized by the Federal Employees Health Benefits law. This Plan is sponsored by the American Foreign Service Protective Association and administered by the Claims Administration Corporation, which is an Aetna Company. The contact information for the **Foreign Service Benefit Plan** administrative office is:

Foreign Service Benefit Plan

1620 L Street, NW

Suite 800

Washington, DC 20036-5629

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

Hours of operation:

- **Telephone: Monday – Friday: 8:30 a.m. - 5:30 p.m. (ET)**
- **Walk-in: Monday – Friday: 8:30 a.m. - 4:00 p.m. (ET)**

www.AFSPA.org/FSBP

E-mail:

- **Non-secure: health@AFSPA.org and enrollment@AFSPA.org;**
- **Secure e-mail and secure claim submission instructions:** Visit our secure Member Portal at www.myafspa.org. Login to the Member Portal with your username and password. Once inside the portal, select “Submit A Claim” under the "Secure Forms" tab. Follow the screen prompts to upload your PDF claim documents. You have the options to include questions or comments and send your secure claims to a specific customer service representative. **Please ensure your name and member ID number appear on the claim. Make sure the image quality of your electronic documents is clear and legible. Any unclear or illegible supporting documentation may cause your claim to be delayed or denied.**

This brochure is the official statement of benefits. No verbal 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 Plus One or 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, 2021 unless those benefits are also shown in this brochure.

OPM negotiates benefits and rates with each plan annually. Benefit changes are effective January 1, 2021 and changes are summarized on page 15. Rates are shown on the back cover of this brochure.

Plain Language

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

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

Stop Health Care Fraud!

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

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

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

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

CALL --THE HEALTH CARE FRAUD HOTLINE
877-499-7295
OR go to www.opm.gov/our-inspector-general/hotline-to-report-fraud-waste-or-abuse/complaint-form/
The online reporting form is the desired method of reporting fraud in order to ensure accuracy, and a quicker response time.
You can also write to:
United States Office of Personnel Management
Office of the Inspector General Fraud Hotline
1900 E Street, NW, Room 6400
Washington, DC 20415-1100

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

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

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

A carrier may request that an enrollee verify the eligibility of any or all family members listed as covered under the enrollee's FEHB enrollment.

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

Discrimination is Against the Law

The **Foreign Service Benefit Plan** complies with all applicable Federal civil rights laws, including Title VII of the Civil Rights Act of 1964.

You can also file a civil rights complaint with the Office of Personnel Management by mail at: Office of Personnel Management Healthcare and Insurance Federal Employee Insurance Operations, Attention: Assistant Director FEIO, 1900 E Street NW, Suite 3400 S, Washington, DC 20415-3610.

Preventing Medical Mistakes and Member Rights and Responsibilities

Medical mistakes continue to be a significant cause of preventable deaths within the United States. 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. Medical mistakes and their consequences also add significantly to the overall cost of health care. Hospitals and health care providers are being held accountable for the quality of care and reduction in medical mistakes by their accrediting bodies. You can also improve the quality and safety of your own health care and that of your family members by learning more about and understanding your risks. Your provider has the responsibility to provide you with complete information concerning your diagnosis, evaluation, treatment and prognosis. Additionally, providers should allow your participation in decisions involving your health care. 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 take notes, ask questions and understand answers.
- Provide complete and accurate information to the best of your ability.
- Inform the provider about any living will, medical power of attorney or other directive that could affect care.
- Treat all health care providers respectfully.
- Follow the treatment plan prescribed by your health care provider.

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

- Bring the actual medication or give your doctor and pharmacist a list of all the medications and dosage that you take, including non-prescription (over-the-counter) medications and nutritional supplements.
- Tell your doctor and pharmacist about any drug, food, and other allergies you have, such as latex.
- Ask about any risks or side effects of the medication and what to avoid while taking it. Be sure to write down what your doctor or pharmacist says.
- Make sure your medication is what the doctor ordered. Ask the pharmacist about your medication if it looks different than you expected.
- Read the label and patient package insert when you get your medication, including all warnings and instructions.
- Know how to use your medication. Especially note the times and conditions when your medication should and should not be taken.
- Contact your doctor or pharmacist if you have any questions.
- Understand both the generic and brand names of your medication. This helps ensure you do not receive double dosing from taking both a generic and a brand. It also helps prevent you from taking a medication to which you are allergic.

3. Get the results of any test or procedure.

- Ask when and how you will get the results of tests or procedures. Will it be in person, by phone, mail, or through the Provider's portal?
- Do not assume the results are fine if you do not get them when expected. Contact your health care provider and ask for your results.
- Ask what the results mean for your care.

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

- Ask your doctor about which hospital or clinic has the best care and results for your condition if you have more than one hospital or clinic 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 or clinic.

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

- Make sure you, your doctor, and your surgeon all agree on exactly what will be done during the operation.
- Ask your doctor, “Who will manage my care when I am in the hospital?”
- Ask your surgeon:
  - “Exactly what will you be doing?"
  - “About how long will it take?"
  - “What will happen after surgery?"
  - “How can I expect to feel during recovery?”
- Tell the surgeon, anesthesiologist, and nurses about any allergies, bad reactions to anesthesia, and any medications or nutritional supplements you are taking.

Patient Safety Links

For more information on patient safety, please visit:

- www.jointcommission.org/speakup.aspx. The Joint Commission's Speak Up™ patient safety program.
- www.jointcommission.org/topics/patient_safety.aspx. The Joint Commission helps health care organizations to improve the quality and safety of the care they deliver.

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

Preventable Health Care Acquired Conditions ("Never Events")

When you enter the hospital for treatment of one medical problem, you do not expect to leave with additional injuries, infections, or other serious conditions that occur during the course of your stay. Although some of these complications may not be avoidable, patients do suffer from injuries or illnesses that could have been prevented if doctors or the hospital had taken proper precautions. Errors in medical care that are clearly identifiable, preventable and serious in their consequences for patients, can indicate a significant problem in the safety and credibility of a health care facility. These conditions and errors are sometimes called “Never Events” or “Serious Reportable Events.”

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

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

FEHB Facts

Coverage information

- **No pre-existing condition limitation**

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

- **Minimum essential coverage (MEC)**

  Coverage under this plan qualifies as minimum essential coverage. Please visit the Internal Revenue Service (IRS) website at www.irs.gov/uac/Questions-and-Answers-on-the-Individual-Shared-Responsibility-Provision for more information on the individual requirement for MEC.

- **Minimum value standard**

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

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

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

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

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

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

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

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

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

  If you have a Self Only enrollment, you may change to a Self Plus One or 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 Plus One or 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 Plus One or 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 are married. A carrier may request that an enrollee verify the eligibility of any or all family members listed as covered under the enrollee's FEHB enrollment.

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

If you or one of your family members is enrolled in one FEHB plan, you or they cannot be enrolled in or covered as a family member by another enrollee in another FEHB plan.

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

- **Family Member Coverage**

Family members covered under your Self and Family enrollment are your spouse (including a valid common law marriage) and children as described in the chart below. A Self Plus One enrollment covers you and your spouse, or one other eligible family member as described in the chart below.

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

Newborns of covered children are insured only for routine nursery care during the covered portion of the mother's maternity stay.

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

- **Children's Equity Act**

OPM has implemented the Federal Employees Health Benefits Children's Equity Act of 2000. This law mandates that you be enrolled for Self Plus One or 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 in Self Plus One or 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 in Self Plus One or Self and Family coverage, as appropriate, in the lowest-cost nationwide plan option as determined by OPM.
- 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 Plus One or Self and Family, as appropriate, 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 Plus One or Self and Family, as appropriate, in the lowest-cost nationwide plan option as determined by OPM.

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 does not 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 does not serve the area in which your children live as long as the court/administrative order is in effect. Similarly, you cannot change to Self Plus One if the court/administrative order identifies more than one child. 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 processed according to the 2021 benefits of your prior plan or option.** If you have met (or pay cost-sharing that results in your meeting) the out-of-pocket maximum under the prior plan or option, you will not pay cost-sharing for services covered between January 1 and the effective date of coverage under your new plan or option. However, if your prior plan left the FEHB Program at the end of the year, you are covered under that plan's 2020 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 assistance with enrolling in 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 additional information about your coverage choices. You also can visit OPM's website www.opm.gov/healthcare-insurance/healthcare/plan-information/guides. A carrier may request that an enrollee verify the eligibility of any or all family members listed as covered under the enrollee's FEHB enrollment.

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

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

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

Enrolling in TCC. Get the RI 79-27, which describes TCC, from your employing or retirement office or from www.opm.gov/healthcare-insurance/healthcare/plan-information/guides. It explains what you have to do to enroll.

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

- **Finding Replacement Coverage**

We will provide you with assistance in finding a non-group contract available inside or outside the Marketplace 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 decide 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.

You must contact us in writing within 31 days after you are no longer eligible for coverage. For assistance in finding coverage, please contact us at 202-833-4910 or visit our website at www.AFSPA.org/FSBP.

Benefits and rates under the replacement coverage will differ from benefits and rates 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.

- **Health Insurance Marketplace**

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

Section 1. How This Plan Works

This Plan is a fee-for-service (FFS) plan. OPM requires that FEHB plans be accredited to validate that plan operations and/or care management meet nationally recognized standards. The **Foreign Service Benefit Plan** holds the following accreditation: Comprehensive Health Plan Accreditation through the Accreditation Association for Ambulatory Health Care, Inc. (AAAHC).The Plan's administrator, Claims Administration Corporation, an Aetna company, holds the following accreditations: NCQA accredited for Health Utilization Review and Case Management Programs; NCQA, URAC and CMS credentialed and recredentialed for AETNA Choice POS II (Open Access) Product; and the Plan's Pharmacy Benefit Manager, Express Scripts holds the following accreditations: URAC accredited for Pharmacy Benefit Management and Mail Pharmacy Services; NCQA Certification for Utilization Management; National Association of Boards of Pharmacy for Verified Internet Pharmacy Practice Site; URAC and the Joint Commission accredited for Accredo Specialty Pharmacy. You can choose your own physicians, hospitals, and other health care providers. To learn more about this Plan's accreditation(s), please visit the following websites:

- Accreditation Association for Ambulatory Health Care (www.aaahc.org)
- National Committee for Quality Assurance (www.ncqa.org)
- URAC (www.URAC.org)

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

General features of our High Option

We have network providers:

Our network providers offer services through our fee-for-service Plan. The Plan uses the Aetna Choice POS II (Open Access) Product as its network in the 50 United States and NetCare in Guam. This means that certain hospitals and other health care providers are in-network. When you use an in-network provider, generally you will receive covered services at reduced cost. We encourage you to establish a primary care provider to assist in coordinating your medical care in the safest and most cost effective manner. Aetna is solely responsible for the selection of in-network providers in your area. Contact us for names of in-network providers and to verify their continued participation. Access our network directory as a link through our website www.AFSPA.org/FSBP or call 202-833-4910 (M-F 8:30 a.m. - 5:30 p.m. ET) for additional information. In addition, you can reach our website through the FEHB website, www.opm.gov/healthcare-insurance/.

Aetna Choice POS II (Open Access) identifies high performing in-network physicians and physician groups in twelve medical specialty areas with an Aexcel designation. See Section 5(h), *Aexcel Designated Providers* for additional information.

The out-of-network benefits are the standard benefits of this Plan. In-network benefits apply only when you use an in-network provider. Provider networks may be more extensive in some areas than others. In-network benefit levels also apply to providers outside the 50 United States. We cannot guarantee the availability of every specialty in all areas. We cannot guarantee the continued participation of any specific provider. In the network, if no network provider is available or you do not use a network provider, the standard out-of-network benefits apply. When you use a network facility, keep in mind that the health care professionals who provide services to you in the facility may not be in-network providers in our network. We will pay up to the Plan allowance at the in-network provider percentage for services you receive from out-of-network anesthesiologists (including Certified Registered Nurse Anesthetists), radiologists, pathologists, emergency room physicians, hospitalists, intensivists and neonatologists. This provision also applies when an out-of-network surgeon's immediate or emergency care is required. You will be responsible to pay the in-network coinsurance and any difference between the Plan allowance and billed amount for these out-of-network providers. When non-emergency care by out-of-network surgeons is provided, regular out-of-network benefits apply.

Follow these procedures when you use an in-network provider in order to receive in-network benefits:

- **Verify that the provider is in the network when you make your appointment. Confirm that the address for your appointment is the same location as on our website. Providers may choose to be an in-network provider at one location but not at another;**

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

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

Other out-of-network participating providers:

This Plan offers you access to other out-of-network participating health care providers that have agreed to discount their charges. Covered services provided by these other-out-of network participating providers are considered at the negotiated rate subject to applicable deductibles, copayments and coinsurance. Since these other out-of-network participating providers are not considered in-network providers, out-of-network benefit levels will apply. Contact us at 202-833-4910 for more information about these other out-of-network participating providers.

How we pay providers

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

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

For providers in the 50 United States (including the District of Columbia and also Guam), whether you use an in-network or an out-of-network provider, generally we will pay the provider directly unless payment is noted on the bill we receive. If you have made payment to the provider, please advise us when you submit your claim.

We use National Standardized Criteria Sets and other nationally recognized clinical guidelines and resources 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 prior approval (see Section 3, *You need prior Plan approval for certain services*). These determinations can affect how we provide benefits.

We apply the American Medical Association's (AMA) and/or Centers for Medicare and Medicaid Services (CMS) correct coding in reviewing billed services and making Plan benefit payments for them. There are exceptions based on benefits, published Medical Policies and when a provider's contract with our network or other participating provider contract stipulates otherwise.

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

Your rights and responsibilities

OPM requires that all FEHB plans provide certain information to their FEHB members. You may get information about us, our networks, and our providers. OPM's FEHB website (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 and on the next page.

- **Years in existence** – The American Foreign Service **Protective Association (AFSPA)**, which sponsors the **Foreign Service Benefit Plan**, was established in 1929.

- **Profit status** – AFSPA was incorporated in 1951 as a 501(c)(9) not-for-profit organization.

You are also entitled to a wide range of consumer protections and have specific responsibilities as a member of this Plan. You can view the complete list of these rights and responsibilities in the *Preventing Medical Mistakes and Member Rights and Responsibilities* section of this Brochure or by visiting our website, **Foreign Service Benefit Plan**, www.AFSPA.org/FSBP. You can also contact us to request that we mail a copy to you.

If you want more information about us, call 202-833-4910, (M-F 8:30 a.m. - 5:30 p.m. ET) or write to the **Foreign Service Benefit Plan**, 1620 L Street, NW, Suite 800, Washington, DC 20036-5629. You also may contact us by non-secure e-mail at health@AFSPA.org or enrollment@AFSPA.org, or through our secure Member Portal at www.myafspa.org. Login to the Member Portal with your username and password.

By law, you have the right to access your protected health information (PHI). For more information regarding access to PHI, visit our website, **Foreign Service Benefit Plan**, at www.AFSPA.org/FSBP to obtain our Notice of Privacy Practices. You can also contact us to request that we mail you a copy of that Notice.

Your medical and claims records are confidential

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

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

Section 2. Changes for 2021

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

Changes to this Plan

- Your share of the premium will increase by $2.76 for Self Only, or increase by $6.94 for Self Plus One, or increase by $6.83 for Self and Family. See back cover.
- The Plan has updated our prior approval list to include gene therapy, gene editing, and gene silencing (see Section 3, under *How You Get Care*).
- The Plan now covers telemedicine visits for medical, mental health and substance use disorders in addition to Teladoc (see Section 5(a), under *Diagnostic and treatment services* and *5(e),* under *Telehealth Services*).
- The Plan has changed the cost share for hearing treatment related to non-auditory illness or injury (see Section 5(a), under *Diagnostic and treatment services*).
- The Plan now pays for services rendered at a CVS Minute Clinic at 100% with no member cost share (see Section 5(a), under *Diagnostic and treatment services.)*
- The Plan now offers overseas telehealth services through vHealth (see Section 5(a), under *Telehealth Services*).
- The Plan now covers lab testing through LabCorp in addition to Quest Diagnostics at no member cost share as part of our Lab Savings Program (see Section 5(a), under *Lab, X-ray and other diagnostic tests*).
- The Plan now covers physical, occupational and speech therapy for autism and developmental delays with no visit limit (see Section 5(e), *Mental health and substance use disorder benefits).*
- The Plan has added coverage for multifocal, accommodating, toric and other premium intraocular lenses (see Section 5(a), under *Vision services).*
- The Plan has increased the visit limit for chiropractic services to 50 visits per person, per calendar year (see Section 5(a), under *Chiropractic).*
- The Plan has increased the visit limit for acupuncture and massage therapy to 50 visits each per person, per calendar year (see Section 5(a), under *Alternative treatments*).
- The Plan has changed the requirements for bariatric surgery (see Section 5(b), under *Surgical procedures*).
- The Plan now pays for observation stays over 24 hours at the same benefit level as inpatient benefits (see Section 5(c), under *Outpatient hospital or ambulatory surgical center* and 5(e), under *Outpatient hospital and other outpatient services).*
- The Plan has added coinsurance maximums for a 30-day supply of prescription drugs at network retail (see Section 5(f), under *Covered medications and supplies).*
- The Plan has enhanced our Simple Steps to Living Well Together Program and Incentives (see section 5(h), under *Simple Steps to Living Well Together Program and Wellness Incentives).*
- The Plan has removed the exclusion for conjoint therapy.

Section 3. How You Get Care

Identification cards

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

If you do not receive your ID card within 30 days after the effective date of your enrollment, or if you need replacement cards, call us at 202-833-4910 (M-F 8:30 a.m. - 5:30 p.m. ET) or write to us at **Foreign Service Benefit Plan**, 1620 L Street, NW, Suite 800, Washington, DC 20036-5629. You may also request replacement cards by secure e-mail through our secure Member Portal at www.myafspa.org. Login to the Member Portal with your username and password.

Where you get covered care

You can get care from any "covered provider" or "covered facility." We do not require referrals to see a specialist. How much we pay – and you pay – depends on the type of covered provider or facility you use. If you use our in-network providers, you will pay less.

- **Covered providers**

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

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

- **Covered facilities**

Covered facilities include:

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

- 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.

- **Residential Treatment Center** — Residential treatment centers (RTCs) are accredited by a nationally recognized organization and licensed by the state, district, or territory to provide residential treatment for medical conditions, mental health conditions, and/or substance use disorder. RTCs provide 24-hour residential evaluation, treatment and comprehensive specialized services relating to the individual's medical, physical, mental health, and/or substance use disorder therapy needs, all under the active participation and direction of a licensed physician who is participating within the scope of the physician's license. RTCs offer programs for persons who need short-term transitional services designed to achieve predicted outcomes focused on fostering improvement or stability in functional, physical and/or mental health, recognizing the individuality, strengths, and needs of the persons served.
- **Skilled Nursing Facility** — An institution or that part of an institution, which provides convalescent skilled nursing care 24-hours-a-day and is classified as a skilled nursing facility under Medicare.
- **Urgent Care Center** — A free-standing ambulatory care center, outside of a hospital emergency department, that provides emergency treatment for medical conditions that are not life-threatening, but need prompt attention, on a walk-in basis.

- **Transitional care**

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

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

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

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

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

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

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

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

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

You need prior Plan approval for certain services

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

You must get prior approval for certain services. Failure to do so may result in a $500 penalty to be taken from any inpatient or Skilled Nursing Facility benefits provided by the Plan. Please see *Warning* below. In addition, we may deny benefits for services listed in this Section, under *Other services*.

- **Inpatient hospital and skilled nursing facility admissions**

Precertification is the process by which – prior to your inpatient hospital or Skilled Nursing Facility admission – we evaluate the medical necessity or to confirm coverage 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 will not change our decision on medical necessity.

- **Warning:**

Your in-network physician, hospital, or skilled nursing facility will take care of requesting precertification. You should always ask your physician, hospital, or skilled nursing facility whether or not they have contacted us for precertification. For out-of-network hospitals and Skilled Nursing Facility admissions, we will reduce our benefits for the out-of-network inpatient hospital or Skilled Nursing Facility stay by $500 if no one contacts us for precertification (see page 61). If the stay is not medically necessary, we will only pay for any covered medical services and supplies that are otherwise payable on an outpatient basis.

- **Exceptions:**

You do not need precertification in these cases:

- You are admitted to a hospital, Skilled Nursing Facility or residential treatment center outside the 50 United States. However, the Plan will review all services to establish medical necessity or to confirm coverage. 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**

When you see an in-network physician, that physician must obtain precertification or prior approval for certain services such as inpatient hospitalization and the following services. If you see an out-of-network physician, you must obtain precertification or prior approval.

For a complete list of services that require precertification or prior approval, refer to www.aetna.com/health-care-professionals/precertification/precertification-lists.html.

- Ambulance – prior approval required for transportation by fixed-wing aircraft (plane)
- Autologous chondrocyte implantation, Carticel
- BRCA genetic testing
- Cardiac rhythm implantable devices
- Certain mental health services, inpatient admissions, Residential treatment center (RTC) admissions, Partial hospitalization programs (PHPs), Transcranial magnetic stimulation (TMS) and Applied Behavior Analysis (ABA - even if rendered outside the 50 United States)
- Chiari malformation decompression surgery
- Cochlear device and/or implantation
- Covered transplant surgeries
- Dialysis visits – when request is initiated by an in-network provider, and dialysis to be performed at an out-of-network facility
- Dorsal column (lumbar) neurostimulators: trial or implantation

- Electric or motorized wheelchairs and scooters
- Endoscopic nasal balloon dilation procedures
- Gender reassignment surgery, even if rendered outside the 50 United States
- Gene therapy, gene editing and gene silencing, even if rendered outside the 50 United States
- Hip and knee arthroplasties
- Hip surgery to repair impingement syndrome
- Hyperbaric oxygen therapy
- Inpatient confinements (except hospice). For example, surgical and non-surgical stays; stays in a skilled nursing or rehabilitation facility; and maternity and newborn stays that exceed the standard length of stay (LOS)
- Lower limb prosthetics
- Observation stays more than 24 hours
- Orthognathic surgery procedures, bone grafts, osteotomies and surgical management of the temporomandibular joint (TMJ)
- Osseointegrated implant
- Osteochondral allograft/knee
- Out-of-network freestanding ambulatory surgical facility services, when referred by an in-network provider
- Pain management such as facet and spinal injections
- Pediatric congenital heart surgery
- Polysomnography (attended sleep studies)
- Power morcellation with uterine myomectomy, with hysterectomy or for removal of uterine fibroids
- Private duty nursing
- Proton beam radiotherapy
- Radiation oncology
- Radiology imaging such as CT scans, MRIs, MRAs, and nuclear stress tests
- Reconstructive or other procedures that may be considered cosmetic, such as:
  - Blepharoplasty/canthoplasty
  - Breast reconstruction/breast enlargement
  - Breast reduction/mammoplasty
  - Cervicoplasty
  - Excision of excessive skin due to weight loss
  - Gastroplasty/gastric bypass
  - Lipectomy or excess fat remova
  - Surgery for varicose veins, except stab phlebectomy
- Shoulder arthroplasty
- Spinal procedures, such as:
  - Artificial intervertebral disc surgery
  - Cervical, lumbar and thoracic laminectomy/laminotomy procedure
  - Spinal fusion surgery
- Uvulopalatopharyngoplasty, including laser-assisted procedures
- Ventricular assist devices
- Video electroencephalographic (EEG)

Note: Chemotherapy also requires prior approval. See Section 5(a), *Medical Services and supplies provided by physicians and other health care professionals.*

Note: We only cover medically necessary services, drugs or supplies. Services, drugs or supplies that are not medically necessary, are not accepted standards of medical, dental, or psychiatric practice, or are experimental or investigational are not covered. We encourage you to contact the Plan to confirm coverage for proposed treatment prior to incurring services.

Note: Prescription drugs - Some medications and injectables are not covered unless you receive prior authorization. See Section 5(f), *Prescription drug benefits.* You are required to obtain all specialty drugs used for long term therapy from Accredo. To speak to an Accredo representative, please call 800-922-8279.

Note: We do not require precertification, prior approval or concurrent review if you receive treatment outside the 50 United States (including Guam), *except as noted on the previous pages.* However, the Plan will review all services to establish medical necessity or to confirm coverage. We may request medical records from you or your provider in order to determine medical necessity.

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

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

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

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

Next, provide the following information:

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

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

- **Non-urgent care claims**

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

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

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

- **Urgent care claims**

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

  If you fail to provide sufficient information, we will contact you within 24 hours after we receive the claim to let you know what information we need to complete our review of the claim. You will then have up to 48 hours to provide the required information. We will make our decision on the claim within 48 hours of (1) the time we received the additional information or (2) the end of the time frame, whichever is earlier.

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

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

- **Concurrent care claims**

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

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

- **The Federal Flexible Spending Account Program – *FSAFEDS***

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

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

- **Emergency inpatient admission**

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

- **Maternity care**

  You do not need precertification of a maternity admission for a routine delivery. However, if your medical condition requires you to stay more than 3 days after admission for a vaginal delivery or 5 days after admission for 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, your physician or the hospital must contact us for precertification of additional days for your baby.

  Note: When a newborn requires definitive treatment after the mother's confinement, the newborn is considered a patient in his or her own right. If the newborn is eligible for coverage, regular medical or surgical benefits apply rather than maternity benefits.

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

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

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

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

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

If you disagree with our pre-service claim decision

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

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

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

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

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

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

- **To reconsider an urgent care claim**

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

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

- **To file an appeal with OPM**

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

Section 4. Your Costs for Covered Services

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

Cost-sharing

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

Copayment

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

Example:

- When you purchase prescriptions from the Express Scripts Pharmacy℠ (home delivery), you pay a copayment of $15 for generic, or $60 for preferred brand name.
- When you go into an out-of-network hospital, you pay $200 per person, per hospital stay.

We do not reimburse you for copayments.

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

Deductible

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

The calendar year deductible is $300 per person for in-network providers (including Guam) and providers outside the 50 United States or $400 per person for out-of-network providers (including Guam). Any expenses incurred that apply toward deductibles for in-network or out-of-network apply toward both in and out-of-network limits.

Under a Self Only enrollment, the deductible is considered satisfied and benefits are payable for you when your covered expenses applied to the calendar year deductible for your enrollment reach $300 for in-network providers (including Guam) and providers outside the 50 United States or $400 for out-of-network providers (including Guam).

Under a Self Plus One enrollment, the deductible is considered satisfied and benefits are payable for you and one other eligible family member when the combined covered expenses applied to the calendar year deductible for your enrollment reach $600 for in-network providers (including Guam) and providers outside the 50 United States or $800 for out-of-network providers (including Guam).

Under a Self and 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 for in-network providers (including Guam) and providers outside the 50 United States or $800 for out-of-network providers (including Guam).

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 for in-network (including Guam) and providers outside the 50 United States or $400 for out-of-network providers (including Guam)) 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 prior plan between January 1 and the effective date of your new plan. If you change plans at another time during the year, you must begin a new deductible under your new plan.

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

Coinsurance

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

Example: You pay 10% of the Plan allowance for surgery performed by an in-network provider.

If your provider routinely waives your cost

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

For example, if your out-of-network physician or other health care professional ordinarily charges $100 for a service but routinely waives your 30% coinsurance, the actual charge is $70. We will pay $49 (70% of the actual charge of $70).

Waivers

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

Differences between our allowance and the bill

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

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

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

- **In-network providers** (including Guam) agree to limit what they will bill you. Because of that, when you use an in-network provider, your share of covered charges consists only of your deductible and coinsurance. Here is an example about coinsurance: You see an in-network physician or other health care professional who charges $150, but our allowance is $100. If you have met your deductible, you are only responsible for your coinsurance. That is, you pay just 10% of our $100 allowance ($10). Because of the agreement, your in-network physician or other health care professional will not bill you for the $50 difference between our allowance and his/her bill. **Follow these procedures when you use an in-network provider in order to receive in-network benefits:**
  - **Verify that the provider is in the network when you make your appointment. Confirm that the address for your appointment is the same location as on our website. Providers may choose to be an in-network provider at one location but not at another;**
  - **Present your Foreign Service Benefit Plan Identification (ID) card at the time you visit your health care provider, confirming in-network participation in order to receive in-network benefits and the provider's continued participation in our network. If you do not present your ID card, the provider may not give you the in-network discount; and**
  - **Generally, you do not pay an in-network provider at the time of service. In-network providers must bill us directly. We must reimburse the provider directly. In-network providers will bill you for any balance after our payment to them.**

- **Out-of-network providers,** on the other hand, have no agreement to limit what they will bill you. For instance:
  - **When you use an out-of-network provider,** you will pay your deductible and coinsurance plus any difference between our allowance and charges on the bill. Here is an example: You see an out-of-network physician or other health care professional who charges $150 and our allowance is again $100. If you have met your deductible, you are responsible for your coinsurance, so you pay 30% of our $100 allowance ($30). Plus, because there is no agreement between the out-of-network physician or other health care professional and us, the physician or other health care professional can bill you for the $50 difference between our allowance and his/her bill.
- **Other participating providers (See Section 1, *How This Plan Works*)** agree to limit what they will bill you. You still will have to pay your deductible and the out-of-network benefit level. These providers have agreed not to bill you for the difference between the billed charges and the discounted amount.
- **Providers outside the 50 United States** charges generally are not subject to a Plan allowance, that is, our Plan allowance is the amount billed by the provider or as part of our Direct Billing Arrangements. Similar to the in-network example 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). Generally, you do not pay a provider in our Direct Billing Arrangement. We must reimburse the provider directly for any covered expenses. You are responsible, however, for any deductible and coinsurance, which we do not reimburse. See Section 7 for more information.

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

EXAMPLE	In-network provider (including Guam)	Out-of-network provider (including Guam)	Provider outside the 50 United States
Provider's charge	$150	$150	$150
Our allowance	We set it at: 100	We set it at: 100	We set it at: 150
We pay	90% of our allowance: 90	70% of our allowance: 70	90% of our allowance: 135
You owe: Coinsurance	10% of our allowance: 10	30% of our allowance: 30	10% of our allowance: 15
+Difference up to charge?	No: 0	Yes: 50	No: 0
TOTAL YOU PAY	**$10**	**$80**	**$15**

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

We protect you against catastrophic out-of-pocket expenses for covered services. The IRS limits annual out-of-pocket expenses for covered services, including deductibles and copayments, to no more than $6,900 for Self Only enrollment, and $13,800 for a Self Plus One or Self and Family. The out-of-pocket limit for this Plan may differ from the IRS limit, but cannot exceed that amount.

For those benefits where copayments, coinsurance or deductibles apply, we pay 100% of the Plan allowance for the rest of the calendar year after your expenses total to:

- For Self Only enrollment $5,000 and for Self Plus One or Self and Family enrollment $7,000 for in-network providers (including Guam) and providers outside the 50 United States and when you use the Plan's network retail pharmacy through Express Scripts (ESI), or home delivery (mail order) through the Express Scripts Pharmacy^{SM}, or purchase prescriptions outside the 50 United States from a retail pharmacy or Military Treatment Facility (including Guam);
- For Self Only enrollment $7,000 and for Self Plus One or Self and Family enrollment $9,000 for in- and out-of-network providers combined (including Guam) and when you use the Plan's network retail pharmacy through Express Scripts or home delivery (mail order) through the Express Scripts Pharmacy^{SM} or purchase prescriptions outside the 50 United States from a retail pharmacy or Military Treatment Facility (including Guam).

For Self Plus One and Self and Family enrollments, once any individual family member reaches the Self Only catastrophic protection out-of-pocket maximum during the calendar year, that member's claims will no longer be subject to associated cost-sharing amounts for the rest of the year. All other family members will be required to meet the balance of the catastrophic protection out-of-pocket maximum.

Any expenses incurred that apply toward the catastrophic out-of-pocket maximum for in-network or out-of-network apply toward both in and out-of-network limits.

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

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

- Expenses in excess of Plan allowances, maximum benefit or visit limitations;
- Expenses for a transplant above the $400,000 maximum in-network benefit or expenses at an out-of-network facility;
- Expenses for dental care;

- Any amounts you pay because benefits have been reduced for non-compliance with precertification, prior approval, prior authorization requirements (see Section 3, *How you get care*);
- Expenses for prescriptions purchased at pharmacies in the 50 United States without using the Plan's identification card or purchased from a source other than the Plan's mail order pharmacy;
- Expenses for maintenance prescription medications (drugs you take regularly for ongoing conditions) not purchased through the Express Scripts Home Delivery Pharmacy or through a participating Smart90® Retail Network 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 prior 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 prior 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 prior 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 prior 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.

Section 5. Benefits

See page 15 for how our benefits changed this year. Pages 128-131 are a benefits summary of our High Option.

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High Option Overview

"Caring for Your Health Worldwide®"

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

This Section is divided into subsections. Please read *Important things you should keep in mind* at the beginning of the subsections. Also read the general exclusions in Section 6; they apply to the benefits in the following subsections. To obtain claim forms, claims filing advice, or more information about High Option benefits, contact us by phone (M-F 8:30 a.m. - 5:30 p.m. ET) at 202-833-4910 (members) or 202-833-5751 (health care providers), or by e-mail through our secure Member Portal (see below).

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

- Benefits available worldwide
- Electronic Funds Transfer (EFT) of claim payments to your U.S. bank account
- Secure method to submit claims and correspondence via the Internet – eliminates lengthy mail time
  - Visit our secure Member Portal at www.myafspa.org. Login to the Member Portal with your username and password. Once inside the portal, select "Submit A Claim". Follow the screen prompts to upload your PDF claim documents. You have the options to include questions or comments and send your secure claims to a specific customer service representative. **Please ensure your name and member ID number appear on the claim. Make sure the image quality of your electronic documents is clear and legible. Any unclear or illegible supporting documentation may cause your claim to be delayed or denied.**
- Charges from providers outside the 50 United States (except Guam) generally considered at the billed amount
- Plan translates claims and uses currency exchange rates provided by member. For details, see Section 7, *Filing a claim for covered services* under *Overseas Claims.*
- Lower calendar year deductible for using in-network providers (lower deductible applies to providers outside the 50 United States also)
- Telehealth services at 100% coverage through the following telehealth vendors:
  - Teladoc® available to members in the U.S. for medical conditions and mental health/substance use disorder
  - vHealth by Aetna available to members residing or traveling outside the U.S for general medicine
- Lab Savings Program - Covered lab charges paid at 100% through Quest Diagnostics and LabCorp (U.S. only)
- Direct billing arrangements with health care providers in several foreign countries
- Overseas second opinion program
- Massage therapy as part of our generous alternative treatments benefits
- Wellness and preventive care benefits for children and adults payable at 100% of Plan allowance with no deductible (in-network providers (including Guam) and providers outside the 50 United States)
- Comprehensive Wellness and Incentive Program providing choice of several programs within our *Simple Steps to Living Well Together* Program
- myStrength™ on-line mental health support program
- In Touch Care Program
- 24-Hour Nurse Advice and Translation Lines; and Healthwise Knowledgebase
- Dietary and nutritional counseling; and Diabetic education benefits
- Orthodontic benefits
- Web based customer service
  - Aetna's secure member website allows members access to Web based claim information (electronic copies of Explanations of Benefits), in-network provider search, health information, and other tools.
  - Prescription management website allows members to refill and renew prescriptions, obtain prescription information, locate Network pharmacies, compare costs of prescriptions, obtain refill reminders, and use other tools.

Section 5(a). Medical Services and Supplies Provided by Physicians and Other Health Care Professionals

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- The calendar year deductible is: $300 per person ($600 per Self Plus One enrollment or $600 per Self and Family enrollment) for in-network providers (including Guam) and providers outside the 50 United States; or $400 per person ($800 per Self Plus One enrollment or $800 per Self and Family enrollment) for out-of-network providers (including Guam). The calendar year deductible applies to almost all benefits in this Section. We added "(No deductible)" to show when the calendar year deductible does not apply.
- The out-of-network benefits are the standard benefits of this Plan. In-network benefits (including Guam) apply only when you use an in-network provider or when you use a provider outside the 50 United States. When no in-network provider is available in the network, out-of-network benefits apply.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost-sharing works. Also, read Section 9 for information about how we pay if you have other coverage, or if you are age 65 or over.
- **YOU MUST GET PRIOR APPROVAL FOR CERTAIN SERVICES IN THIS SECTION, SUCH AS, BUT NOT LIMITED TO: ELECTRIC OR MOTORIZED WHEELCHAIRS, COCHLEAR DEVICES AND/OR IMPLANTATION, BRCA GENETIC TESTING, CHEMOTHERAPY, RADIATION ONCOLOGY, CT SCANS, MRIS, MRAS AND NUCLEAR STRESS TESTS.**

Note: We do not require prior approval or concurrent review in this section for services you receive outside the 50 United States (including Guam) *except for ABA assessment or treatment and gene therapy.* For more information, see Section 3. *You need prior Plan approval for certain services.* However, the Plan will review all services to establish medical necessity or to confirm coverage. We may request medical records in order to determine medical necessity before and/or during continued treatment.

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

Benefits Description	You pay After the calendar year deductible...
Note: The calendar year deductible applies to almost all benefits in this Section. We say "(No deductible)" when it does not apply.	
Diagnostic and treatment services	**High**
• Professional services of physicians or other health care professionals during a hospital or skilled nursing facility stay (except when billed by the hospital or skilled nursing facility), in the physician's or other health care professional's office, at home, or consultations • Office consultation including second opinion • Telemedicine consultations • Psychological tests and pharmacological visits • Office visits by a dentist in relation to covered oral and maxillofacial surgical procedures	In-network (includes Guam): 10% of the Plan allowance Out-of-network (includes Guam): 30% of the Plan allowance and any difference between our allowance and the billed amount Providers outside the 50 United States (does not include Guam): 10% of the Plan allowance

Diagnostic and treatment services - continued on next page

Benefits Description	You pay After the calendar year deductible...
Diagnostic and treatment services (cont.)	**High**
• Non-specialty drugs and medical supplies billed by a physician or other health care professional • Hearing treatment related to non-auditory illness or disease Note: Telemedicine consultations are covered when your provider uses a Health Insurance Portability and Accountability Act (HIPAA) compliant tool such as Vidyo or Bluejeans for facilitating telehealth consultations. Note: See Section 5(h), *In Touch Care Program,* for information on advance care planning. Note: See Section 5(f), *Prescription drug benefits,* for information on specialty drugs administered in your physician's office or an outpatient setting. The Plan has an exclusive arrangement with Accredo (Home Delivery) for dispensing all specialty drugs used for long term therapy (chronic specialty drugs).	In-network (includes Guam): 10% of the Plan allowance Out-of-network (includes Guam): 30% of the Plan allowance and any difference between our allowance and the billed amount Providers outside the 50 United States (does not include Guam): 10% of the Plan allowance
• Outpatient care in an urgent care facility Note: See this Section, *Telehealth Services* for information on the Plan's Telehealth benefit you may use in non-medical emergencies. Note: Services received for routine preventive care are paid under this Section, *Preventive care, adult* or *Preventive care, children.* Note: For services related to an accidental injury or medical emergency, see Section 5(d).	In-network (includes Guam): $35 copayment per occurrence (No deductible) Out-of-network (includes Guam): $35 copayment per occurrence and any difference between our allowance and the billed amount (No deductible) Providers outside the 50 United States (does not include Guam): $35 copayment per occurrence (No deductible)
• Professional non-emergency services provided in a CVS Minute Clinic	In-network: Nothing (No deductible) Out-of-network: No benefit Providers outside the 50 United States (includes Guam): No benefit
• Professional non-emergency services provided in a convenient care clinic (except in a CVS Minute Clinic) (see Section 3, *Covered facilities*) Note: See this Section, *Telehealth Services* for information on the Plan's Telehealth benefit you may use in non-medical emergencies. Note: For services related to an accidental injury, see Section 5(d). Note: Services received for routine preventive care are paid under this Section, *Preventive care, adult* or *Preventive care, children.*	In-network (includes Guam): $10 copayment per visit (No deductible) Out-of-network (includes Guam): 30% of the Plan allowance and any difference between our allowance and the billed amount Providers outside the 50 United States (does not include Guam): $10 copayment per visit (No deductible)
Not covered: • *Procedures, services, drugs, and supplies related to the treatment of impotency, sexual dysfunction, or sexual inadequacy*	*All charges*

Benefits Description	You pay After the calendar year deductible...
Telehealth Services	**High**
Telehealth consultations are available to members in the 50 United States with primary care and specialty providers through our telehealth vendor Teladoc® such as: • Doctors of Medicine (MD) • Doctors of Osteopathic Medicine (DO) • Nutritionists • Licensed Clinical Social Workers (LCSW) • Psychiatrists • Psychologists • Dermatologists Access telehealth services 24/7/365 by web, phone, and the Teladoc® mobile app to receive treatment within minutes for non-emergency, acute general medical needs such as: flu, cough, colds, seasonal allergies, sinus problems, arthritis, upper respiratory infection, backaches and food poisoning. You also can see a behavioral health provider for depression, anxiety and stress, as well as a nutritionist for dietary conditions or dermatologist for skin conditions. Note: Because of the complexity of medical licensure/prescribing laws among the 50 United States and foreign countries, Teladoc® cannot offer this service to members outside the 50 United States. Note: See also Section 5(e), *Mental health and substance use disorder benefits* for telehealth services for members **in** the 50 United States through Teladoc®. See also Section 5(e), *Mental health and substance use disorder benefits* for telehealth services for members **outside** the 50 United States. Note: Telehealth is available in all 50 United States. **To sign up:** See www.teladoc.com/Aetna or call 855-Teladoc (1-855-835-2362) for information regarding telehealth consults.	In-network: Nothing (No deductible) Out-of-Network: No benefit Providers outside the 50 United States (includes Guam): No benefit
Telehealth consultations are available to members outside the 50 United States through our telehealth vendor, vHealth by Aetna. Access telehealth services 24/7/365 by web, phone, and the vHealth mobile app to receive treatment for general medicine. Treatment may include preventive care as well as treatment for acute and chronic illnesses. A provider also may give referrals and prescribe medications, when appropriate. Note: Telehealth through vHealth is available to members with a foreign address (including APO, FPO, DPO and Pouch Mail addresses). In addition, members with a stateside address may access telehealth through vHealth while traveling outside the 50 United States. **To sign up:** Download vHealth by Aetna in the App Store or Google Play Store or visit https://globalcareondemand.com/aetna. Call 857-256-3784 (US) or +44 (0) 20 3499 2851 (UK) for information regarding telehealth consultations.	In-network: Nothing (No deductible) Out-of-Network: No benefit Providers outside the 50 United States (includes Guam): No benefit

Benefits Description	You pay After the calendar year deductible...
Lab, X-ray and other diagnostic tests	**High**
Tests, such as: • Blood tests • Urinalysis Note: Urinalysis for drug testing/screening purposes is covered only as described in "FEHBP Urine Drug Testing Coverage", available on our website www.AFSPA.org/FSBP or by calling us at 202-833-4910. • Non-routine pap tests • Pathology • X-rays • Non-routine mammograms • CT Scan/PET Scan/SPECT/MRI Note: Prior approval is required for Radiology imaging procedures, such as, but not limited to, CT Scans, PET Scans, SPECT Scans, and MRIs except in the case of an accident or a medical emergency (see Section 3, *How you get care*, under *Other services*). • Ultrasound • Electrocardiogram and EEG • Hearing exam for non-auditory illness or disease • FDA recommended pharmacogenetic testing to optimize prescription drug therapies used to treat certain conditions, such as: - For prevention of major adverse cardiovascular events (Plavix) - For prevention of blood clots (Warfarin) Note: The Plan may add tests as they are recommended by the FDA. • Medically appropriate genetic counseling and testing Note: We cover only certain genetic tests determined medically appropriate by the Plan. We encourage you to confirm coverage for the proposed tests prior to incurring services, please e-mail us at FSBPhealth@aetna.com or call us at 800-593-2354. Note: The Plan offers confidential telephone and web-based genetic counseling services. These services are offered through Informed DNA, a national genetic counseling company staffed with independent board-certified genetic counselors. For more information or to schedule an appointment for genetic counseling, call Informed DNA at 800-975-4819. Note: For genetic counseling and testing for maternity, please refer to Section 5(a), *Maternity care.*	In-network (includes Guam): 10% of the Plan allowance Out-of-network (includes Guam): 30% of the Plan allowance and any difference between our allowance and the billed amount Providers outside the 50 United States (does not include Guam): 10% of the Plan allowance

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

Benefits Description	You pay After the calendar year deductible...
Lab, X-ray and other diagnostic tests (cont.)	**High**
Lab Savings Program You may use this voluntary program for covered outpatient lab tests performed at Quest Diagnostics or LabCorp. Show your FSBP identification card each time you obtain lab work and tell your physician you would like to use Quest Diagnostics or LabCorp. If the physician draws the specimen, he/she can call Quest Diagnostics at 800-646-7788 or LabCorp at 888-522-2677 for pick up or you can go to an approved collection site and show your FSBP ID card along with the test requisition from your physician and have the specimen drawn there. Note: To find an approved collection site near you, call Quest Diagnostics at 800-646-7788 or LabCorp at 888-522-2677 or search for Quest Diagnostics or LabCorp using your Zip Code in the Plan's Online Provider Directory at www.fsbphealth.com.	Nothing (No deductible) Note: This benefit applies to expenses for lab tests performed in the 50 United States only. Related expenses for services by a physician (or lab tests performed by an associated Laboratory not participating in the Lab Savings Program) are subject to the applicable deductibles and coinsurance.
Preventive care, adult	**High**
• One routine physical examination per person, per calendar year Note: This includes a separate gynecological exam once per calendar year. Note: Obtaining a Biometric Screening through your physician completes one step of the *Simple Steps to Living Well Together* Incentive Program as described in Section 5(h). The **following** preventive services are covered at the time interval recommended at each of the links below unless otherwise stated in this Section. • Immunizations such as Pneumococcal, influenza, shingles, tetanus/ DTaP, and human papillomavirus (HPV). For a complete list of immunizations go to the Centers for Disease Control (CDC) website at https://www.cdc.gov/vaccines/schedules • Travel immunizations recommended by the CDC Note: The Plan has no age limitations on Influenza, Pneumococcal, Human Papillomavirus (HPV) and Zostavax (Shingles) vaccines. Note: Immunizations obtained from a participating retail network pharmacy have a $0 copay and are covered under Section 5(f), *Prescription drug benefits*. Note: These benefits do not apply to children under age 22 (see *Preventive care, children*). Note: See Section 10, *Definitions*, *Routine preventive services/ immunizations*. • Screenings such as cancer, osteoporosis, depression, diabetes, high blood pressure, total blood cholesterol, HIV, and colorectal cancer screening. For a complete list of screenings go to the U.S. Preventive Services Task Force (USPSTF) website at www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/ • Screening and counseling for interpersonal and domestic violence	In-network (includes Guam): Nothing (No deductible) Out-of-network (includes Guam): 30% of the Plan allowance and any difference between our allowance and the billed amount Providers outside the 50 United States (does not include Guam): Nothing (No deductible)

Preventive care, adult - continued on next page

Benefits Description	You pay After the calendar year deductible...
Preventive care, adult (cont.)	**High**
• Osteoporosis routine screening for members age 50 and older once per calendar year • Colorectal cancer screening: - Fecal occult blood test - once per calendar year - Sigmoidoscopy screening - one every five years for members age 50 and older - Colonoscopy screening, including facility and anesthesia charges related to the colonoscopy exam - one every 10 years for members age 50 and older • Prostate cancer screening (PSA) – once per calendar year for members age 40 and older Note: Age and frequency limitations do not apply to the cancer screenings listed above if there is a family history or high risk factor that indicates the need for screenings. • Dietary and nutritional counseling (includes individual and group behavioral counseling) up to 26 visits combined per calendar year • Individual counseling on prevention and reducing health risks • Well woman care such as Pap smears, gonorrhea prophylactic medication to protect newborns, annual counseling for sexually transmitted infections, contraceptive methods, and screening for interpersonal and domestic violence. For a complete list of Well Women preventive care services go to the Health and Human Services (HHS) website at https://www.healthcare.gov/preventive-care-women	In-network (includes Guam): Nothing (No deductible) Out-of-network (includes Guam): 30% of the Plan allowance and any difference between our allowance and the billed amount Providers outside the 50 United States (does not include Guam): Nothing (No deductible)
Note: Any procedure, injection, diagnostic service, laboratory, or X-ray service done in conjunction with a routine examination and is not included in the preventive recommended listing of services will be subject to the applicable member copayments, coinsurance, and deductible.	
Not covered: • *Physical exams required for obtaining or continuing employment or insurance*	*All charges*
Preventive care, children	**High**
• Well-child visits, examinations, and other preventive services as described in the Bright Future Guidelines provided by the American Academy of Pediatrics. For a complete list of the American Academy of Pediatrics Bright Futures Guidelines go to https://brightfutures.aap.org • 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) • Dietary and nutritional counseling (includes individual and group behavioral counseling), unlimited	In-network (includes Guam): Nothing (No deductible) Out-of-network (includes Guam): Only the difference between our allowance and the billed amount (No deductible) Providers outside the 50 United States (does not include Guam): Nothing (No deductible)

Preventive care, children - continued on next page

Benefits Description	You pay After the calendar year deductible...
Preventive care, children (cont.)	**High**
Note: A gynecological exam and Pap smear once per calendar year for members under the age of 22, if medically recommended, are covered under this Section, *Preventive care, adult.* Note: Dependent children between the ages of 18 and 22 who obtain a Biometric Screening through their physician complete one step of the *Simple Steps to Living Well Together* Incentive Program, which is described in Section 5(h). Note: Dependent children 22 and older are covered under this Section, *Preventive care, adult.* • Immunizations such as DTaP, Polio, Measles, Mumps, and Rubella (MMR), and Varicella. For a complete list of immunizations go to the Centers for Disease Control (CDC) website at https://www.cdc.gov/vaccines/schedules/index.html • Travel immunizations recommended by the CDC Note: Immunizations obtained from a participating retail network pharmacy have a $0 copay and are covered under Section 5(f), *Prescription drug benefits*. • You may also find a complete list of preventive care services recommended under the U.S. Preventive Services Task Force (USPSTF) online at www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/	In-network (includes Guam): Nothing (No deductible) Out-of-network (includes Guam): Only the difference between our allowance and the billed amount (No deductible) Providers outside the 50 United States (does not include Guam): Nothing (No deductible)
Note: Any procedure, injection, diagnostic service, laboratory, or X-ray service done in conjunction with a routine examination and is not included in the preventive recommended listing of services will be subject to the applicable member copayments, coinsurance, and deductible.	
Not covered: • *Physical exams required for obtaining or continuing employment or insurance*	*All charges*
Maternity care	**High**
Complete maternity (obstetrical) care, such as: • Prenatal care (including laboratory tests) Note: See Section 5(h), *Special features* for information on the Plan's Healthy Pregnancy Program. • Specialty visits for complications of pregnancy • Delivery • Anesthesia • Postnatal care • Sonograms • Amniocentesis • Gestational diabetes screening – once per pregnancy • Medically appropriate genetic counseling and testing	In-network (includes Guam): Nothing (No deductible) Out-of-network (includes Guam): 30% of the Plan allowance and any difference between our allowance and the billed amount (No deductible) Providers outside the 50 United States (does not include Guam): Nothing (No deductible)

Maternity care - continued on next page

Benefits Description	You pay After the calendar year deductible...
Maternity care (cont.)	**High**
Note: We cover only certain genetic tests determined medically appropriate by the Plan. We encourage you to confirm coverage for the proposed tests prior to incurring services, please e-mail us at FSBPhealth@aetna.com or call us at 800-593-2354. Note: The Plan offers confidential telephone and web-based genetic counseling services. These services are offered through Informed DNA, a national genetic counseling company staffed with independent board-certified genetic counselors. For more information or to schedule an appointment for genetic counseling, call Informed DNA at 800-975-4819. Note: For services related to an accidental injury or medical emergency, see Section 5(d).	In-network (includes Guam): Nothing (No deductible) Out-of-network (includes Guam): 30% of the Plan allowance and any difference between our allowance and the billed amount (No deductible) Providers outside the 50 United States (does not include Guam): Nothing (No deductible)
• Breastfeeding support, supplies and counseling for each birth Note: Breast pump and supplies are limited to: • Purchase or rental of breastfeeding equipment to an amount no greater than what we would have paid if the equipment had been purchased. We cover the cost of breastfeeding equipment including hospital grade equipment and the items included in the initial supply kit provided with a new pump order. Supplies do not include coverage for other breastfeeding supplies such as maternity bras, nursing pads or additional bottles. When breastfeeding equipment and supplies are purchased at a participating Express Scripts (ESI) Pharmacy or retail store which houses an ESI participating pharmacy (including its websites), you pay nothing (No deductible). Purchase the items and submit a claim to us for reimbursement.	In-network (includes Guam): Nothing (No deductible) Out-of-network (includes Guam): 30% of the Plan allowance and any difference between our allowance and the billed amount (No deductible) Providers outside the 50 United States (does not include Guam): Nothing (No deductible)
Note: Here are some things to keep in mind: • You do not need to precertify your vaginal delivery; see Section 3, *How you get care* for other circumstances when you must precertify, such as extended stays for you or your baby. • You may remain in the hospital up to 3 days after admission for a vaginal delivery and 5 days after admission for a cesarean delivery. We will cover an extended stay if medically necessary. See Section 3, *How you get care* for other circumstances. • Hospital services are covered under Section 5(c) and Surgical benefits under Section 5(b). • For facility care related to maternity, including care at birthing centers, see Section 5(c), *Inpatient hospital* or *Outpatient hospital or ambulatory surgical center.*	
• 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. If the newborn is eligible for coverage, regular medical or surgical benefits apply rather than maternity benefits. We cover these expenses only if the child is covered by a Self Plus One or 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 Plus One or Self and Family enrollment, you must pay a separate hospital copayment of $200 for out-of-network facilities. *If your child is not covered under a Self Plus One or Self and Family enrollment, you pay all of your child's charges after your discharge.*

Maternity care - continued on next page

Benefits Description	You pay After the calendar year deductible...
Maternity care (cont.)	**High**
Note: Maternity care expenses incurred by a Plan member serving as a surrogate mother are covered by the Plan subject to reimbursement from the other party to the surrogacy contract or agreement. The involved Plan member must execute our Reimbursement Agreement against any payment she may receive under a surrogacy contract or agreement. Expenses of the new-born child are not covered under this or any other benefit in a surrogate mother situation.	Note: If your child stays after your discharge and is covered under a Self Plus One or Self and Family enrollment, you must pay a separate hospital copayment of $200 for out-of-network facilities. *If your child is not covered under a Self Plus One or Self and Family enrollment, you pay all of your child's charges after your discharge.*
Note: A complete list of preventive care services recommended under the USPSTF is available online at: www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/ HHS: https://www.healthcare.gov/preventive-care-benefits/ CDC: www.cdc.gov/vaccines/schedules/index.html **Women's preventive services:** www.healthcare.gov/preventive-care-women/ For additional information: www.healthfinder.gov/myhealthfinder/default.aspx	
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	**High**
A range of voluntary family planning services, including patient education and counseling, limited to: • Contraceptive methods and counseling • Voluntary sterilization for women (e.g., tubal ligation) and for men (e.g., vasectomy) (see Section 5(b), *Surgical procedures*) • Injection of contraceptive drugs (such as Depo-Provera) • Contraceptive drugs supplied by your physician or other health care professional • Surgically implanted contraceptives to include fitting, inserting or removing intrauterine devices (IUDs) (see Section 5(b), *Surgical procedures*) Note: We cover oral contraceptive drugs, diaphragms, cervical caps, vaginal rings, and contraceptive hormonal patches (see Section 5(f), *Prescription Drug Benefits*). Note: For genetic counseling and testing, please refer to Section 5(a) *Lab, X-ray and other diagnostic tests.*	In-network (includes Guam): Nothing (No deductible) Out-of-network (includes Guam): 30% of the Plan allowance and any difference between our allowance and the billed amount (No deductible) Providers outside the 50 United States (does not include Guam): Nothing (No deductible)
Not covered: • *Reversal of voluntary surgical sterilization* • *Assisted reproductive technology (ART) procedures, such as:* - *Artificial insemination (AI)*	*All charges*

Family planning - continued on next page

Benefits Description	You pay After the calendar year deductible...
Family planning (cont.)	**High**
- *In vitro fertilization (IVF)* - *Embryo transfer and gamete intrafallopian transfer (GIFT) and Zygote intrafallopian transfer (ZIFT)* - *Intracytoplasmic sperm injection (ICSI)* - *Intravaginal insemination (IVI)* - *Intracervical insemination (ICI)* - *Intrauterine insemination (IUI)* • *Services and supplies related to ART procedures* • *Infertility drugs used in conjunction with ART Procedures* • *Costs of donor sperm and donor egg*	*All charges*
Infertility services	**High**
Diagnosis and treatment of infertility, except as shown in *Not covered*, includes: • Initial diagnostic tests and procedures done only to identify the cause of infertility; • Fertility drugs, hormone therapy and related services; and • Medical or surgical procedures done to create or enhance fertility. Note: Prescription drugs may not be purchased through the Plan's Prescription drug benefit. You must file a claim for them under this benefit. Note: The Plan defines infertility as the inability to conceive after 12 months of unprotected intravaginal sexual relations (or 12 cycles of artificial insemination) for women under age 35, and 6 months of unprotected intravaginal sexual relations (or 6 cycles of artificial insemination) for women age 35 and over.	In-network (includes Guam): 10% of the Plan allowance Out-of-network (includes Guam): 30% of the Plan allowance and any difference between our allowance and the billed amount Providers outside the 50 United States (does not include Guam): 10% of the Plan allowance
Not covered: • *Infertility services after voluntary sterilization* • *Assisted reproductive technology (ART) procedures, such as:* - *Artificial insemination (AI)* - *In vitro fertilization (IVF)* - *Embryo transfer and gamete intrafallopian transfer (GIFT) and Zygote intrafallopian transfer (ZIFT)* - *Intracytoplasmic sperm injection (ICSI)* - *Intravaginal insemination (IVI)* - *Intracervical insemination (ICI)* - *Intrauterine insemination (IUI)* • *Services and supplies related to ART procedures* • *Infertility drugs used in conjunction with ART Procedures* • *Costs of donor sperm and donor egg*	*All charges*

Benefits Description	You pay After the calendar year deductible...
Allergy care	**High**
Testing, treatment, and injections including materials (such as allergy serum)	In-network (includes Guam): 10% of the Plan allowance Out-of-network (includes Guam): 30% of the Plan allowance and any difference between our allowance and the billed amount Providers outside the 50 United States (does not include Guam): 10% of the Plan allowance
Not covered: • *Provocative food testing, end point titration techniques, sublingual allergy desensitization and hair analysis*	*All charges*
Treatment therapies	**High**
• Chemotherapy and radiation therapy (includes radium and radioactive isotopes) Note: Chemotherapy and radiation oncology require prior approval (see Section 3, *Other services).* Note: High dose chemotherapy in association with autologous bone marrow transplants is limited to those transplants listed in Section 5(b), *Organ/tissue transplants.* Note: See Section 5(h), *Special features* for more information on how you can take advantage of the Plan's Cancer Support Program that provides education and nursing support for cancer patients. • Intravenous (IV)/infusion therapy (supplies) – Home IV and antibiotic therapy (supplies) Note: See also this Section, *Home health services* • Growth hormone therapy • Respiratory and inhalation therapies (includes oxygen and equipment for its administration) • Cardiac rehabilitation therapy Note: The Plan provides benefits only for Phase 1 and Phase 2 cardiac rehabilitation therapy. • Renal dialysis (includes other covered charges associated with the dialysis treatment) • Biofeedback only when treating incontinence, migraine headaches, temporomandibular joint (TMJ) dysfunction, irritable bowel syndrome (IBS) and to assist with pain management Note: Applied behavior analysis (including the assessment) is covered under Section 5(e), *Mental health and substance use disorder benefits*, and requires prior approval. See Section 3, *How you get care.*	In-network (includes Guam): 10% of the Plan allowance Out-of-network (includes Guam): 30% of the Plan allowance and any difference between our allowance and the billed amount Providers outside the 50 United States (does not include Guam): 10% of the Plan allowance

Benefits Description	You pay After the calendar year deductible...
Physical, occupational, and speech therapies	**High**
125 total combined outpatient physical, occupational, and speech therapy visits per calendar year for all three listed therapies Note: See Section 5(e), *Mental health and substance use disorder benefits* for physical, occupational and speech therapy for the diagnoses of autism and developmental delays.	In-network (includes Guam): 10% of the Plan allowance Out-of-network (includes Guam): 30% of the Plan allowance and any difference between our allowance and the billed amount Providers outside the 50 United States (does not include Guam): 10% of the Plan allowance
Not covered: • *Custodial care (see Section 10, Definitions)* • *Exercise programs*	*All charges*
Hearing services (testing, treatment, and supplies)	**High**
• Routine hearing exam and testing for hearing loss Note: For benefits for the devices, see this Section, *Orthopedic and prosthetic devices*. Note: For child screening, testing, diagnosis, and treatment (including hearing aids for hearing loss), see this Section, *Preventive care, children*. Note: For hearing treatment related to non-auditory illness or disease see this Section, *Diagnostic and treatment services*.	In-network (includes Guam): Nothing (No deductible) Out-of-network (includes Guam): 30% of the Plan allowance and any difference between our allowance and the billed amount Providers outside the 50 United States (does not include Guam): Nothing (No deductible)
Not covered: • *Hearing services that are not shown as covered*	*All charges*
Vision services (testing, treatment, and supplies)	**High**
One pair of eyeglasses or contact lenses (including fitting) and refractions per incident if required to correct an impairment directly caused by: • Accidental ocular injury or intraocular surgery • Keratoconus • Glaucoma Note: Routine eye examinations are not covered, except when needed for covered eyeglasses or contact lenses above. Note: Diabetic retinal eye exams are covered in this Section, *Lab, X-ray and other diagnostic tests*. Note: Expenses related to any of the conditions noted above must be incurred within one year of the date of accident, surgery or diagnosis. Note: See Non-FEHB Section for information about the vision discount plan (for exams, glasses and contact lenses) and QualSight Lasik (for LASIK surgery) offered by the American Foreign Service Protective Association.	In-network (includes Guam): 10% of the Plan allowance Out-of-network (includes Guam): 30% of the Plan allowance and any difference between our allowance and the billed amount Providers outside the 50 United States (does not include Guam): 10% of the Plan allowance

Vision services (testing, treatment, and supplies) - continued on next page

Benefits Description	You pay After the calendar year deductible...
Vision services (testing, treatment, and supplies) (cont.)	**High**
Not covered: • *Routine eye examinations, except when needed for covered eyeglasses or contact lenses as noted on the previous page* • *Deluxe lens features for eyeglasses or contact lenses such as special coating, polarization, UV treatment, etc.* • *Eyeglasses or contact lenses, except as noted on the previous page* • *Eye exercises and visual training (orthoptics)* • *Refractions, except as noted on the previous page* • *All refractive surgeries, except as noted on the previous page*	*All charges*
Foot care	**High**
Routine foot care when you are under active treatment for a metabolic or peripheral vascular disease, such as diabetes Note: For foot orthotic devices, see this Section, *Orthopedic and prosthetic devices*	In-network (includes Guam): 10% of the Plan allowance Out-of-network (includes Guam): 30% of the Plan allowance and any difference between our allowance and the billed amount Providers outside the 50 United States (does not include Guam): 10% of the Plan allowance
Not covered: • *Cutting, trimming or removal of corns, calluses, or the free edge of toenails, and similar routine treatment of conditions of the foot, except as stated above*	*All charges*
Orthopedic and prosthetic devices	**High**
• Artificial limbs and eyes • Prosthetic sleeve or sock • Externally worn breast prostheses and surgical bras, including necessary replacements following a mastectomy • Internal prosthetic devices, such as artificial joints, pacemakers, implanted hearing-related devices (such as bone anchored hearing aids (BAHA) and cochlear implants) and surgically implanted breast implants following mastectomy • Foot orthotic devices prescribed by a physician or other health care professional and custom fitted for the feet, including necessary repair and adjustment Note: Foot orthotic devices for the feet include, but are not limited to: • Impression casting; and • Corrective shoes for treatment of malformation and weakness of the foot Note: For information on the professional charges for the surgery to insert an implant, see Section 5(b), *Surgical and anesthesia services*. For information on the hospital and/or ambulatory surgery center benefits, see Section 5(c), *Services provided by a hospital or other facility, and ambulance services*.	In-network (includes Guam): 10% of the Plan allowance Out-of-network (includes Guam): 30% of the Plan allowance and any difference between our allowance and the billed amount Providers outside the 50 United States (does not include Guam): 10% of the Plan allowance

Orthopedic and prosthetic devices - continued on next page

Benefits Description	You pay After the calendar year deductible...
Orthopedic and prosthetic devices (cont.)	**High**
Note: A prosthetic device is surgically inserted or physically attached to the body to restore a bodily function or replace a physical portion of the body. Note: See Section 5(b), *Surgical and anesthesia services* for coverage of the surgery to insert the device and Section 5(c), *Services provided by a hospital or other facility, and ambulance services,* if billed by the facility.	In-network (includes Guam): 10% of the Plan allowance Out-of-network (includes Guam): 30% of the Plan allowance and any difference between our allowance and the billed amount Providers outside the 50 United States (does not include Guam): 10% of the Plan allowance
• Wigs needed as a result of chemotherapy or radiation treatment for cancer	In-network, out-of-network, and providers outside the 50 United States: Nothing (No deductible) up to $500 per wig limited to one wig per person, per calendar year and all charges after $500 per wig, per person, per calendar year
• Adult hearing aid devices or replacement per person every 3 consecutive calendar years Note: Hearing aids may be purchased at any time during the third calendar year from the last date of purchase. Note: Repairs for hearing aids are not covered. Note: Child hearing aid exams and child hearing aids are covered under this Section, *Preventive care, children.* Note: Implanted hearing related devices such as bone anchored hearing aids (BAHA) and cochlear implants are covered as stated on the previous page along with internal prosthetic devices.	In-network, out-of-network, and providers outside the 50 United States: Nothing (No deductible) up to the Plan maximum of $4,000 per person or replacement per person every 3 consecutive calendar years and all charges after the Plan maximum
Not covered: • *Orthopedic and corrective shoes, arch supports, heel pads, and heel cups, except as listed on the previous page* • *Lumbosacral supports* • *Corsets*	*All charges*
Durable medical equipment (DME)	**High**
Durable medical equipment (DME) is equipment and supplies that: • Are prescribed by your attending physician (i.e., the physician or other medical professional who is treating your illness or injury); • Are medically necessary; • Are primarily and customarily used only for a medical purpose; • Are generally useful only to a person with an illness or injury; • Are designed for prolonged use; and • Serve a specific therapeutic purpose in the treatment of an illness or injury. We cover rental, up to the purchase price, or purchase (at our option), including necessary repair and adjustment, of durable medical equipment such as:	In-network (includes Guam): 10% of the Plan allowance Out-of-network (includes Guam): 30% of the Plan allowance and any difference between our allowance and the billed amount Providers outside the 50 United States (does not include Guam): 10% of the Plan allowance

Durable medical equipment (DME) - continued on next page

Benefits Description	You pay After the calendar year deductible...
Durable medical equipment (DME) (cont.)	**High**
• Wheelchairs • Hospital beds • Oxygen and equipment for its administration • Dialysis equipment • Crutches • Braces • Casts, splints, and trusses • Walkers • CPAP machines and supplies • Elastic stockings and support hose that require a physician's or other health care professional's written prescription Note: We will cover only the cost of medically necessary standard equipment. Coverage for specialty items (such as all-terrain wheelchairs, sports prosthetics, etc.) is limited to the cost of the standard equipment. Note: We will cover charges for service contracts for medically necessary durable medical equipment that you purchase or rent. Seat lift mechanisms for lift chairs based on the following criteria: • The patient must have severe arthritis of the hip or knee or a severe neuromuscular disease; • The seat lift mechanism must be a part of the physician's or other health care professional's course of treatment and be prescribed to affect movement, or arrest or retard deterioration in the patient's condition; • The patient must be completely incapable of standing up from a regular armchair or any chair in their home; • Once standing, the patient must have the ability to walk; and • Coverage is limited to seat lift mechanism even if incorporated into a chair. Medical supplies: • Medical foods and nutritional supplements only when administered by catheter or nasogastric tubes • Nutritional formulas taken orally for the treatment of Phenylketonuria (PKU) when administered under the direction of a physician Note: For colostomy, ostomy, insulin, and diabetic supplies, see Section 5(f), *Covered medications and supplies.* Note: See Section 5(h), *Special features*, for information about Livongo, the Plan's remote diabetes monitoring program.	In-network (includes Guam): 10% of the Plan allowance Out-of-network (includes Guam): 30% of the Plan allowance and any difference between our allowance and the billed amount Providers outside the 50 United States (does not include Guam): 10% of the Plan allowance

Durable medical equipment (DME) - continued on next page

Benefits Description	You pay After the calendar year deductible...
Durable medical equipment (DME) (cont.)	**High**
Augmentative and alternative communications (AAC) devices such as: • Computer story boards • Light talkers • Enhanced vision systems • Speech aid prostheses for pediatrics • Speech aid prostheses for adults • Magnifier Viewing System • Script Talk reader devices Note: For surgical insertion of speech aid prostheses, see Section 5(b), *Surgical procedures*.	In-network, out-of-network, and providers outside the 50 United States: Nothing (No deductible) up to one device per person, per calendar year up to the Plan allowance of $1,000 per device, per person, per calendar year and all charges after $1,000 per device
Not covered: • *Other items that do not meet the definition of durable medical equipment such as sun or heat lamps, whirlpool baths, heating pads, cold therapy units, air purifiers, humidifiers, air conditioners, and exercise devices* • *Desktop and laptop computers, pagers, personal digital assistants (PDAs), smart phones, and tablet devices (e.g., iPads), or other devices that are not dedicated speech generating devices* • *Oral nutritional supplements that do not require a prescription under Federal law even if your physician or other health care professional prescribes them or if a prescription is required under your state law, or are not administered by catheter or nasogastric tubes except for nutritional formulas taken orally for the treatment of Phenylketonuria (PKU) when administered under the direction of a physician*	*All Charges*
Home health services	**High**
Limited to 90 visits per calendar year when the attending physician or other health care professional: • Orders the care; • Identifies the specific professional skills required by the patient and the medical necessity for skilled services; and • Indicates the length of time the services are needed. Note: Services of a licensed social worker (LCSW) are included in the 90 visit calendar year maximum. Note: A home health aide must provide medically necessary skilled services under the supervision of a Registered Nurse (R.N.) consisting of mainly medical care and therapy provided solely for the care of the insured person. A home health agency (or visiting nurses where services of a home health agency are not available) must furnish the care in accord with a home health care plan (see definition on the next page). The home health care plan must be certified by your physician or other health care professional and furnished in your home.	In-network (includes Guam): 10% of Plan allowance and any visits above 90 visits per calendar year (No deductible); and all charges above one visit per day Out-of-network (includes Guam): 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.)	**High**
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 or other health care professional, for continued care and treatment of a Plan member: • Who is under the care of a physician or other health care professional; and • Who would need a continued stay in a Hospital or Skilled Nursing Facility without the home health care. We cover private duty nursing when: • Care is ordered by the attending physician or other health care professional; and • Your physician or other health care professional identifies the specific professional nursing skills that you require, as well as the length of time needed. Note: Private duty nursing requires prior approval. See Section 3, *Other Services,* for additional details on prior approval. Note: Private duty nursing visits are included in the 90 home health services visit maximum. Note: Physical, occupational and/or speech therapy services performed in an outpatient setting and/or at home will count toward the 125-therapy visit limitation per calendar year, as listed in *Physical, occupational and speech therapy,* except for the diagnoses of autism and developmental delays. See Section 5(e), *Mental health and substance use disorder benefits* for physical, occupational and speech therapy for the diagnosis of autism and developmental delays.	In-network (includes Guam): 10% of Plan allowance and any visits above 90 visits per calendar year (No deductible); and all charges above one visit per day Out-of-network (includes Guam): 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.
Not covered: • *Nursing care requested by, or for the convenience of, the patient or the patient's family* • *Home care primarily for personal assistance that does not include a medical component and is not diagnostic, therapeutic, or rehabilitative* • *Services rendered by a Home Health Aide are covered only as stated on the previous page* • *Custodial care (see Section 10, Definitions)*	*All charges*
Chiropractic	**High**
Covered services are limited to 50 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.	In-network (includes Guam): Nothing (No deductible) up to the Plan maximum of $60 per visit and then all charges up to the Plan allowance; and all charges above 50 visits per person, per calendar year

Chiropractic - continued on next page

Benefits Description	You pay After the calendar year deductible...
Chiropractic (cont.)	**High**
Note: Consultations and diagnostic services are covered under Section 5(a), *Diagnostic and treatment services* and also *Lab, X-ray and other diagnostic tests*; and do not count toward the visit limit.	In-network (includes Guam): Nothing (No deductible) up to the Plan maximum of $60 per visit and then all charges up to the Plan allowance; and all charges above 50 visits per person, per calendar year Out-of-network (includes Guam) and providers outside the 50 United States: Nothing (No deductible) up to the Plan maximum of $60 per visit; and all charges above $60 per visit and/or 50 visits per person, per calendar year
Alternative treatments	**High**
Acupuncture limited to 50 visits per person, per calendar year Note: The Plan defines acupuncture as the practice of insertion of needles into specific exterior body locations to relieve pain, to induce surgical anesthesia, or for therapeutic purposes. Note: These providers are required to submit itemized bills and their Federal Tax I.D. Number (if a United States provider) as outlined in Section 7, *Filing a claim for covered services*.	In-network (includes Guam): Nothing (No deductible) up to the Plan maximum of $60 per visit and then all charges up to the Plan allowance; and all charges above 50 visits per person, per calendar year Out-of-network (includes Guam) and providers outside the 50 United States: Nothing (No deductible) up to the Plan maximum of $60 per visit; and all charges above $60 per visit and/or 50 visits per person, per calendar year
Massage therapy only when performed by a covered provider (see Section 3) limited to 50 visits per person, per calendar year Note: These providers are required to submit itemized bills and their Federal Tax I.D. Number and/or Massage Therapy License Number (if a United States provider) as outlined in Section 7, *Filing a claim for covered services*. Note: See also Section 7, *Filing a claim for covered services* under *Overseas Claims* when filing a claim for a provider outside the 50 United States.	In-network (includes Guam): Nothing (No deductible) up to the Plan maximum of $60 per visit and then all charges up to the Plan allowance; and all charges above 50 visits per person, per calendar year Out-of-network (includes Guam) and providers outside the 50 United States: Nothing (No deductible) up to the Plan maximum of $60 per visit; and all charges above $60 per visit and/or 50 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 medications* • *Homeopathic services and medications* • *Rolfing*	*All charges*

Benefits Description	You pay After the calendar year deductible...
Educational classes and programs	**High**
Simple Steps to Living Well Together Program (See Section 5(h), *Special features,* for information on this Program.) • Tobacco Cessation Program - Two quit attempts per calendar year as part of the Plan's Tobacco Cessation Program. The quit attempts include proactive phone counseling and up to four tobacco and nicotine counseling sessions of at least 30 minutes each in each quit attempt. • Over-the-counter (OTC) medications approved by the FDA to treat nicotine dependence can be obtained through the Tobacco Cessation Program at no charge (see Section 5(f), *Prescription drug benefits* for more details). Note: To enroll in the program, contact a Health Coach at 855-406-5122 or 479-973-7168. Coaches are available Monday – Thursday from 8:00 a.m. – 10:00 p.m. Eastern Time (ET) and Friday from 8:00 a.m.– 6:00 p.m. ET. You may also enroll online at http://enroll.trestletree.com (passcode: FSBP). • Health Coaching Program - The Health Coaching Program provides you and your covered dependents the opportunity to work one-on-one with a Health Coach to improve your health. A Health Coach is a health care professional who partners with you to transform your health goals into action. Your Health Coach will provide guidance, support, and resources to help you overcome obstacles that may be keeping you from realizing optimal health. You can talk to a Health Coach about the following health-related matters: • Tobacco cessation • Weight management • Exercise • Nutrition • Stress management See the Plan's benefit, Health Coaching Program, in Section 5(h), *Special features.*	In-network, out-of-network, and providers outside the 50 United States: Nothing (No deductible)
Simple Steps to Living Well Together Program (See Section 5(h), *Special features,* for information on this Program.) • Diabetic education or training	In-network (includes Guam) and providers outside the 50 United States (does not include Guam): 10% of the Plan allowance (No deductible) Out-of-network (includes Guam): 30% of the Plan allowance and any difference between our allowance and the billed amount (No deductible)

Educational classes and programs - continued on next page

Benefits Description	You pay After the calendar year deductible...
Educational classes and programs (cont.)	**High**
myStrength™ – on-line mental health support program The **myStrength™** program provides you and your covered dependents age 13 and older, evidence-based resources to help overcome obstacles of depression, anxiety, and substance use disorder while improving overall well-being through a personalized evidence based internet-enabled program. This program focuses on the management of depression, anxiety, and substance use disorder through easy to use tools, weekly exercises, informational articles and daily inspiration in a safe and confidential environment. The program uses interactive web and mobile applications that deliver evidence-based psychotherapy models like: • Cognitive behavioral therapy (CBT) • Acceptance and commitment therapy (ACT) • Mindfulness acceptance Personalized inspirational and wellness approaches increase personal relevance, improve outcomes and focus on total well-being. If you would like to enroll in the program visit www.mystrength.com, select "Sign-up", enter the access code "FSBP" and complete the myStrength sign-up process with a brief Wellness Assessment and personal profile.	In-network, out-of-network, and providers outside the 50 United States: Nothing (No deductible)

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 Self Plus One enrollment or $600 per Self and Family enrollment) for in-network providers (including Guam) and providers outside the 50 United States; or $400 per person ($800 per Self Plus One enrollment or $800 per Self and Family enrollment) for out-of-network providers (including Guam). The calendar year deductible does not apply to any benefits in this Section. We added "(No deductible)" to show when the calendar year deductible does not apply.
- The out-of-network benefits are the standard benefits of this Plan. In-network benefits (including Guam) apply only when you use an in-network provider or when you use a provider outside the 50 United States. When no in-network provider is available in the network, out-of-network benefits apply.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost-sharing works. Also, read Section 9 for information about how we pay if you have other coverage, or if you are age 65 or over.
- The services listed below are for the charges billed by a physician or other health care professional for your surgical care. See Section 5(c) for charges associated with the facility (i.e., hospital, surgical center, etc.).
- **YOU OR YOUR PHYSICIAN MUST GET PRIOR APPROVAL FOR SOME SURGICAL PROCEDURES INCLUDING BUT NOT LIMITED TO: GENDER REASSIGNMENT SURGERY, BARIATRIC SURGERY AND ORGAN/TISSUE TRANSPLANTS.** Please refer to precertification information shown in Section 3, *You need prior Plan approval for certain services*, for additional services requiring prior approval.

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

Benefits Description	You pay
Note: The calendar year deductible does not apply to benefits in this Section. We say "(No deductible)" when it does not apply.	
Surgical procedures	**High**
A comprehensive range of services, such as: • Operative procedures • Treatment of fractures, including casting • Normal pre- and post-operative care by the surgeon • Correction of amblyopia and strabismus • Endoscopy procedures • Biopsy procedures • Removal of tumors and cysts	In-network (includes Guam): 10% of the Plan allowance (No deductible) Out-of-network (includes Guam): 30% of the Plan allowance and any difference between our allowance and the billed amount (No deductible) Providers outside the 50 United States (does not include Guam): 10% of the Plan allowance (No deductible)

Surgical procedures - continued on next page

Benefits Description	You pay
Surgical procedures (cont.)	**High**
• Gender reassignment surgery to treat gender dysphoria – In order for the Plan to consider benefits, all of the following Plan requirements must have been met: 1) You must be at least 18 years old; 2) You have been diagnosed as a transexual, as determined by the Plan; 3) You have completed a recognized program of transgender identity treatment, as determined by the Plan; and 4) You have obtained prior approval for the surgery *even if the proposed treatment is outside of the 50 United States* (see Section 3, *Other services*). Covered surgical procedures, limited to: - For female to male surgery: mastectomy, hysterectomy, vaginectomy, salpingo-oophorectomy, metoidioplasty, phalloplasty, urethroplasty, scrotoplasty, and placement of testicular and erectile prosthesis - For male to female surgery: penectomy, orchidectomy, vaginoplasty, clitoroplasty, and labiaplasty • Surgical treatment (bariatric surgery, such as gastric bypass, gastric sleeve, stomach stapling, or lap band procedure) of morbid obesity – 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; 2) been under at least one medically supervised weight loss program for at least 3 months. The program should be multi-disciplinary by combining diet and nutritional counseling with an exercise program and a behavior modification program; and 3) completed a psychological evaluation. 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 • Treatment of burns Note: Second opinion is covered under Section 5(a), *Diagnostic and treatment services* and in Section 5(h), *Special features, Overseas Second Opinion.*	In-network (includes Guam): 10% of the Plan allowance (No deductible) Out-of-network (includes Guam): 30% of the Plan allowance and any difference between our allowance and the billed amount (No deductible) Providers outside the 50 United States (does not include Guam): 10% of the Plan allowance (No deductible)
• Voluntary sterilization for women (e.g., tubal ligation) and for men (e.g., vasectomy) • Surgical implantation and removal of intrauterine devices (IUDs) • Surgical implantation and removal of contraceptive devices • Routine circumcision of a newborn child (only when the child is covered under a Self Plus One or Self and Family enrollment) Note: Related and necessary services for voluntary sterilization, such as anesthesia and outpatient facility charges, are covered at 100% of the Plan allowance for in-network providers and providers outside the 50 United States and at regular Plan benefits for out-of-network providers. Note: Includes related services including anesthesia.	In-network (includes Guam): Nothing (No deductible) Out-of-network (includes Guam): 30% of the Plan allowance and any difference between our allowance and the billed amount (No deductible) Providers outside the 50 United States (does not include Guam): Nothing (No deductible)

Surgical procedures - continued on next page

Benefits Description	You pay
Surgical procedures (cont.)	**High**
When multiple or bilateral surgical procedures are performed during the same operative session by the same surgeon, the Plan's benefit is determined as follows: • For the primary procedure, the Plan's allowance • For the secondary procedures - 50% of the Plan's allowance (unless the provider is an in-network or other participating provider in the United States and their contract provides for a different amount) • For tertiary and subsequent procedures: - 25% of the Plan's allowance (unless the provider is an in-network or other participating provider in the United States and their contract provides for a different amount) Note: This does not apply to providers outside the 50 United States. Note: For certain surgical procedures, we may apply a value of less than 50% for subsequent procedures. Note: Multiple or bilateral surgical procedures performed through the same incision are "incidental" to the primary surgery. That is, the procedure would not add time or complexity to patient care. We do not pay extra for incidental procedures.	In-network (includes Guam): 10% of the Plan allowance for the individual procedure (No deductible) Out-of-network (includes Guam): 30% of the Plan allowance for the individual procedure and any difference between our allowance and the billed amount (No deductible) Providers outside the 50 United States (does not include Guam): 10% of the Plan allowance for the individual procedure (No deductible)
• Assistant Surgeon Assistant surgical services provided by a surgeon when medically necessary to assist the primary surgeon. When a surgery requires an assistant surgeon, the Plan's allowance for the assistant surgeon is 16% of the allowance for the surgery and 12% of our allowance for the surgery when provided by a registered nurse first assistant or certified surgical assistant (unless the provider is an in-network or other participating provider in the United States and their contract provides for a different amount). Note: This does not apply to providers outside the 50 United States.	In-network (includes Guam): 20% of the Plan allowance (No deductible) Out-of-network (includes Guam): 20% of the Plan allowance and any difference between our allowance and the billed amount (No deductible) Providers outside the 50 United States (does not include Guam): 20% of the Plan allowance (No deductible)
• Co-surgeons (inpatient/outpatient) Note: When the surgery requires two surgeons with different skills to perform the surgery, the Plan's allowance for each surgeon is 62.5% of what it would allow for a single surgeon for the same procedure(s) (unless the provider is an in-network or other participating provider in the United States and their contract provides for a different amount). Note: This does not apply to providers outside the 50 United States.	In-network (includes Guam): 10% of the Plan allowance (No deductible) Out-of-network (includes Guam): 30% of the Plan allowance and any difference between our allowance and the billed amount (No deductible) Providers outside the 50 United States (does not include Guam): 10% of the Plan allowance (No deductible)

Surgical procedures - continued on next page

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

Benefits Description	You pay
Oral and maxillofacial surgery	**High**
Oral surgical procedures, limited to: • Reduction of fractures of the jaws or facial bones • Surgical correction of severe functional malocclusion only when we determine the correction of the malocclusion to be medically necessary • Removal of stones from salivary ducts • Excision of leukoplakia or malignancies • Excision of non-dentigerous cysts and incision of non-dentigerous abscesses • Surgical correction of temporomandibular joint (TMJ) dysfunction to include initial consultation and post operative medical exam • Surgical removal of impacted teeth, including anesthesia charges • Other surgical procedures not involving the teeth or their supporting structures	In-network (includes Guam): 10% of the Plan allowance (No deductible) Out-of-network (includes Guam): 30% of the Plan allowance and any difference between our allowance and the billed amount (No deductible) Providers outside the 50 United States (does not include Guam): 10% of the Plan allowance (No deductible)
Not covered: • *Oral implants, transplants and related services except those required to treat accidental injuries as described under Section 5(g), Dental benefits* • *Procedures that involve the teeth or their supporting structures (such as the periodontal membrane, gingival and alveolar bone) except as provided under Section 5(g), Dental benefits* • *Excision of non-impacted teeth*	*All charges*
Organ/tissue transplants	**High**
Solid organ transplants are subject to medical necessity and experimental/investigational review. Refer to Section 3, *Other services* for prior approval 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: • Autologous pancreas islet cell transplant (as an adjunct to total or near total pancreatectomy) only for patients with chronic pancreatitis • Cornea • Heart • Heart/lung • Intestinal transplants - Isolated small intestine - Small intestine with the liver - Small intestine with multiple organs, such as the liver, stomach, and pancreas • Kidney • Kidney-Pancreas • Liver • Lung single/bilateral/lobar • Pancreas	Plan-designated transplant network facility for tissue and organ transplant (see Section 5(h) *Special features*, *Institutes of Excellence*): 10% of the Plan allowance (No deductible) In-network (includes Guam): 20% of the Plan allowance (No deductible) subject to a maximum payable of $400,000 per transplant (No catastrophic coverage) Out-of-network (includes Guam): 100% of all charges (No catastrophic coverage) Providers outside the 50 United States (does not include Guam): 10% of the Plan allowance (No deductible)

Organ/tissue transplants - continued on next page

Benefits Description	You pay
Organ/tissue transplants (cont.)	**High**
The **tandem blood or marrow stem cell transplants for covered transplants** below are subject to medical necessity review by the Plan. Refer to Section 3, *Other services* for prior approval procedures. • Autologous tandem transplants for: - AL Amyloidosis - Multiple myeloma (de novo and treated) - Recurrent germ cell tumors (including testicular cancer)	Plan-designated transplant network facility for tissue and organ transplant (see Section 5(h) *Special features*, *Institutes of Excellence*): 10% of the Plan allowance (No deductible) In-network (includes Guam): 20% of the Plan allowance (No deductible) subject to a maximum payable of $400,000 per transplant (No catastrophic coverage) Out-of-network (includes Guam): 100% of all charges (No catastrophic coverage) Providers outside the 50 United States (does not include Guam): 10% of the Plan allowance (No deductible)
Blood or marrow stem cell transplants The Plan extends coverage for the diagnoses as indicated below. • Allogeneic transplants for: - Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia - Acute myeloid leukemia - Advanced Hodgkin's lymphoma with recurrence (relapsed) - Advanced myeloproliferative disorders (MPDs) - Advanced non-Hodgkin's lymphoma with recurrence (relapsed) - Amyloidosis - Chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL) - Hemoglobinopathy - Infantile malignant osteopetrosis - Kostmann's syndrome - Leukocyte adhesion deficiencies - Marrow failure and related disorders (i.e., Fanconi's, Paroxysmal Nocturnal Hemoglobinuria (PNH), Pure Red Cell Aplasia) - Mucolipidosis (e.g., Gaucher's disease, metachromatic leukodystrophy - Mucopolysaccaridosis (e.g., Hunter's syndrome, Hurler's syndrome, Sanfillippo's syndrome, Maroteaux-Lamy syndrome variants) - Myelodysplasia/myelodysplastic syndromes - Myeloproliferative disorders - Paroxysmal nocturnal hemoglobinuria - Phagocytic/hemophagocytic deficiency diseases (e.g., Wiskott-Aldrich syndrome) - Severe combined immunodeficiency - Severe or very severe aplastic anemia	Plan-designated transplant network facility for tissue and organ transplant (see Section 5(h) *Special features*, *Institutes of Excellence*): 10% of the Plan allowance (No deductible) In-network (includes Guam): 20% of the Plan allowance (No deductible) subject to a maximum payable of $400,000 per transplant (No catastrophic coverage) Out-of-network (includes Guam): 100% of all charges (No catastrophic coverage) Providers outside the 50 United States (does not include Guam): 10% of the Plan allowance (No deductible)

Organ/tissue transplants - continued on next page

Benefits Description	You pay
Organ/tissue transplants (cont.)	**High**
- Sickle cell anemia - X-linked lymphoproliferative syndrome • Autologous transplants for: - Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia - Advanced Hodgkin's lymphoma with recurrence (relapsed) - Advanced non-Hodgkin's lymphoma with recurrence (relapsed) - Amyloidosis - Breast cancer - Ependymoblastoma - Epithelial ovarian cancer - Ewing's sarcoma - Medulloblastoma - Multiple myeloma - Neuroblastoma - Pineoblastoma - Testicular, mediastinal, retroperitoneal, and ovarian germ cell tumors - Waldenstrom's macroglobulinemia	Plan-designated transplant network facility for tissue and organ transplant (see Section 5(h) *Special features*, *Institutes of Excellence*): 10% of the Plan allowance (No deductible) In-network (includes Guam): 20% of the Plan allowance (No deductible) subject to a maximum payable of $400,000 per transplant (No catastrophic coverage) Out-of-network (includes Guam): 100% of all charges (No catastrophic coverage) Providers outside the 50 United States (does not include Guam): 10% of the Plan allowance (No deductible)
Mini-transplants (non-myeloablative, reduced intensity conditioning or RIC) for members with a diagnosis listed below are subject to medical necessity review by the Plan. Refer to Section 3, *Other services* for prior approval procedures. • Allogeneic transplants for: - Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia - Acute myeloid leukemia - Advanced Hodgkin's lymphoma with recurrence (relapsed) - Advanced Myeloproliferative Disorders (MPDs) - Advanced non-Hodgkin's lymphoma with recurrence (relapsed) - Amyloidosis - Breast cancer - Chronic lymphocytic leukemia - Chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL) - Chronic myelogenous leukemia - Colon cancer - Early stage (indolent or non-advanced) small cell lymphocytic lymphoma - Hemoglobinopathy - Marrow failure and related disorders (i.e., Fanconi's PNH, Pure Red Cell Aplasia) - Multiple myeloma - Multiple sclerosis - Myelodysplasia/Myelodysplastic syndromes - Myeloproliferative disorders (MDDs) - Non-small cell lung cancer	Plan-designated transplant network facility for tissue and organ transplant (see Section 5(h) *Special features*, *Institutes of Excellence*): 10% of the Plan allowance (No deductible) In-network (includes Guam): 20% of the Plan allowance (No deductible) subject to a maximum payable of $400,000 per transplant (No catastrophic coverage) Out-of-network (includes Guam): 100% of all charges (No catastrophic coverage) Providers outside the 50 United States (does not include Guam): 10% of the Plan allowance (No deductible)

Organ/tissue transplants - continued on next page

Benefits Description	You pay
Organ/tissue transplants (cont.)	**High**
- Ovarian cancer - Paroxysmal nocturnal hemoglobinuria - Prostate cancer - Renal cell carcinoma - Sarcomas - Sickle cell disease - Severe combined immunodeficiency - Severe or very severe aplastic anemia • Autologous transplants for: - Acute lymphocytic or nonlymphocytic (i.e., myelogenous) leukemia - Advanced Hodgkin's lymphoma with recurrence (relapsed) - Advanced non-Hodgkin's lymphoma with recurrence (relapsed) - Amyloidosis - Neuroblastoma	Plan-designated transplant network facility for tissue and organ transplant (see Section 5(h) *Special features*, *Institutes of Excellence*): 10% of the Plan allowance (No deductible) In-network (includes Guam): 20% of the Plan allowance (No deductible) subject to a maximum payable of $400,000 per transplant (No catastrophic coverage) Out-of-network (includes Guam): 100% of all charges (No catastrophic coverage) Providers outside the 50 United States (does not include Guam): 10% of the Plan allowance (No deductible)
These blood or marrow stem cell transplants are covered only in a National Cancer Institute or National Institutes of health **approved clinical trial** or a Plan-designated center of excellence and if approved by the Plan's medical director in accordance with the Plan's protocols. If you are a participant in a clinical trial, the Plan will provide benefits for related routine care that is medically necessary (such as doctor visits, lab tests, X-rays and scans, and hospitalization related to treating the patient's condition) if it is not provided by the clinical trial. Section 9 has additional information on costs related to clinical trials. We encourage you to contact the Plan to discuss specific services if you participate in a clinical trial. • Allogenic transplants for: - Advanced Hodgkin's lymphoma - Advanced non-Hodgkin's lymphoma - Beta thalassemia major - Chronic inflammatory demyelination polyneuropathy (CIDP) - Early state (indolent or non-advanced) small cell lymphocytic lymphoma - Multiple myeloma - Multiple sclerosis - Sickle cell anemia • Autologous transplants for: - Advanced childhood kidney cancers - Advanced Ewing sarcoma - Advanced Hodgkin's lymphoma - Advanced non-Hodgkin's lymphoma - Aggressive non-Hodgkin lymphomas - Breast cancer - Childhood rhabdomyosarcoma	Plan-designated transplant network facility for tissue and organ transplant (see Section 5(h) *Special features*, *Institutes of Excellence*): 10% of the Plan allowance (No deductible) In-network (includes Guam): 20% of the Plan allowance (No deductible) subject to a maximum payable of $400,000 per transplant (No catastrophic coverage) Out-of-network (includes Guam): 100% of all charges (No catastrophic coverage) Providers outside the 50 United States (does not include Guam): 10% of the Plan allowance (No deductible)

Organ/tissue transplants - continued on next page

Benefits Description	You pay
Organ/tissue transplants (cont.)	**High**
- Chronic lymphocytic lymphoma/small lymphocytic lymphoma (CLL/SLL) - Chronic myelogenous leukemia - Early state (indolent or non-advanced) small cell lymphocytic lymphoma - Epithelial ovarian cancer - Mantle cell (Non-Hodgkin lymphoma) - Multiple sclerosis - Small cell lung cancer - Systemic lupus erythematosus - Systemic sclerosis • Autologous transplants for the following autoimmune diseases: - Multiple sclerosis - Systemic lupus erythematosus - Systemic sclerosis - Scleroderma - Scleroderma-SSC (severe, progressive)	Plan-designated transplant network facility for tissue and organ transplant (see Section 5(h) *Special features*, *Institutes of Excellence*): 10% of the Plan allowance (No deductible) In-network (includes Guam): 20% of the Plan allowance (No deductible) subject to a maximum payable of $400,000 per transplant (No catastrophic coverage) Out-of-network (includes Guam): 100% of all charges (No catastrophic coverage) Providers outside the 50 United States (does not include Guam): 10% of the Plan allowance (No deductible)
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 tests for up to four potential transplant donors per year from individuals unrelated to the patient, in addition to testing of family members. Note: The Plan has special arrangements with facilities to provide services for tissue and organ transplants only (see Section 5(h), *Special features, Institutes of Excellence*). The transplant network was designed to give you an opportunity to access providers that demonstrate high quality medical care for transplant patients. We also may assist you and one family member or caregiver with travel and lodging arrangements if you use one of our Institutes of Excellence. Your health care professional can coordinate arrangements by calling a case manager in the Plan's Medical Management Department at 800-593-2354. For additional information regarding the transplant network, please call this number.	
Not covered: • *Donor screening tests and donor search expenses, except those performed for the actual donor or as specified above* • *Services or supplies for, or related to, surgical transplant procedures for artificial or human organ transplants not listed as covered* • *Transplants not listed as covered* • *Services or supplies for, or related to, surgical transplant procedures performed at out-of-network facilities*	*All charges*

Benefits Description	You pay
Anesthesia	**High**
Professional services (except when billed by the hospital or skilled nursing facility) 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 this Section, *Oral and maxillofacial surgery*). Note: When multiple anesthesia providers are involved during the same surgical session, the Plan's allowance for each provider will be determined using CMS guidelines.	In-network (includes Guam): 10% of the Plan allowance (No deductible) Out-of-network (includes Guam): 30% of the Plan allowance and any difference between our allowance and the billed amount (No deductible) Providers outside the 50 United States (does not include Guam): 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 Self Plus One enrollment or $600 per Self and Family enrollment) for in-network providers (including Guam) and providers outside the 50 United States; or $400 per person ($800 per Self Plus One enrollment or $800 per Self and Family enrollment) for out-of-network providers (including Guam).
- The out-of-network benefits are the standard benefits of this Plan. In-network benefits (including Guam) apply only when you use an in-network provider or when you use a provider outside the 50 United States. When no in-network provider is available in the network, out-of-network benefits apply.
- When you use an in-network facility (including Guam), keep in mind that the health care professionals who provide services to you in the facility may not be in-network providers. We will pay up to the Plan allowance at the in-network provider percentage for services you receive from out-of-network anesthesiologists (including Certified Registered Nurse Anesthetists), radiologists, pathologists, emergency room physicians, hospitalists, intensivists and neonatologists. This provision also applies when an out-of-network surgeon's immediate or emergency care is required. You will be responsible to pay the in-network coinsurance and any difference between the Plan allowance and billed amount for these out-of-network providers. When non-emergency care by out-of-network surgeons is provided, regular out-of-network benefits apply.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost-sharing works. Also, read Section 9 for information about how we pay if you have other coverage, or if you are age 65 or over.
- The amounts listed on the following pages are for the charges billed by the facility (i.e., hospital or surgical center) or ambulance service for your surgery or care. Any costs associated with the professional charges (i.e., physicians, etc.) and supplies are in Sections 5(a), (b), (d) or (e), except when billed by the hospital or skilled nursing facility.
- Note: Observation care is billed as outpatient facility care. Observation stays for more than 24 hours require prior approval. See Section 3, *Other Services* for additional details on prior approval.
- **YOUR NETWORK PHYSICAN, HOSPITAL, OR SKILLED NURSING FACILITY MUST PRECERTIFY HOSPITAL OR SKILLED NURSING FACILITY STAYS AND CONCURRENT CARE (FOR DAYS BEYOND THE PLAN'S INITIAL APPROVAL) FOR IN-NETWORK FACILITY CARE. YOU MUST PRECERTIFY HOSPITAL OR SKILLED FACILITY STAYS AND CONCURRENT CARE FOR OUT-OF-NETWORK FACILITY CARE; FAILURE TO DO SO WILL RESULT IN A $500 PENALTY FOR OUT-OF-NETWORK FACILITY CARE.**
- **YOU, YOUR PHYSICIAN, OR AIR AMBULANCE PROVIDER MUST GET PRIOR APPROVAL FOR FIXED-WING AIRCRAFT (PLANE) TRANSPORT.**
- Please refer to the information shown in Section 3, *Other services* to confirm which services require precertification or prior approval.

Note: We do not require precertification, prior approval, or concurrent review in this section for services you receive outside the 50 United States (including Guam) *except for gene therapy*. However, the Plan will review all services to establish medical necessity or to confirm coverage. We may request medical records in order to determine medical necessity or to confirm coverage before and/or during continued treatment.

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

Benefits Description	You pay
Note: The calendar year deductible applies ONLY when we say below: "(calendar year deductible applies)".	
Inpatient hospital	**High**
Room and board, such as: • Ward, semiprivate, or intensive care accommodations • General nursing care • Meals and special diets Note: We only cover a private room when you must be isolated to prevent contagion. Otherwise, we will pay the hospital's average charge for semiprivate accommodations. If the hospital only has private rooms, then we will consider the private room rate. Note: Staying overnight in a hospital does not always mean you are an inpatient. You are considered an inpatient the day a physician formally admits you to a hospital with a physician's order. Confinement as an inpatient or an outpatient affects your out-of-pocket expenses. Always ask your physician or the hospital staff if you are an inpatient, outpatient, or observation care. Although you may stay overnight in a hospital room and receive meals and other hospital services, some hospital services including "observation care" are actually outpatient care (see this Section, *Outpatient hospital or ambulatory surgical center*). If you are admitted to the hospital as an inpatient after your observation care ends, you must precertify the inpatient admission per Section 3. Other services and supplies you receive while in a hospital, such as: • Use of operating, recovery, maternity, and other treatment rooms • Rehabilitative services • Prescribed drugs and medications for use in the hospital • X-ray, laboratory, and pathology services and machine diagnostic tests • Blood or blood plasma, if not donated or replaced, and its administration • Dressings, splints, casts, and sterile tray services • Medical supplies and equipment, including oxygen • Anesthetics, including nurse anesthetist services • Drugs, medical supplies, medical equipment, prosthetic, and orthopedic devices and any covered items billed by a hospital • Professional services of a physician or health care professional • Special overseas benefit – Inpatient private duty nursing services by an R.N. or L.P.N. when the services are rendered outside the 50 United States Note: We pay emergency room fees billed by the hospital as Inpatient hospital benefits if you are admitted as an inpatient through the emergency room. Note: We base our benefits on whether the facility or a health care professional bills for the services or supplies. For example, charges for professional services such as surgery, anesthesiology, medical or therapy services, etc., we pay the specific surgery, anesthesia, medical or therapy benefit under Section 5(a) and the calendar year deductible applies, except when billed by the hospital. Note: We cover hospital services and supplies related to dental procedures when necessitated by a non-dental physical impairment to safeguard the health of the patient, even though we may not cover the services of dentists, physicians, or other health care professionals in connection with the dental treatment.	Precertification is not required for admissions outside the 50 United States (including Guam). In-network (includes Guam): Nothing Out-of-network (includes Guam): $200 copayment per hospital admission and 20% of the Plan allowance and any difference between our allowance and the billed amount Providers outside the 50 United States (does not include Guam): Nothing

Inpatient hospital - continued on next page

Benefits Description	You pay
Inpatient hospital (cont.)	**High**
Not covered: • *Admission to nursing homes, rest homes, places for the aged, convalescent homes, or any place that is not a hospital, skilled nursing care facility, or hospice (see Section 3, Covered providers and Covered facilities)* • *Custodial care (see Section 10, Definitions)* • *Any part of a hospital admission that is not medically necessary (see Section 10, Definitions), such as when you do not need acute hospital inpatient (overnight) care, but could receive care in some other setting without adversely affecting your condition or the quality of your medical care. Note: In this event, we pay benefits for services and supplies other than room and board and in-hospital physician or other health care professional care at the inpatient level for other medically necessary services and supplies you receive while in the hospital.* • *Inpatient private duty nursing except as provided on the previous page* • *Personal comfort items, such as radio, television, beauty and barber services, identification tags, baby beads, footprints, guest cots and meals, newspapers, and similar items* • *Inpatient hospital services/supplies for surgery we do not cover except as noted on the previous page for non-covered dental procedures*	*All charges*
Outpatient hospital or ambulatory surgical center	**High**
• Operating, recovery, and other treatment rooms • Observation stays of 24 hours or less • Prescribed drugs and medications 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 • Anesthetics and anesthesia service • Drugs, medical supplies, medical equipment including oxygen, prosthetic and orthopedic devices, and any covered items billed by a hospital Note: We cover hospital services and supplies related to dental procedures when necessitated by a non-dental physical impairment to safeguard the health of the patient, even though we may not cover the services of dentists, physicians or other health care professionals in connection with the dental treatment.	In-network (includes Guam): 10% of the Plan allowance (calendar year deductible applies) (cost share waived for maternity related services) Out-of-network (includes Guam): 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 (does not include Guam): 10% of the Plan allowance (calendar year deductible applies) (cost share waived for maternity related services)
Observation stays for more than 24 hours performed and billed by a hospital or freestanding ambulatory facility Note: Observation stays for more than 24 hours require prior approval. See Section 3, *Other Services* for additional details on prior approval. Note: All outpatient services billed by the facility during the time you are receiving observation services are included in the cost-share amounts shown here. See Section 5(a), for any costs associated with the professional charges.	In-network (includes Guam): Nothing Out-of-network (includes Guam): $200 copayment per observation stay and 20% of the Plan allowance and any difference between our allowance and the billed amount Providers outside the 50 United States (does not include Guam): Nothing
Not covered: • *Outpatient hospital services/supplies for surgery we do not cover except as noted above for non-covered dental procedures*	*All charges*

Benefits Description	You pay
Extended care benefits/Skilled nursing care facility benefits	**High**
We cover semiprivate room, board, services, and supplies in a Skilled Nursing Facility (SNF) for up to 90 days per calendar year when the admission is: • medically necessary; and • under the supervision of a physician. Note: When Medicare A is primary, the initial days paid in full by Medicare are considered part of the 90 day per calendar year benefit.	Precertification is not required for admissions outside the 50 United States (including Guam). In-network (includes Guam): Nothing up to the Plan allowance for up to 90 days per calendar year and all charges after 90 days. Out-of-network (includes Guam): $200 copayment per admission and 20% of the Plan allowance and any difference between our allowance and the billed amount up to a maximum of 90 days per calendar year and all charges after 90 days. Providers outside the 50 United States (does not include Guam): Nothing up to the Plan allowance for up to 90 days per calendar year and all charges after 90 days.
Not covered: • *Custodial care (see Section 10, Definitions)*	*All charges*
Hospice care	**High**
Note: This benefit does not apply to services covered under any other provisions of the Plan. Note: We define Hospice Care Program as a coordinated program of home or inpatient pain control and supportive care for a terminally ill patient and the patient's family. Care must be provided by a medically supervised team under the direction of an independent hospice administration that we approve. Note: See Section 5(h), *In Touch Care Program*, for information on advance care planning.	In-network (includes Guam): 10% of Plan allowance Out-of-network (includes Guam): 30% of Plan allowance and any difference between our allowance and the billed amount Providers outside the 50 United States (does not include Guam): 10% of Plan allowance
Ambulance	**High**
• Professional ambulance service to the nearest facility equipped to handle your medical condition, including air ambulance, when medically necessary. Note: If you are outside the 50 United States and need assistance arranging for air ambulance transportation to the nearest facility equipped to handle your medical condition, please call us at 800-593-2354, Monday-Friday from 6:00 a.m. - 5:00 p.m. Mountain Standard Time (MST) or, after hours only, you can call 866-895-7795 or +44 (0)1252 351 200. Note: We also cover medically necessary emergency care provided when transport services are not required.	In-network (includes Guam): 10% of the Plan allowance Out-of-network (includes Guam): 10% of the Plan allowance and any difference between our allowance and the billed amount Providers outside the 50 United States (does not include Guam): 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 Self Plus One enrollment or $600 per Self and Family enrollment) for in-network providers (including Guam) and providers outside the 50 United States; or $400 per person ($800 per Self Plus One enrollment or $800 per Self and Family enrollment) for out-of-network providers (including Guam). We added "(No deductible)" to show when the calendar year deductible does not apply.
- The out-of-network benefits are the standard benefits of this Plan. In-network benefits (including Guam) apply only when you use an in-network provider or when you use a provider outside the 50 United States. When no in-network provider is available in the network, out-of-network benefits apply.
- When you use an in-network facility (including Guam), keep in mind that the health care professionals who provide services to you in the facility may not be in-network providers. We will pay up to the Plan allowance at the in-network provider percentage for services you receive from out-of-network anesthesiologists (including Certified Registered Nurse Anesthetists), radiologists, pathologists, emergency room physicians, hospitalists, intensivists, neonatologists, and surgeons when immediate or emergency care is required. You will be responsible to pay the in-network coinsurance and any difference between the Plan allowance and billed amount for these out-of-network providers.
- Be sure to read Section 4, *Your costs for covered services,* for valuable information about how cost-sharing works. Also, read Section 9 for information about how we pay if you have other coverage, or if you are age 65 or over.
- **YOU, YOUR PHYSICIAN, OR AIR AMBULANCE PROVIDER MUST GET PRIOR APPROVAL FOR FIXED-WING AIRCRAFT (PLANE) TRANSPORT.**
- Prior approval for radiology imaging procedures is not required in the case of an accident or a medical emergency. See Section 3, *Other services.*

Note: We do not require prior approval in this section for services you receive outside the 50 United States (including Guam). However, the Plan will review all services to establish medical necessity or to confirm coverage. We may request medical records in order to determine medical necessity or to confirm coverage before and/or during continued treatment.

What is an accidental injury?

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

What is a medical emergency?

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

Benefits Description	You pay After the calendar year deductible…
Note: The calendar year deductible applies to some benefits in this Section. We say "(No deductible)" when it does not apply.	
Accidental injury	**High**
We pay 100% of the Plan allowance for the following care you receive as a result of an accidental injury: • Emergency Room (ER) or urgent care facility charges, ER, urgent care physician's, or other health care professional's charges and ancillary services performed at the time of the ER visit or initial urgent care facility visit; **or** • Office visit and ancillary services performed at the time of the initial office visit for accidental injury; **or** • Series of rabies vaccinations. Note: See Section 5(a), *Telehealth Services* for information on the Plan's Telehealth benefit you may use in non-medical emergencies. Note: Regular Plan benefits apply after the initial ER, urgent care, physician, or other health care professional office visit. Note: We pay for services performed outside the ER or urgent care facility under the appropriate Plan benefit. Note: We pay hospital benefits as specified in Section 5(c), Services provided by a hospital or other facility if you are admitted to the hospital. Note: We pay prescription medications under Sections 5(a), 5(c) or 5(f) as appropriate.	In-network (includes Guam): Nothing (No deductible) Out-of-network (includes Guam): Only the difference between the Plan allowance and the billed amount (No deductible) Providers outside the 50 United States (does not include Guam): Nothing (No deductible)
Medical emergency	**High**
Initial services and items you receive in the outpatient Emergency Room (ER), physician's, or other health care professional's office because of a medical emergency (non-accident). Services and items covered include: • Medical services and supplies • Physician and professional services • X-ray, laboratory, pathology services, and machine diagnostic tests • Professional services for anesthesia Note: See Section 5(a), *Telehealth Services* for information on the Plan's Telehealth benefit you may use in non-medical emergencies. Note: Regular Plan benefits apply after initial ER, physician's, or other health care professional's office visit. Note: Non-medical emergency services received at a Convenience Care Clinic are paid under Section 5(a), *Diagnostic and treatment services*. Note: We pay emergency room fees billed by the hospital as Inpatient hospital benefits as specified in Section 5(c), *Inpatient hospital* if you are admitted as an inpatient through the emergency room.	In-network (includes Guam): 10% of the Plan allowance Out-of-network (includes Guam): 10% of the Plan allowance and any difference between our allowance and the billed amount Providers outside the 50 United States (does not include Guam): 10% of the Plan allowance

Medical emergency - continued on next page

Benefits Description	You pay After the calendar year deductible…
Medical emergency (cont.)	**High**
• Outpatient care in an urgent care facility because of a medical emergency Note: See Section 5(a), *Telehealth Services* for information on the Plan's Telehealth benefit you may use in non-medical emergencies. Note: Services received from an in-network provider for routine preventive care are paid under Section 5(a), *Preventive care, adult* or *Preventive care, children.*	In-network (includes Guam): $35 copayment per occurrence (No deductible) Out-of-network (includes Guam): $35 copayment per occurrence and any difference between our allowance and the billed amount (No deductible) Providers outside the 50 United States (does not include Guam): $35 copayment per occurrence (No deductible)
Ambulance	**High**
• Professional ambulance service to the nearest facility equipped to handle your medical condition, including air ambulance, when medically necessary. Note: If you are outside the 50 United States and need assistance arranging for air ambulance transportation to the nearest facility equipped to handle your medical condition, please call us at 800-593-2354, Monday-Friday from 6:00 a.m. - 5:00 p.m. Mountain Standard Time (MST) or, after hours only, you can call 866-895-7795 or +44 (0)1252 351 200. Note: We also cover medically necessary emergency care provided when transport services are not required.	In-network (includes Guam): 10% of the Plan allowance (No deductible) Out-of-network (includes Guam): 10% of the Plan allowance and any difference between our allowance and the billed amount (No deductible) Providers outside the 50 United States (does not include Guam): 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 Use Disorder Benefits

You may choose to get care from an in-network or an out-of-network provider if you live in the 50 United States (including Guam). When you receive **any** care in the 50 United States, you must get our prior approval for inpatient hospitalization and partial hospitalization (does not include Guam). Cost-sharing and limitations for mental health and substance use disorder benefits are no greater than for similar benefits for other illnesses and conditions.

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- The calendar year deductible or, for facility care, the inpatient copayment applies to almost all benefits in this Section. We added "(No deductible)" to show when the calendar year deductible does not apply.
- The out-of-network benefits are the standard benefits of this Plan. In-network benefits (including Guam) apply only when you use an in-network provider or when you use a provider outside the 50 United States. When no in-network provider is available in the network, out-of-network benefits apply.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost-sharing works. Also, read Section 9 for information about how we pay if you have other coverage, or if you are age 65 or over.
- **YOUR NETWORK PHYSICIAN OR HOSPITAL MUST PRECERTIFY OR OBTAIN PRIOR APPROVAL FOR THE SERVICES LISTED BELOW, INCLUDING CONCURRENT CARE (FOR DAYS OR VISITS BEYOND THE PLAN'S INITIAL APPROVAL). YOU MUST PRECERTIFY OR OBTAIN PRIOR APPROVAL FOR THE SERVICES LISTED BELOW FOR YOUR OUT-OF-NETWORK PHYSICIAN OR HOSPITAL, INCLUDING CONCURENT CARE (FOR DAYS OR VISITS BEYOND THE PLAN'S INITIAL APPROVAL); FAILURE TO DO SO WILL RESULT IN A $500 PENALTY FOR OUT-OF-NETWORK FACILITY CARE.** Please refer to the precertification information shown in Section 3, to confirm which services require precertification.
  - Applied behavior analysis (ABA)
  - Inpatient admissions
  - Partial hospitalization programs (PHPs)
  - Residential treatment center (RTC) admissions
  - Transcranial magnetic stimulation (TMS)
  - **To precertify, obtain prior approval, or obtain concurrent review for continuing care,** you, your representative, your health care professional, or your hospital **must** call the Plan at 800-593-2354 prior to the admission or care.

Note: We do not require precertification, prior approval or concurrent review for continuing care in this Section for services you receive outside the 50 United States (including Guam), *except for ABA assessment or treatment*. However, the Plan will review all services to establish medical necessity or to confirm coverage. We may request medical records in order to determine medical necessity.

Note: We do not require precertification, prior approval or concurrent review when Medicare Part A and/or Part B or another group health insurance policy is the primary payor. However, precertification, prior approval, and concurrent review for continuing care is required for inpatient, partial hospitalization or for ABA assessment or treatment 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.	
Professional services	**High**
We cover professional services by licensed professional mental health and substance use disorder practitioners when acting within the scope of their license, such as psychiatrists, psychologists, clinical social workers, licensed professional counselors, or family therapists.	Your cost-sharing responsibilities are no greater than for other illnesses or conditions.
Professional services including: • Psychiatric office visits to a behavioral health practitioner • Substance use disorder office visits • Behavioral therapy • Telemedicine consultations Note: Telemedicine consultations are covered when your provider uses a Health Insurance Portability and Accountability Act (HIPAA) compliant tool such as Vidyo or Bluejeans for facilitating telehealth consultations.	In-network (includes Guam): 10% of the Plan allowance Out-of-network (includes Guam): 30% of the Plan allowance and any difference between our allowance and the billed amount Providers outside the 50 United States (does not include Guam): 10% of the Plan allowance
Applied behavior analysis (ABA) Note: The Plan covers medically necessary assessment and treatment with Applied Behavior Analysis therapy only when provided by behavioral health providers. These providers include: • Providers who are licensed or who possess a state-issued or state-sanctioned certification in ABA therapy. • Behavior analysts certified by the Behavior Analyst Certification Board (BACB). • Registered Behavior Technicians (RBTs) certified by the BACB or equivalent paraprofessionals who work under the supervision of a licensed provider or a certified behavior analyst. Note: Assessment or treatment with ABA requires prior approval. See Section 3, *How you get care* for information on how to obtain prior approval.	In-network (includes Guam): 10% of the Plan allowance Out-of-network (includes Guam): 30% of the Plan allowance and any difference between our allowance and the billed amount Providers outside the 50 United States (does not include Guam): 10% of the Plan allowance
Skilled behavioral health services provided in the home, but only when all of the following criteria are met: • You are homebound • Your physician orders the services • The services take the place of an admission to a hospital or a residential treatment facility, or you are unable to receive the same services outside your home • The skilled behavioral health care is appropriate for the active treatment of a condition, illness or disease to avoid placing you at risk for serious complications	In-network (includes Guam): 10% of the Plan allowance Out-of-network (includes Guam): 30% of the Plan allowance and any difference between our allowance and the billed amount Providers outside the 50 United States (does not include Guam): 10% of the Plan allowance
Not covered: • *Assessment or treatment with ABA for which you have not obtained prior approval or received concurrent care review approval* • *See Section 6, General exclusions, for other non-covered services* *Note: OPM will base its review of disputes about treatment plans on the treatment plan's clinical appropriateness. OPM will generally not order us to pay or provide one clinically appropriate treatment plan in favor of another.*	*All charges*

Benefits Description	You pay After the calendar year deductible…
Telehealth Services	**High**
Telehealth consultations are available to members **in the 50 United States** with primary care and specialty providers **through our telehealth vendor Teladoc®** such as: • Doctors of Medicine (MD) • Doctors of Osteopathic Medicine (DO) • Nutritionists • Licensed Clinical Social Workers (LCSW) • Psychiatrists • Psychologists • Dermatologists Access telehealth services 24/7/365 by web, phone, and the Teladoc® mobile app to receive treatment within minutes for non-emergency, acute general medical needs such as: flu, cough, colds, seasonal allergies, sinus problems, arthritis, upper respiratory infection, backaches and food poisoning. You also can see a behavioral health provider for depression, anxiety and stress, as well as a nutritionist for dietary conditions or dermatologist for skin conditions. Note: Because of the complexity of medical licensure/prescribing laws among the 50 United States and foreign countries, Teladoc® cannot offer this service to members outside the United States. Note: See also Section 5(a), *Telehealth Services* for medical telehealth services for members in the 50 United States. Note: Telehealth is available in all 50 United States. **To sign up:** See www.teladoc.com/Aetna or call 855-Teladoc (1-855-835-2362) for information regarding telehealth consults.	In-network: Nothing (No deductible) Out-of-network: No benefit Providers outside of the 50 United States (includes Guam): No benefit
Not covered: • *Consultations through Skype, FaceTime and other non-HIPAA compliant tools*	*All charges*
Diagnostics	**High**
• Psychological testing provided and billed by a licensed mental health and substance use practitioner • Outpatient diagnostic tests provided and billed by a laboratory, hospital or other covered facility	In-network (includes Guam): 10% of the Plan allowance Out-of-network (includes Guam): 30% of the Plan allowance and any difference between our allowance and the billed amount Providers outside the 50 United States (does not include Guam): 10% of the Plan allowance

Benefits Description	You pay After the calendar year deductible…
Inpatient hospital or other covered facility	**High**
• Inpatient services provided and billed by a hospital or other covered facility, including an overnight Residential Treatment Center (RTC) Note: RTC benefits are not available for facilities licensed as a skilled nursing facility, group home, therapeutic boarding school, halfway house, or similar type facility. Note: We only cover a private room when you must be isolated to prevent contagion. Otherwise, we will pay the hospital's average charge for semiprivate accommodations. If the hospital only has private rooms, then we will consider the private room rate. Note: Benefits are not available for non-covered services, including: respite care; outdoor residential programs; services provided outside of the provider's scope of practice; recreational therapy; educational therapy; educational classes; bio-feedback; Outward Bound programs; equine therapy provided during the approved stay; personal comfort items, such as guest meals and beds, phone, television, beauty and barber services; custodial or long term care; and domiciliary care provided because care in the home is not available or is unsuitable.	In-network inpatient facility (includes Guam): Nothing for room and board and other services (No deductible) Out-of-network inpatient facility (includes Guam): $200 copayment per person, per hospital admission and 20% of the Plan allowance and any difference between our allowance and the billed amount for room and board and other services (No deductible) Providers outside the 50 United States (does not include Guam): Nothing for room and board and other services (No deductible)
Outpatient hospital and other outpatient services	**High**
Outpatient services provided and billed by a hospital or other covered facility All other outpatient mental health treatment, including: • Ambulatory detoxification, which is outpatient services that monitor withdrawal from alcohol or other substance use, including administration of medications • Electro-convulsive therapy (ECT) • Intensive outpatient program provided in a facility or program for mental health treatment provided under the direction of a physician • Mental health injectables • Observation stays of 24 hours or less • Outpatient detoxification • Partial hospitalization treatment provided in a facility or program for mental health treatment provided under the direction of a physician • Substance use injectables • Transcranial magnetic stimulation • Treatment of withdrawal symptoms Note: Intensive outpatient programs must be licensed to provide mental health and/or substance use disorder treatment. Services must be provided for at least two hours per day and may include group, individual, and family therapy along with psychoeducational services and adjunctive psychiatric medication management. Note: Partial hospitalization programs must be licensed to provide mental health and/or substance use disorder treatment. Services must be at least four hours per day and may include group, individual, and family therapy along with psychoeducational services and adjunctive medication management.	In-network (includes Guam): 10% of the Plan allowance Out-of-network (includes Guam): 30% of the Plan allowance and any difference between our allowance and the billed amount Providers outside the 50 United States (does not include Guam): 10% of the Plan allowance

Outpatient hospital and other outpatient services - continued on next page

Benefits Description	You pay After the calendar year deductible…
Outpatient hospital and other outpatient services (cont.)	**High**
Observation stays for more than 24 hours performed and billed by a hospital or freestanding ambulatory facility Note: Observation stays for more than 24 hours require prior approval. See Section 3, *Other Services* for additional details on prior approval. Note: All outpatient services billed by the facility during the time you are receiving observation services are included in the cost-share amounts shown here. See Section 5(a), for any costs associated with the professional charges.	In-network (includes Guam): Nothing Out-of-network (includes Guam): $200 copayment per observation stay and 20% of the Plan allowance and any difference between our allowance and the billed amount Providers outside the 50 United States (does not include Guam): Nothing
Physical, occupational, and speech therapies	**High**
Outpatient physical, occupational, and speech therapy visits for the diagnoses of autism and developmental delays	In-network (includes Guam): 10% of the Plan allowance Out-of-network (includes Guam): 30% of the Plan allowance and any difference between our allowance and the billed amount Providers outside the 50 United States (does not include Guam): 10% of the Plan allowance

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 this Section, *Covered medications and supplies*.
- 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.
- Federal law prevents the pharmacy from accepting unused medications.
- The calendar year deductible is: $300 per person ($600 per Self Plus One enrollment or $600 per Self and Family enrollment) for in-network providers (including Guam) and providers outside the 50 United States; or $400 per person ($800 per Self Plus One enrollment or $800 per Self and Family enrollment) for out-of-network providers (including Guam). The calendar year deductible does not apply to any benefits in this Section. We added "(No deductible)" to show when the calendar year deductible does not apply.
- Be sure to read Section 4, *Your costs for covered services,* for valuable information about how cost-sharing works. Also, read Section 9 for information about how we pay if you have other coverage, or if you are age 65 or over.
- During the year, the Plan's formulary may change. Tier changes for brand medications (including specialty) may occur due to generic availability, cost increases or safety concerns. Tier changes are not considered benefit changes.
- During the year, the Plan may implement new health and safety programs, as they become available. These programs may focus on appropriate dosing, preferred therapy and/or adherence as examples.
- To manage an affordable prescription benefit, it is important the Plan react to excessive cost increases. Safety and efficacy of medication will remain a priority. However, one drug may be more cost effective than another. During the course of the year, the Plan may act upon excessive cost increases and cover a less costly medication in the same therapeutic class.
- **YOU MUST GET PRIOR AUTHORIZATION FOR CERTAIN DRUGS, INCLUDING SPECIALTY DRUGS AND CERTAIN SPECIALTY DRUGS SUPPLIED BY PRESCRIBER'S OFFICES AND OUTPATIENT FACILITIES; AND PRIOR AUTHORIZATION MUST BE RENEWED PERIODICALLY.** Prior authorization uses Plan rules based on FDA-approved prescribing and safety information, and clinical guidelines and uses that are considered reasonable, safe, and effective. See the prior authorization information shown in Section 3, *Other Services* and in this Section, *Prescription Drug Utilization Management*, for more information about this important program.

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

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

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

We will send each new enrollee a Foreign Service Benefit Plan Identification (ID) Card that also serves as a prescription ID card, a Health, Allergy & Medication Questionnaire, Express Scripts Pharmacy℠ home delivery forms, and envelopes.

You must present your Foreign Service Benefit Plan ID Card when filling your prescription at a Plan network pharmacy.

Who can write your prescription.

- A licensed physician or dentist, and in states allowing it, licensed/certified providers with prescriptive authority prescribing within their scope of practice must prescribe your medication.

When you have to purchase a prescription.

- We will provide you with a **Foreign Service Benefit Plan** ID Card.
- In most cases, you simply present the card together with the prescription to a network pharmacy in the 50 United States. You do not file a prescription card claim with the Plan.
- See the following pages about purchasing a prescription outside the 50 United States.

Where you can obtain your prescription.

- **Network pharmacies within the 50 United States**
  - *Your prescriber must be licensed in the United States.*
  - You must fill your prescription at a network pharmacy participating with Express Scripts (ESI). You may obtain the names of network pharmacies by calling 800-818-6717 or on the Internet as a link through the Plan's website at www.AFSPA.org/FSBP (click on the "Prescription" tab). You may purchase up to a 30-day supply at network pharmacies. **You must purchase non-specialty maintenance prescription medications (drugs you take regularly for ongoing conditions, up to a 90-day supply) from a participating Smart90® Retail Network pharmacy or home delivery after two courtesy 30-day fills at regular network retail (see below in *Participating Smart90 Retail Network pharmacies within the 50 United States* and in *These are the dispensing limitations*).** To find a Smart90 Retail Network pharmacy that participates in filling up to 90-day supplies, log in or register at express-scripts.com/90day, select "Manage Prescriptions," and look for a link directing you to the Participating Smart90 Retail Network pharmacies. The pharmacy can tell you how to transfer your non-specialty maintenance medication prescription or start a new one. You must present your **Foreign Service Benefit Plan** ID Card when filling your prescription in order to receive this benefit. *Prescriptions you purchase at network pharmacies without the use of your card are not covered.*
  - Note: Immunizations obtained from a participating retail network pharmacy have a $0 copay.
- **Participating Smart90 Retail Network pharmacies within the 50 United States**
  - *Your prescriber must be licensed in the United States.*
  - **To avoid paying full cost for your non-specialty maintenance prescription medications (drugs you take regularly for ongoing conditions) after two 30-day retail courtesy fills, you must obtain a 90-day supply at a participating Smart90 Retail Network pharmacy through the Smart90 Program or through the Express Scripts Pharmacy (home delivery).** You can transfer your non-specialty maintenance prescription medications to a participating Smart90 Retail Network pharmacy. The pharmacist can contact your doctor to get a new 90-day prescription or have your doctor write a new prescription for a 90-day supply and take it to a participating Smart90 Retail Network pharmacy.
  - Your copayment for your 90-day supply will be the same whether you fill your prescriptions through Express Scripts home delivery or at a participating Smart90 Retail Network pharmacy. After two courtesy fills at retail, you will pay full cost of maintenance medications if you do not obtain your prescription from Express Scripts home delivery or a participating Smart90® Retail Network pharmacy.
  - Visit www.express-scripts.com or call 800-818-6717 to locate a participating Smart90 Retail Network pharmacy in your area.

- The Plan participates in the SafeGuardRx program through Express Scripts. This suite of programs addresses specific chronic therapeutic conditions and focuses on reducing cost and improving care. The emphasis is on ensuring members receive appropriate therapy and specialized care for their condition to achieve better therapy outcomes and remain adherent. The programs may include prior authorization, step therapy and quantity limits. Some medications may be preferred over others based on FDA indications. *These programs may require that you receive your medications from a specific network pharmacy and/or Home Delivery.* You will pay the full cost for your medications at any other retail network pharmacy after two courtesy fills. Medications used to treat high cholesterol, diabetes, asthma/COPD, migraines and multiple sclerosis are a few of the targeted therapies. The Plan will incorporate additional therapies where appropriate to address our members' needs. The Plan will grandfather members who are stabilized on a clinically appropriate treatment that is included in the program. To find a specific network pharmacy participating in the SafeGuardRx program in the United States or to obtain additional information, contact Express Scripts at 800-818-6717. In addition, Home Delivery through Express-Scripts.com participates in the SafeGuardRx program.

- **Out-of-network pharmacies in the 50 United States**
  - Prescriptions you purchase at out-of-network pharmacies in the 50 United States are not covered.

- **Home Delivery (the Express Scripts Pharmacy^{SM}) within the 50 United States**
  - *Your prescriber must be licensed in the United States.*
  - If your physician prescribes a new medication that will be taken over an extended period of time and you prefer to receive your maintenance prescription medications (drugs you take regularly for ongoing conditions) through the mail, you should request two prescriptions – one to be used at a participating retail network pharmacy (for up to a 30-day supply) and the other for Home Delivery (for up to a 90-day supply).
  - You will receive forms for refills and future prescription orders each time you receive drugs or supplies through Home Delivery.
    - To order by mail: 1) Complete the initial Home Delivery form; 2) Enclose your prescription and copayment; 3) Mail your order to Express Scripts, Home Delivery Service, P.O. Box 747000, Cincinnati, OH 45274-7000 (*do not mail your order to the Plan*); and 4) Allow approximately two weeks for delivery.
    - Log in at www.express-scripts.com or call 800-818-6717 to learn how to get started with home delivery. Express Scripts can contact your doctor to have a new 90-day prescription sent right to you.
  - You also may order refills on the Internet by logging in at Express-Scripts.com. 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 800-818-6717 in the United States. *Prescriptions you purchase through home delivery from a source other than the Express Scripts Pharmacy or Accredo Health Group (Accredo), the Plan's specialty pharmacy, are not covered.*

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

- **Home Delivery (the Express Scripts Pharmacy) outside the 50 United States**
  - *Your prescriber must be licensed in the United States.*
  - Use the same forms as for home delivery within the 50 United States referenced above. If you have any questions about a particular drug or a prescription or to request order forms, you may call 800-497-4641 (available in over 140 countries) from outside the 50 United States. Also, you can call the Express Scripts Pharmacy collect at 724-765-3077 or 724-765-3074 if the toll-free number for outside the 50 United States does not work for you. In addition, you may contact Express Scripts' Expatriate Team at ExpressprocessingGen@express-scripts.com.
  - **Note: Per Federal regulations, the Express Scripts Pharmacy can mail only to addresses in the United States or to APO, FPO, DPO, and Pouch Mail addresses.** Allow appropriate mailing time to reach them, for them to fill your prescription, and for the prescription to reach you.
  - If you are posted, living, or traveling outside the 50 United States, you may request up to a 1-year supply of most medications. Ask your prescriber to write you a prescription for a 1-year supply with no refills. Contact the Plan or refer to our website if you need additional assistance. There are limitations to sending temperature sensitive medications outside the 50 United States. Please contact the Express Scripts Pharmacy if you have been prescribed a temperature sensitive medication.

- You also may order refills on the Internet by logging in at Express-Scripts.com. 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 must purchase non-specialty maintenance prescription medications (drugs you take regularly for ongoing conditions) through a participating Smart90 Retail Network pharmacy or the Express Scripts Pharmacy (home delivery) after two courtesy fills at regular network retail.** Per the home delivery reference on the previous page, if you are posted, living or traveling outside the 50 United States, you may request up to a 1-year supply of most medications.
- You may not obtain more than a 30-day supply through the network pharmacy arrangement except in the following situations:
  - You are traveling to a foreign country, do not have time to use the Express Scripts Pharmacy (home delivery) and need to purchase more than a 30-day supply of prescriptions to take with you;
  - You are visiting the United States for a short time period, do not have time to use the Express Scripts Pharmacy and need to purchase more than a 30-day supply of prescriptions to take with you; and
  - You use the Smart90 Retail Program.
- We cover all drugs and supplies referenced on the following pages except for those that require constant temperature control (temperature sensitive), are too heavy to mail, or that must be administered by a prescriber.
- **As stated on the previous page, per Federal regulations, the Express Scripts Pharmacy (home delivery) can mail only to addresses in the United States or to APO, FPO, DPO, and Pouch Mail addresses.**
- You may not obtain hormone therapy treatment (for infertility) with your **Foreign Service Benefit Plan** ID Card or through the Express Scripts Pharmacy (home delivery).

Prescription Drug Utilization Management

The Plan's prescription drug utilization management programs help ensure that you receive the prescription drugs you need at a reasonable cost. The information below and on the next few pages describes the features of these programs and explains how the Plan will cover certain medications.

To find out if your prescription is affected by our prescription drug utilization management programs, visit the Express Scripts Pharmacy online at www.express-scripts.com. If you are a first-time visitor to the site, register with your member ID, or call their Member Services at 800-818-6717. Members outside the United States who use Express Scripts home delivery may call 800-497-4641 (available in over 140 countries). Also, you can call the Express Scripts Pharmacy collect at 412-829-5932 or 412-829-5933 if the toll-free number for outside the 50 United States does not work for you. In addition, if you are outside the U.S., you may contact Express Script's Expatriate Team at ExpressprocessingGen@express-scripts.com.

- **Prior authorization review may be required: Some medications are not covered unless you receive approval through a coverage review (prior authorization). See below for important information.**

  - **Prior authorization review** uses Plan rules based on FDA-approved prescribing and safety information, and clinical guidelines and uses that are considered reasonable, safe, and effective. There are other medications that may be covered with limits (for example, only for a certain amount or for certain uses) unless you receive approval through a coverage review. Examples of drug categories requiring prior authorization include, but are not limited to, growth hormones, certain hormone therapies, interferons, erythroid stimulants, anti-narcoleptics, sleep aids, migraine medication, weight loss medications, opioids, and oncologic agents. During this review, the Express Scripts Pharmacy asks your prescriber for more information than what is on the prescription before the medication may be covered under the Plan. If coverage is approved, you simply pay your normal copayment for the medication. *If coverage is not approved, you will be responsible for the full cost of the medication.*

- **Quantity Management**
  - The Drug Quantity Management program manages prescription costs by ensuring that the quantity of units and/or number of refills supplied for each copayment are consistent with clinical dosing guidelines. The program is designed to support safe, effective, and economic use of drugs while giving patients access to quality care.
- **Step Therapy (Non-specialty and specialty)**
  - Within specific therapy classes, multiple drugs are available to treat the same condition. Step Therapy manages drug costs by ensuring that patients try frontline (first step), clinically effective, lower-cost medications before they "step up" to a higher-cost medication.
  - The Step Therapy program applies edits to drugs in specific therapeutic classes at the point of sale. Coverage for back-up therapies (second/third step) is determined at the patient level based on the presence or absence of front-line drugs.
- **The Plan participates in other managed care programs, as deemed necessary, to insure patient safety and appropriate quantities in accordance with the Plan rules based on FDA-approved guidelines referenced on the previous pages.**

Specialty Drugs

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

- The requirement for frequent dosing adjustments and intensive clinical monitoring to decrease the potential for drug toxicity and increase the probability for beneficial treatment outcomes;
- The need for intensive patient training and compliance assistance to facilitate therapeutic goals;
- Limited or exclusive specialty pharmacy distribution;
- Specialized product handling and/or administration requirements;
- Exceptions may exist based on certain characteristics of the drug or therapy which will still require the drug to be classified as a specialty drug; and
- Some examples of the disease categories currently in the Plan's specialty pharmacy programs include cancer, cystic fibrosis, Gaucher disease, growth hormone deficiency, hemophilia, immune deficiency, Hepatitis C, multiple sclerosis, rheumatoid arthritis, and RSV prophylaxis. In addition, all specialty drugs needed as a result of a transplant are included in the Plan's specialty pharmacy programs.

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

- Express Scripts customer service can advise you if your prescription is required to be obtained from Accredo and cannot be obtained from a retail pharmacy. Your prescriber can fax your prescription directly to Accredo at 800-391-9707 or you can mail your prescription to: Express Scripts, P.O. Box 747000, Cincinnati, OH 45274-7000.
- If you purchase your chronic specialty drugs from a retail pharmacy, you will be responsible for their full cost. Note: This does not apply to specialty medications you purchase from a retail pharmacy or Military Treatment Facility outside the 50 United States. You file a claim for them as you would for other medications purchased in this manner.

In addition, certain specialty drugs must be obtained from Accredo (home delivery) and not from your prescriber's office or outpatient facility. See below for important information.

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

General specialty drug information:

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

Compound Medication

You should contact Express Scripts Member Services at 800-818-6717 before you fill your compound medication prescription to determine if it is covered by the Plan.

- The U.S. Food and Drug Administration (FDA) defines a compound medication as one that requires a licensed pharmacist to combine, mix or alter the ingredients of a medication when filling a prescription. Pharmacies must submit all ingredients in a compound prescription as part of the claim for both online claims and paper claim submissions. All ingredients submitted with the compound prescription claim must be covered and at least one of the ingredients must require a physician's prescription in order to be considered for reimbursement by the Plan.
- Prescriptions containing certain ingredients *(such as, over-the-counter (OTC) products, bulk powders, kits, solid dosage forms, and proprietary bases) when compounded for dispensing* are **not** covered through the prescription benefit. Investigational drugs are not FDA approved. If the compound includes an investigational drug, the compound will not be covered.
  - In addition, certain topical analgesics for the temporary relief of minor aches and muscle pains may be marketed contrary to the Federal Food, Drug and Cosmetic Act (the FD&C Act) and are excluded by the Plan. Your prescription drug benefit includes other medications that are approved by the U.S. Food and Drug Administration (FDA) for the temporary relief of minor aches and muscle pains by means of the prescribed route of administration.

The Plan participates in a formulary.

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

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

The Formulary will continue to change from time to time.

Please be sure to check before the drug is purchased to make sure it is covered on the Formulary, as you may not have received notice that a drug has been removed from the Formulary. Certain drugs, even if covered on the Formulary, will require prior authorization in advance of receiving the drug. Other Formulary-covered drugs may not be covered under the Plan unless an established protocol is followed first; this is known as Step Therapy and described on page 77. As with all aspects of the Formulary, these requirements may also change from time to time.

Six-tier drug benefit – We divide prescription drugs into six tiers. The six-tier drug benefit is not applicable to prescription drugs you purchase from a retail pharmacy or Military Treatment Facility (MTF) outside the 50 United States and file as a claim (see pages 75 and 82-84 for information on claims from outside the 50 United States).

- **Tier I (Generic Drug):** Generic drugs are chemically and therapeutically equivalent to their corresponding brand name drugs, but cost less. The FDA must approve all generic versions of a drug and assure that they meet strict standards for quality, strength and purity. The FDA requires that generic equivalent medications contain the same active ingredients and be equivalent in strength and dosage to brand name drugs. The main difference between a generic and its brand name drug is the cost of the product. Generic drugs are preferred by the Plan.
- **Tier II (Preferred Brand Name Drug):** Single-source brand name drugs are available from only one manufacturer and are patent-protected. No generic equivalent is available. Certain brands are preferred by the Plan and included in the Plan formulary.
- **Tier III (Non-Preferred Brand Name Drug):** Non-preferred drugs consist of multi-source brand drugs and single source brand drugs. Multi-source brand name drugs are brand name drugs for which the patent protection has expired. As a result, generic equivalent drugs are available. When an approved generic equivalent is available, that is the drug you will receive, unless you or your prescriber specifies that the prescription must be filled as written ("Dispense as Written – DAW"). **If an approved generic equivalent is available, but you or your prescriber specifies that the prescription must be filled as written, you will pay the Level III Non-Preferred copay.**
- **Tier IV (Generic Specialty Drugs):** Specialty drugs are described on pages 77-78. The Generic Specialty Drug definition is the same as Tier I, above.
- **Tier V (Preferred Brand Name Specialty Drugs):** Preferred Specialty medications are those branded medications included on the Plan formulary.
- **Tier VI (Non-Preferred Brand Name Specialty Drugs):** Non-Preferred Specialty medications are those branded medications included on the Plan formulary, but require a higher copay than the Generic and Preferred Specialty medication. Speak with your physician about which medication is appropriate for you.

Personal Medication Coach Program

- The Personal Medication Coach Program improves the way you manage your medications. We will contact candidates and invite them to participate in the Program that includes a Personalized Medication Assessment.
- During a Personalized Medication Assessment, the pharmacist conducts a comprehensive review of your retail and mail medications (including OTC medications) and assists you in taking an active role in managing your multiple medications. This is accomplished by providing helpful information, education and support around adherence, the proper use of the therapy prescribed as well as drug-drug alerts (if appropriate) and formulary alignment.
- At the conclusion of a Personalized Medication Assessment, we mail members an Individual Medication Record and a Medication Usage Plan. The Individual Medication Record provides you with a general overview and summary of your pharmacy claims and history. The Medication Usage Plan includes best practices for taking medications and questions to ask when starting a new medication.
- As part of the program we will perform regular Individual Prescription Reviews (IPR) with you. These reviews focus on treatment guidelines, safety issues, and cost savings. We contact your prescriber as needed, based on information from the IPR, to request an addition or change to drug therapy, information about drug-to-drug interactions, or safety issues.

Express Scripts Specialist Pharmacists Program

For those who need the highest degree of clinical support, Express Scripts enables members and their caregivers to engage with highly trained specialist pharmacists and nurses. The specialist pharmacists specialize in caring for patients with the most complex and costly conditions, including cardiovascular disease, diabetes, cancer, HIV, asthma, depression, and many rare and specialty conditions.

For direct access to a specialist pharmacist, call 800-818-6717 or log on to www.express-scripts.com and send your question via secure email.

When you do have to file a claim.

- See **Where you can obtain your prescription** at the beginning of this Section for instructions when you purchase prescriptions from a retail pharmacy or Military Treatment Facility outside the 50 United States.
- When you must file a claim for a prescription medication you purchased without your **Foreign Service Benefit Plan** ID card (in the United States), please submit a letter explaining why you were unable to use your ID card and include the itemized pharmacy receipt from a network pharmacy. The submission must be itemized and show:
  - Patient's name, date of birth, and address
  - Patient's Plan identification number
  - Name and address of the pharmacy providing the medication
  - Dates that prescription drugs were furnished
  - Name, dose and strength of medication
  - Valid NDC number (your pharmacist will know what this is)
- If you are in a nursing home that requires unit dosing or the purchase of medication from an out-of-network pharmacy, contact the Plan for assistance.

Information about prescription drug coordination of benefits (COB) with Medicare Part B and/or Part D

Retail:

- If you have Medicare Part B or Part D, be sure to present your Medicare ID card whenever using a retail pharmacy. If your medication or supplies are eligible for Medicare Part B or Part 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 800-633-4227.

Home delivery:

- To receive your Medicare Part B-eligible medications and supplies by mail, send your home delivery prescriptions to the Express Scripts Pharmacy. They will review the prescriptions to determine if they are eligible for Medicare Part B coverage.
- When Medicare Part B is primary, contact Medicare at www.medicare.gov/supplier/home.asp or call Medicare at 800-633-4227 about your options for submitting claims for Medicare-covered medications and supplies, whether you use a Medicare-approved supplier or the Express Scripts Pharmacy. Prescriptions typically covered by Medicare Part B include diabetes supplies, specific medications used to aid tissue acceptance (organ transplants), certain oral medications used to treat cancer, and ostomy supplies.
- Once Medicare Part B pays the claim, it will submit the claim to the Plan for you.
- To receive your Medicare Part D-eligible medications and supplies by mail, send your home delivery prescriptions to your Medicare Part D Prescription Drug Plan (PDP). If your Medicare Part D PDP is the Express Scripts Pharmacy, they will submit a claim first to Medicare and then to the Plan for you. If your Medicare Part D PDP is not the Express Scripts Pharmacy, you will need to submit a paper claim to the Plan.

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	**High**
You must present your Foreign Service Benefit Plan ID Card when filling your prescription at a Plan network pharmacy. You may purchase the following medications and supplies prescribed for you by a United States licensed physician or other health care professional from either a Plan network pharmacy or by mail through the Express Scripts Pharmacy: • Drugs and medications that by Federal law of the U.S. require a physician's or other health care professional's written prescription for their purchase except those listed as not covered • Insulin and diabetic supplies Note: See Section 5(h), *Special features*, for information about Livongo, the Plan's remote diabetes monitoring program. • Prescription drugs for weight management • Vitamins (including injectable B-12) and minerals that by Federal law of the U.S. require a physician's or other health care professional's prescription for their purchase • FDA approved women's oral contraceptives, including the "morning after pill" (non-preferred brand name drugs) that require a prescription (see elsewhere in this Section for generic, single source brand name drugs and prescribed "dispense as written (DAW1)" medication coverage) • Tobacco cessation drugs and medications (see elsewhere in this Section). See also *Educational classes and programs* in Section 5(a), *Medical services and supplies* for information about the Plan's Tobacco Cessation Program. • Needles and syringes for the administration of covered medications Prescription drugs you receive from a physician or other health care professional or facility are covered only as specified under Sections 5(a), *Medical services and supplies* and 5(c), *Services provided by a hospital and other facilities* and below. **Note: The Plan requires a coverage review (prior authorization, step therapy, quantity management) of certain prescription drugs based on FDA-approved prescribing and safety information, clinical guidelines and uses that are considered reasonable, safe and effective.** See this Section, *Prescription Drug Utilization Management,* for more information. To find out if your prescription is affected by our Prescription Drug Utilization Management programs or more about your prescription drug benefits, visit the Express Scripts Pharmacy online at www.express-scripts.com. If you are a first-time visitor to the site, register with your member ID or call their Member Services at 800-818-6717. Members outside the United States may call the Pharmacy at 800-497-4641. In addition, if you are outside the United States, you may contact Express Scripts' Expatriate Team at ExpressprocessingGen@express-scripts.com. Note: We do not require Prescription Drug Utilization Management 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 - up to a 30-day supply (non-specialty medications) (No deductible applies for all Levels): - Tier I (Generic Drug): $10 copay - Tier II (Preferred Brand Name Drug): 25% ($30 minimum; $100 maximum) - Tier III (Non-Preferred Brand Name Drug): 35% ($60 minimum; $200 maximum) Note: For non-specialty maintenance medications purchased at a participating Smart90® Retail Network pharmacy, see next page, under *You pay,* for copay/coinsurance information. • Network retail - up to a 30-day supply (specialty medications) (No deductible applies for all Levels): - Tier IV (Generic Specialty Drugs): 25% up to a maximum of $150 - Tier V (Preferred Brand Name Specialty Drugs): 25% up to a maximum of $200 - Tier VI (Non-Preferred Brand Name Specialty Drugs): 35% up to a maximum of $300 Note: Chronic specialty drugs must be obtained from Accredo. If you continue to use retail and the Plan has instructed you to use Accredo, you pay 100% of the cost. • Network retail (Medicare): - The Plan coordinates benefits with Medicare Part B and Part D coverage. - See this Section, *Information about prescription drug coordination of benefits (COB) with Medicare Part B and/or Part D.* • Out-of-network retail (in the 50 United States, including Medicare): 100% of cost • Out-of-network retail (outside the 50 United States, including Medicare): 10% of cost (No deductible) Note: If there is no generic equivalent available, you will still have to pay the Preferred Brand Name Drug or Non-Preferred Brand Name Drug coinsurance or copay.

Covered medications and supplies - continued on next page

Benefits Description	You Pay
Covered medications and supplies (cont.)	**High**
Note: Information in the left hand column of the previous page applies here. Note: Certain preventive migraine medications are required to be obtained through home delivery. Contact Express Scripts at 800-818-6717 to determine if your medication is required to be obtained through home delivery. If you continue to use retail, you pay 100% of the cost.	• Network home delivery – the Express Scripts Pharmacy℠ or participating Smart90® Retail Network pharmacies - up to a 90-day supply (No deductible applies for all Levels): - Tier I (Generic Drug): $15 - Tier II (Preferred Brand Name Drug): $60 - Tier III (Non-Preferred Brand Name Drug): 35% ($80 minimum; $500 maximum) - Tier IV (Generic Specialty Drugs): 25% up to a maximum of $150 - Tier V (Preferred Brand Name Specialty Drugs): 25% up to a maximum of $200 - Tier VI (Non-Preferred Brand Name Specialty Drugs): 35% up to a maximum of $300 • Network home delivery – the Express Scripts Pharmacy (Medicare): - The Plan coordinates benefits with Medicare Part B and Part D coverage. - See this Section, *Information about prescription drug coordination of benefits (COB) with Medicare Part B and/or Part D.* Note: If there is no generic equivalent available, you will still have to pay the Preferred Brand Name Drug or Non-Preferred Brand Name Drug coinsurance or copay. Note: A separate copay applies per prescription fill.
The following are covered: • If you are outside the 50 United States and purchase prescriptions only from a retail pharmacy outside the 50 United States or a Military Treatment Facility (MTF) outside the 50 United States Note: Medications that are considered prescription drugs outside the 50 United States, but are non-prescription (OTC) medications in the 50 United States, are covered. • If you do not use your prescription card to purchase colostomy, ostomy or diabetic supplies Note: See Section 5(h), Special features, for information about Livongo, the Plan's remote diabetes monitoring program.	• 10% of the cost (including Medicare) (No deductible)

Covered medications and supplies - continued on next page

Benefits Description	You Pay
Covered medications and supplies (cont.)	**High**
• FDA-approved women's oral contraceptives, including the "morning after pill" (generic, single-source brand name drugs, and prescribed "dispense as written (DAW1)" medication only) that require a prescription • Diaphragms • Cervical caps • Vaginal rings • Contraceptive hormonal patches • Injectable contraceptives	• Network retail, network home delivery, and out-of-network retail (outside the 50 United States): Nothing (No deductible) • Out-of-network retail (in the 50 United States): 100% of the cost Note: If you are outside the 50 United States and purchase these prescriptions from a retail pharmacy on the economy or from a Military Treatment Facility you must include on your claim submission that the claim is for contraceptives and specify what contraceptive you purchased in order to receive benefits.
• Naloxone-based rescue agents Note: You may purchase Naloxone-based rescue agents without a prescription in those states that do not require one. However, some states require a prescription in order to purchase Naloxone-based rescue agents and you will have to obtain one from your healthcare provider. Please contact your local network pharmacy for more information. Note: A U.S. licensed prescriber's written prescription is required to purchase Naloxone-based rescue agents from the Plan's home delivery pharmacy.	• Network retail, network home delivery, and out-of-network retail (outside the 50 United States): Nothing (No deductible) • Out-of-network retail (in the 50 United States): 100% of the cost Note: If you are outside the 50 United States and purchase these medications from a retail pharmacy on the economy or from a Military Treatment Facility you must include on your claim submission what the claim is for and identify the specific medications in order to receive benefits.
Tobacco cessation drugs and medications approved by the FDA to treat tobacco and nicotine dependence for tobacco cessation purchased *in* the 50 United States Physician or other health care professional prescribed over-the-counter (OTC) medications and prescription drugs approved by the FDA to treat tobacco and nicotine dependence for tobacco cessation are covered when you purchase them through: • A Plan network pharmacy (you must present your **Foreign Service Benefit Plan** ID card) • The Plan's home delivery pharmacy (the Express Scripts Pharmacy) Note: A U.S. licensed prescriber's written prescription is required at a Plan network pharmacy and the Express Scripts Pharmacy for OTC medications.	Nothing (No deductible)
Tobacco cessation drugs and medications approved by the FDA to treat tobacco and nicotine dependence for tobacco cessation purchased *outside* the 50 United States are covered when you purchase them through: • A retail pharmacy outside the 50 United States • A Military Treatment Facility (MTF) outside the 50 United States (Note: A U.S. licensed prescriber's written prescription is required for prescription drugs purchased from an MTF.) Note: You must file a claim for drugs and medications purchased at a retail pharmacy or MTF outside the 50 United States. • The Plan's home delivery pharmacy (the Express Scripts Pharmacy)	Nothing (No deductible)

Covered medications and supplies - continued on next page

Benefits Description	You Pay
Covered medications and supplies (cont.)	**High**
Note: A U.S. licensed prescriber's written prescription is required for OTC medications and prescription drugs purchased from the Plan's home delivery pharmacy.	Nothing (No deductible)
Medications to promote better health recommended under the ACA and by the USPSTF (see Section 10, *Definitions, Routine preventive services and immunizations.*) Note: To receive this benefit in the United States, you must use a network retail pharmacy and present a U.S. licensed prescriber's written prescription to the pharmacist. Note: Benefits are not available for Tylenol, Ibuprofen, Aleve, etc.	• Network retail, network home delivery, and out-of-network retail (outside the 50 United States): Nothing (No deductible) • Out-of-network retail (in the 50 United States): 100% of the cost Note: If you are outside the 50 United States and purchase these medications from a retail pharmacy on the economy or from a Military Treatment Facility you must include on your claim submission what the claim is for and identify the specific medications in order to receive benefits.
Not covered: • *Drugs purchased at a Network pharmacy in the United States that are not in the Plan Formulary* • *Drugs and supplies you purchase at an out-of-network pharmacy in the 50 United States except as covered under Sections 5(a) and 5(c) and except when Medicare Part B and Part D are primary* • *Chronic specialty drugs you purchase at a network pharmacy* • *All specialty drugs you purchase at an out-of-network pharmacy except when Medicare Part B and Part D are primary* • *Drugs and supplies you purchase without using your **Foreign Service Benefit Plan** ID Card at a network pharmacy except as covered under Sections 5(a) and 5(c) and except when Medicare Part B and Part D are primary* • *Non-specialty maintenance prescription medications (drugs you take regularly for ongoing conditions) that you do not purchase through a participating Smart90® Retail Network pharmacy or through home delivery after you have purchased two courtesy fills at regular network retail* • *Drugs and supplies (except colostomy, ostomy, or diabetic supplies) you purchase through home delivery from a source other than the Express Scripts Pharmacy℠, Accredo Health Group, the Plan's specialty pharmacy, or Medicare Part B licensed provider, and except when Medicare Part B and Part D are primary* • *Medications for which you did not obtain prior authorization and which require prior authorization* • *Prescription drugs and over-the-counter (OTC) medications for tobacco cessation except those obtained with the use of your **Foreign Service Benefit Plan** ID Card at a Plan Retail Network Pharmacy, through the Express Scripts Pharmacy (home delivery), or when outside the 50 United States at a retail pharmacy or Military Treatment Facility* • *Non-prescription (OTC) medications, except as noted on page 82* • *Prescription drug coinsurance* • *The Express Scripts Pharmacy (home delivery) copays* • *Drugs and supplies for cosmetic purposes*	*All charges*

Covered medications and supplies - continued on next page

Benefits Description	You Pay
Covered medications and supplies (cont.)	**High**
• *Medical foods and oral nutritional supplements except as described in Section 5(a), Durable medical equipment* • *Vitamins and minerals except as described in Section 5(a) and this Section* • *Medication that under Federal law does not require a prescription, even if your physician or other health care professional prescribes it or State law requires it or for which there is a non-prescription equivalent available* • *You may not obtain hormone therapy treatment for a diagnosis of infertility with your **Foreign Service Benefit Plan** ID Card or through the Express Scripts Pharmacy (home delivery). See Section 5(a), Infertility services for coverage.* • *Drugs and supplies related to the treatment of impotency, sexual dysfunction, or sexual inadequacy*	*All charges*

Section 5(g). Dental Benefits

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- If you are enrolled in a Federal Employees Dental/Vision Insurance Program (FEDVIP) Dental Plan, your FEHB Plan will be First/Primary payor of any Benefit payments and your FEDVIP Plan is secondary to your FEHB Plan. See Section 9, *Coordinating benefits with other coverage*.
- The calendar year deductible is: $300 per person ($600 per Self Plus One enrollment or $600 per Self and Family enrollment) for in-network providers (including Guam) and providers outside the 50 United States; or $400 per person ($800 per Self Plus One enrollment or $800 per Self and Family enrollment) for out-of-network providers (including Guam). The calendar year deductible does not apply to most benefits in this Section. We added "(calendar year deductible applies)" to show when the calendar year deductible does apply.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works. Also, read Section 9 for information about how we pay if you have other coverage, or if you are age 65 or over.
- Note: We cover hospital services and supplies related to dental procedures when necessitated by a non-dental physical impairment to safeguard the health of the patient, even though we may not pay benefits for services of dentists, physicians, or other health care professionals in connection with the dental treatment. See Section 5(c) for inpatient and outpatient hospital benefits.

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

Dental benefits - continued on next page

Only those services listed below are covered

Dental benefits	High	
Dental services	**Plan pays**	**You pay**
Preventive care, limited to two services per person, per calendar year • Oral exam • Prophylaxis (cleaning), adult and child • Prophylaxis with fluoride, child (thru age 22)	Only the following amounts are payable **(scheduled allowance)**: • $13 per exam • $23 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	**Plan pays**	**You pay**
We define orthodontics as the realignment of natural teeth or correction of malocclusion.	50% of the Plan allowance up to $1,000 per course of treatment, per person Note: Courses of treatment are limited to one every five years.	50% of the Plan allowance until benefits stop at $1,000 per course of treatment, per person and all charges after $1,000 Note: Courses of treatment are limited to one every five years.

Note: See Non-FEHB Section for information about supplemental Group Dental Insurance and Discount Care Programs offered by the American Foreign Service Protective Association.

Section 5(h). Wellness and Other Special Features

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

Special feature	Description
Scanned claim submission via secure Internet connection	The Plan provides a secure method for you to submit claims to us via the Internet. Visit our website (www.myafspa.org), enter your username and password and click “Sign In”. Once inside the portal, select “Submit A Claim” under the "Secure Forms" tab. Follow the screen prompts to upload your PDF claim documents. You have the options to include questions or comments and send your secure claims to a specific customer service representative. **Please ensure your name and member ID number appear on the claim. Make sure the image quality of your electronic documents is clear and legible. Any unclear or illegible supporting documentation may cause your claim to be delayed or denied.** In addition, you may correspond with us via secure e-mail through this process.
Electronic copies of Explanations of Benefits (EOBs)	Call the Plan’s customer service department at 202-833-4910 and request to stop receiving a paper copy of your EOB. Follow these easy steps to view and print your EOB on Aetna's secure member website: • Visit www.AFSPA.org/FSBP • Select the "**Helpful Links**" tab and then click on "**Aetna's secure member website**″ • Log on to **Aetna's secure member website** • Select "**Explanation of Benefits**" You will continue to receive your claim reimbursement checks unless you want to take advantage of our Electronic Funds Transfer (EFT) option (see previous page).
24-Hour Nurse Advice Line and Healthwise Knowledgebase	**Informed Health® Line** (the Plan's 24-Hour Nurse Advice Line) provides you with telephone access to registered nurses experienced in providing information on a variety of health topics. Informed Health Line is available 24 hours a day, 7 days a week by phone at 855-482-5750 or 704-834-6782. We provide TDD service for the hearing and speech-impaired. We also offer foreign language translation for non-English speaking members. You may e-mail a nurse by clicking on the “Stay Healthy” icon and selecting "e-mail a nurse" on Aetna's secure member website. A nurse will respond to your inquiry within 24 hours. To access Aetna's secure member website, visit the Plan’s website (www.AFSPA.org/FSBP), select the "Helpful Links” tab and then click on " Aetna's secure member website." **Healthwise Knowledgebase** is an online education support resource available to you through Aetna's secure member website. It is a user-friendly decision-support tool that provides clinical information on 6,000 health topics, 600 medical tests and procedures, 500 support groups and 3,000 medications. The tool promotes informed health decision-making and helps members learn about their treatment options. Once you log on to Aetna's secure member website, select the "Stay Healthy" icon and then select "Healthwise Knowledgebase." Informed Health Line nurses also have access to the Healthwise video library and can relay video links to you upon request or to provide further education/support of the health topic you discussed.
FSBP 24-Hour Translation Line	When you are overseas you have access to a translation service, 24 hours a day, 7 days a week to assist you in discussing your urgent health related conditions (such as accidents and medical emergencies that require immediate attention) with a foreign health care professional. You may call 855-482-5750 or 704-834-6782.

Special feature	Description
Simple Steps to Living Well Together Program and Wellness Incentives	**Foreign Service Benefit Plan (FSBP) is committed to helping you achieve your best health. Members (over 18 years of age) who take simple steps to a healthier lifestyle can earn up to a maximum of $400 in incentives to be deposited in a Wellness Incentive Fund Account for participating in the Simple Steps to Living Well Together Program.** **Complete the Health Risk Assessment (HRA) and earn a $75 wellness incentive.** Completing your HRA annually is an important first step to guiding your personal health goals. **Note: See elsewhere in this Section for information on how to complete the HRA.** **Complete a Biometric Screening through Quest Diagnostics and have a Routine Physical Examination and earn a $100 incentive.** You must pass 3 out of 5 metabolic syndrome criteria (HDL Cholesterol, Triglycerides, Blood Pressure, Waist Circumference, and Glucose) from the Biometric Screening to earn the incentive. If you do not pass 3 out of 5 metabolic syndrome criteria, you will receive the incentive if one of the following is completed: • Mediterranean Wellness Program (see elsewhere in this Section) • Health Coaching Program (Weight Management, Exercise, Nutrition, Stress Management) (see elsewhere in this Section) • Dietary and nutritional counseling (obtain three counseling visits, which includes individual and group behavioral counseling) (see Section 5(a)) **Note: See elsewhere in this Section for information on how to complete the Biometric Screening through Quest Diagnostics.** **Complete a Healthy Action (non-condition specific) by participating in one of the Plan's wellness programs outlined below and earn additional incentives.** • Participate in our Digital Coach Programs (see elsewhere in this Section) - Complete level 3 and earn $75 - Complete level 4 and earn an additional $75 • Participate in our Health Coaching Program (Tobacco Cessation, Weight Management, Exercise, Nutrition, Stress Management) (see elsewhere in this Section) - Complete 6 Health Coaching sessions and earn $75 - Complete 8 Health Coaching sessions and earn an additional $75 • Get your breast cancer screening and earn $25 • Get your cervical cancer screening (pap smear) and earn $25 • Get a flu shot and earn $25 **Note: For benefit information for the breast cancer screening, cervical cancer screening and flu shot, see Section 5(a), *Preventive care, adult.*** **Members identified with the following conditions may be eligible to complete the Healthy Actions outlined below and earn a $75 incentive for each one completed**. *(Simple Steps to Living Well Together Program and Wellness Incentives continued next page)*

Special feature	Description
Simple Steps to Living Well Together Program and Wellness Incentives **(cont.)**	**1. Controlling Blood Pressure for members with high blood pressure** • The Plan will reach out to you if you are identified through claims data as having high blood pressure and will provide you a form for your provider to complete. On the form, your provider must document two (2) controlled blood pressure readings below 140/90 on separate visits during the current calendar year for you to earn the incentive. • If you are unable to meet this goal, you will receive the incentive if one of the following is completed: - Mediterranean Wellness Program (see elsewhere in this Section) - Health Coaching Program (Weight Management, Exercise, Nutrition, Stress Management) (see elsewhere in this Section) - Livongo Remote Hypertension Monitoring Program (Enroll in the Program and check blood pressure using the Livongo connected blood pressure cuff on two different days per continuous calendar month for four months) (see elsewhere in this Section). **2. Controlling Metabolic Syndrome/Pre-Diabetes levels for members with pre-diabetes** • The Plan will reach out to you if you are identified through claims data as having metabolic syndrome/pre-diabetes and ask you to have your provider submit documentation of the following results. To receive the $75 incentive reward, your results must show: - You have reduced your weight by 5%; or - You have lowered your triglycerides by at least 10%; or - You have raised your HDL by 5% • If you are unable to meet these goals, you will receive the incentive if one of the following is completed: - Dietary and nutritional counseling (obtain three counseling visits, which includes individual and group behavioral counseling) (see Section 5(a)) - Mediterranean Wellness Program (see elsewhere in this Section) **3. Controlling A1c Hemoglobin (HbA1c) levels for members with diabetes** • The Plan will reach out to you if you are identified through claims data as having diabetes and ask you to have your provider submit your HbA1c laboratory results. To receive the $75 incentive reward, your test results must show: - Your HbA1c must be less than 8% • If your HbA1c is greater than or equal to 8 percent, you will receive the incentive if one of the following is completed: - Dietary and nutritional counseling (obtain three counseling visits, which includes individual and group behavioral counseling) (see Section 5(a)) - Mediterranean Wellness Program (see elsewhere in this Section) - Diabetic Education or Training (see Section 5(a)) - Livongo Remote Diabetes Monitoring Program (Enroll in the Program and check blood glucose using the Livongo meter four times per continuous calendar month for four months) (see elsewhere in this Section). **Note: You always should follow directions from your health care provider with respect to the frequency of use and glucose testing.** *(Simple Steps to Living Well Together Program and Wellness Incentives continued next page)*

Special feature	Description
Simple Steps to Living Well Together Program and Wellness Incentives **(cont.)**	*Healthy actions that make you eligible to earn $75 (continued):* **4. Eliminating tobacco use for tobacco users** • The Plan will reach out to you if you self-identified as a tobacco user on your HRA and ask you to participate in the Plan's Tobacco Cessation Program (see Section 5(a)). To receive the $75 incentive reward, you must complete: - At least two quit attempts as part of our Tobacco Cessation Program. The quit attempt must include four tobacco cessation counseling sessions of at least 30 minutes each. **5. Prenatal Care for members who are pregnant** • If you are pregnant, your provider must submit documentation of a prenatal care visit during the first trimester. The documentation submitted must include a copy of the prenatal care medical record including Obstetric Panel testing, ultrasound, or prenatal exam from your provider for you to earn the incentive. **Note: To earn an incentive for the completed Healthy Actions above, mail your documentation to: Aetna, C/O FEHB QM, 4400 NW Loop 410, Suite 101, San Antonio, TX 78229.** **Note: Please keep the following in mind when participating in the Simple Steps to Living Well Together Program:** • Allow up to 4 weeks after completion of a wellness activity or reaching a goal for the incentive to be deposited into your Wellness Incentive Fund Account • You can earn each incentive only once per calendar year • You can earn up to a total maximum of $400 combined incentives per calendar year • You must complete all incentives by December 31st of the calendar year, except for the Biometric Screening. The Biometric Screening must be completed by December 1st of the calendar year. • You can use incentives only for "Eligible Medical Expenses" as defined below **Eligible Medical Expenses, as defined by Internal Revenue Code Section 213(d), include your deductible, coinsurance, and copayments (e.g., prescription drug copayments) incurred by you or your covered dependents.** You and your dependents' medical claims and prescription claims submitted for non-network retail pharmacies outside the 50 United States will transfer automatically to the Wellness Incentive Fund Account after processing. Reimbursement for your deductible and coinsurance will be sent to you or your provider if there are funds available. Other expenses, like dental, vision, and prescriptions purchased through the Plan's retail pharmacy network or home delivery program cannot be reimbursed automatically. You will need to submit a copy of your receipt with a completed claim form *(Wellness Incentive Claim Form)* found on Aetna's secure member website. • Visit www.AFSPA.org/FSBP • Select the "**Helpful Links**" tab and then click on "**Aetna's secure member website**" • Log on to **Aetna's secure member website** • Select "**Forms**" • Select "**Wellness Incentive Claim Form**"

	If you are enrolled in a Flexible Spending Account (FSA) and wellness incentives have been deposited into your Wellness Incentive Fund Account, you may not receive reimbursement for the same medical expense from both your Wellness Incentive Fund Account and your FSA. If a medical expense is covered under both your Wellness Incentive Fund Account and your FSA, you must use the funds in your Wellness Incentive Fund Account first. Enrollees may receive reimbursements from their FSAs for medical expenses that are covered by both their Wellness Incentive Fund Account and their FSA only after the funds in the Wellness Incentive Fund Account have been exhausted. In order to receive reimbursement from your Wellness Incentive Fund Account for Eligible Medical Expenses, you must complete and sign a *Wellness Incentive Claim Form* certifying that you have not received reimbursement for the applicable Eligible Medical Expense and that you will not seek such reimbursement under any other plan or arrangement. If you receive reimbursements from more than one plan or arrangement for the same Eligible Medical Expense, the amount received in excess of the Eligible Medical Expense may be taxable to you as income. Any unused funds in your Wellness Incentive Fund Account at the end of the calendar year will remain in the Wellness Incentive Fund Account for Eligible Medical Expenses in the next Plan year as long as you remain enrolled in the Plan. To monitor the availability of funds in your Wellness Incentive Fund Account, visit the Plan's website (www.AFSPA.org/FSBP), select the "Helpful Links" tab and then click on “Aetna's secure member website”. Once you log on to Aetna's secure member website, look for the "Stay Healthy" icon, select “Discover a Healthier You” and proceed. If you would like to contact the Plan for more information about this Program, please call 202-833-4910.
Health Risk Assessment (HRA)*	**Health Risk Assessment (HRA)** Make a difference in your health in just a few minutes by completing a simple health risk assessment (HRA) about your health history and habits. The HRA can: • Help you learn more about your health risks • Provide strategies to improve your health and well-being • Give you personalized health results to share with your doctor You can complete the HRA on-line or over the telephone with a Health Coach. To complete the on-line HRA, visit www.AFSPA.org/FSBP • Select the "**Helpful Links**" tab and then click on "**Aetna's secure member website**" • Log on to **Aetna's secure member website** • Look for the "**Stay Healthy**" icon, select "**Discover a Healthier You**" and proceed To schedule an appointment to complete the HRA over the telephone, contact a Health Coach at 855-406-5122 or 479-973-7168. Coaches are available Monday through Thursday from 8:00 a.m. - 10:00 p.m. Eastern Time (ET) and Friday from 8:00 a.m. - 6:00 p.m. ET. You may also schedule an appointment online at http://enroll.trestletree.com and use passcode: **FSBP**. *****This is part of the Plan’s Simple Steps to Living Well Together Program. Participate in this Program and you are eligible to earn an incentive reward. See this Section, *Simple Steps to Living Well Together Program and Wellness Incentives*.
Quest Diagnostics Biometric Screening*	You can obtain a Biometric Screening at a Quest Diagnostics Patient Service Center (PSC) or you can obtain the screening from your physician by having your physician complete a Biometric Screening Physician Results Form and submit it to Quest Diagnostics. A Biometric Screening obtained through your physician is done generally during a routine physical examination. Visit my.questforhealth.com and enter the registration key "FSBP" to register for your screening, locate a PSC location or print a copy of the Biometric Screening Physician Results Form to take to your physician. You also can register by calling 855-623-9355. Quest Diagnostics will send you your biometric screening results and a **personalized action plan** to help you better understand your health risks.

	*This is part of the Plan's Simple Steps to Living Well Together Program. Participate in this Program and you are eligible to earn an incentive reward. See this Section, *Simple Steps to Living Well Together Program and Wellness Incentives*.
Mediterranean Wellness Program*	**Mediterranean Wellness Program** You can receive up to 100% reimbursement for the Mediterranean Wellness Program once you complete at least 80% of the Program. Once you complete at least 80% of the Program, the Plan will automatically reimburse you for the cost of the program under the Plan's Nutritional counseling benefit. The Mediterranean Wellness Program assists you in maintaining a desirable weight and keeping healthy by eating nutritious, appealing, and hearty food. The interactive, on-line, 8-week program provides you with the flexibility to enroll at any time. You will have access to an 80-page support manual and access to your own Registered Dietician. To learn more about the Program, visit www.AFSPA.org/FSBP, select the "**Helpful Links**" tab and then click on "**Aetna's secure member website**". Once you log on to Aetna's secure member website, look for the "**Stay Healthy**" icon, select "**Discover a Healthier You**" and proceed. If you would like to contact the Plan for more information about this Program, please call 202-833-4910. *Completion of this Program can earn you a Healthy Action Incentive in the Simple Steps to Living Well Together Program (condition specific). See this Section, *Simple Steps to Living Well Together Program and Wellness Incentives*.
Health Coaching Program*	The Health Coaching Program provides you and your covered dependents the opportunity to work one-on-one with a Health Coach to improve your health. A Health Coach is a health care professional who partners with you to transform your health goals into action. Your Health Coach will provide guidance, support, and resources to help you overcome obstacles that may be keeping you from realizing optimal health. You can talk to a Health Coach about the following health-related matters: • Tobacco cessation • Weight management • Exercise • Nutrition • Stress management How does health coaching work? • You talk with your Health Coach over the telephone through conveniently scheduled appointments and create a plan that is right for you to meet your health goals. Everything in the program is tailored to you. • You explore ways to make changes in your behavior that will last. • You receive written materials from your Health Coach that can help you decide where you want to go with your health and how to get there. • Appointments can range from 15 minutes to an hour. How long and how often you meet with your Health Coach depends on your individual needs. To enroll in a program, contact a Health Coach at 855-406-5122 or 479-973-7168. Coaches are available Monday through Thursday from 8:00 a.m.– 10:00 p.m. Eastern Time (ET) and Friday from 8:00 a.m.– 6:00 p.m. ET. You may also enroll online at http://enroll.trestletree.com (passcode: FSBP). Note: See Section 5(a), *Educational classes and programs* for more information. *This is part of the Plan's Simple Steps to Living Well Together Program. Participate in this Program and you are eligible to earn an incentive reward. See this Section, *Simple Steps to Living Well Together Program and Wellness Incentives*.

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 during healthy and high risk pregnancies. Contact the Plan at 800-593-2354 for more information.
Digital Coach Programs*	**Digital coach programs** — These include nine base programs for weight management, smoking cessation, stress management, nutrition, physical activity, cholesterol management, blood pressure, depression management, and sleep improvement. Programs are prioritized based on a member's health risk assessment to help create a personalized plan for successful behavior change. Members can engage and participate through personalized messaging with tools and resources to help track their progress and stay on the path to wellness. Access the Plan's website tool on **Aetna's secure member website** through our link at www.AFSPA.org/FSBP, select the "Helpful Links" tab and then click on "Aetna's secure member website". Once you log on to Aetna's secure member website, look for the "**Stay Healthy**" icon, select "**Discover a Healthier You**" and proceed. This provides you secure access to a broad range of your personal health information after you register. *This is part of the Plan's Simple Steps to Living Well Together Program. Participate in this Program and you are eligible to earn an incentive reward. See this Section, *Simple Steps to Living Well Together Program and Wellness Incentives*.
In Touch Care (ITC) Program	In Touch Care (ITC) Program provides you and your dependents personal support to manage health events or chronic conditions at no additional cost. This combined service formerly fell under three programs, Case Management, Disease Management and Advanced Illness Program. It also broadens the scope of the Program to include a Social Work Program and a Pain Management Program. ITC Program offers you: • Ongoing, one-on-one phone calls with a nurse or social worker who serves as a trusted resource for you and your family. To begin one-on-one nurse or social worker support, call 800-593-2354; • Digital support that provides a variety of resources to help you manage your health better. To begin using the digital support of ITC, log in to Aetna's secure member website. First-time users will need to register and then go to your health dashboard; and • Customized health action plans based on your needs and preferences. We are committed to giving you all the support you deserve. That is why we offer both digital and nurse support, and you can move easily between the two. You will benefit from many digital health and wellness related programs and resources: • Personal health record – organize and store your health history and information, plus get health alerts and notifications. • Health evaluation – get a custom, step-by-step plan based on questions about your health and habits. • Health decision support – learn about your health care and treatment options. • Digital Coach Programs – find dynamic health coaching programs that give you personalized support.(see elsewhere in this Section) • Health dashboard – view your health information and find entry points for health and wellness programs and resources. **Social Work Program:** ITC also includes a Social Work Program designed to improve the quality of life by taking steps to help members locate the right resources. Social workers help connect you with community resources that can provide services to you in times of need. Some examples include: • Local food pantries • Utility or rental assistance programs • Home-delivered meal services

	• Support groups • Counseling services In addition, social workers can refer you to Federal and state programs, such as: • Social Security • Medicare • Medicaid Our social workers are licensed and degreed professionals who work in a variety of settings, including government and non-profit organizations, hospitals, schools and clinics. Social workers also help treat mental, emotional and behavioral issues in clinical settings. **Pain Management Program:** The Pain Management Program is designed for members with chronic pain and either taking opioids or trying to avoid opioids. Members enrolled will receive coaching and support, which includes assisting with identifying the availability of other treatment plans that may include non-pharmacologic modalities for the treatment of pain such as, but not limited to: injection therapies, cognitive therapies, psychosocial supports, medical devices (e.g. nerve stimulators) and additional chiropractic, acupuncture, massage therapy, or physical therapy visits as applicable. The program also provides assistance with psychological effects of chronic pain, reduction of opioid use, avoiding opioid use and resources for those who are dependent on opioid medications. **Compassionate Care Program (formerly Advanced Illness Program):** The Compassionate Care Program is designed to improve the quality of life through health condition management and to reduce costs for members with advanced illness, including those facing imminent end-of-life decisions. It provides tools and information to encourage advance planning for the kind of issues often associated with an advanced illness, such as living wills, advance directives and tips on how to begin conversations about these issues with loved ones. This program is designed to provide quality of life improvement through health condition management and to reduce costs for members at the end of life through timely member and caregiver education. It encourages better use of community-based services and resources, systemic palliative care integration and enhanced hospice utilization and retention. This program is a voluntary program provided to you and your dependents at no additional cost. If you would like to contact the Plan for more information about the ITC Program, please call 800-593-2354. We are available to assist you Monday-Friday from 6:00 a.m. - 5:00 p.m. Mountain Standard Time (MST).
Cancer Support Program	The Plan's Cancer Support Program is designed to provide education and support to members. We will contact candidates and ask them to participate in the Program. Participation is voluntary. The participant and his/her physician or other health care professional remain in charge of the treatment plan. If you would like to contact the Plan for more information about this Program, please call 800-593-2354. We are available to assist you Monday-Friday from 6:00 a.m. - 5:00 p.m. Mountain Standard Time (MST). See Section 5(a), *Treatment therapies* for our benefits for chemotherapy and radiation therapy. See below for information on TherapEase Cuisine, the Plan's cancer nutrition benefit.
TherapEase Cuisine	TherapEase Cuisine, a nutritional program through the Express Scripts Pharmacy℠, the Plan's home delivery pharmacy, offers an easy-to-use online program providing cancer patients access to nutritional information that follows the Academy of Nutrition and Dietetics guidelines for cancer nutrition. TherapEase Cuisine helps answer the question, *"What should I be eating?"* for those diagnosed with cancer. Simply visit www.therapeasecuisine.com, click on "Sign Up" and then enter your first name, last name, full prescription number from one of your oncology medication bottles, and date of birth. You then can create your free account and access online nutrition information. Note: See Section 5(a), *Medical services and supplies, Educational classes and programs* and above in *Cancer Support Program* for more information on how you can take advantage of the Plan's Cancer Support Program that provides education and nursing support for cancer patients.

Special feature	Description
myStrength™ - on-line mental health support program	The myStrength™ program provides you and your covered dependents age 13 and older, evidence-based resources to help overcome obstacles of depression, anxiety, and substance use disorder while improving overall well-being through a personalized evidence based internet-enabled program. This program focuses on the management of depression, anxiety, and substance use disorder through easy to use tools, weekly exercises, informational articles and daily inspiration in a safe and confidential environment. The program uses interactive web and mobile applications that deliver evidence-based psychotherapy models like: • Cognitive behavioral therapy (CBT) • Acceptance and commitment therapy (ACT) • Mindfulness acceptance Personalized inspirational and wellness approaches increase personal relevance, improve outcomes and focus on total well-being. If you would like to enroll in the program visit www.mystrength.com, select "Sign-up", enter the access code "FSBP" and complete the myStrength sign-up process with a brief Wellness Assessment and personal profile.
AbleTo – on-line treatment support program	AbleTo is a web-based video conferencing personalized 8-week treatment support program designed to address the unique emotional and behavioral health needs of individuals learning to live with conditions like heart disease, type 2 diabetes, chronic pain or life events such as losing a loved one or having a baby. Members work with the same therapist and coach each week to set reasonable goals toward healthier lifestyle changes. There are several ways we identify members who may benefit from the AbleTo support such as: • Your nurses or clinicians may refer you to AbleTo as they work directly with you and can refer you if it is determined that you can benefit from AbleTo support. • If identified, an Engagement Specialist from AbleTo will contact you to introduce the treatment option. • If you feel you would benefit from this program, would like more information, or would like to enroll in this program please call 866-287-1802 or visit AbleTo's website at www.AbleTo.com/enroll. Note: AbleTo is not available to members outside the 50 United States.
Pre-Diabetic Alert Program	The Pre-Diabetic Alert Program is focused to provide education and support for members "at risk" for developing diabetes. We will contact those individuals identified at risk and offer them the opportunity to participate in the Program. Participation is voluntary. The participant and his/her physician or other health care professional remain in charge of the participant's treatment plan. See Section 5(a), *Medical services and supplies* for the Plan's Diabetic Education or training benefit. If you would like to contact the Plan for more information about this Program, please call 800-593-2354.
Institutes of Excellence for tissue and organ transplants	The Plan has special arrangements with facilities to provide services for tissue and organ transplants only. The transplant network was designed to give you an opportunity to access providers that demonstrate high quality medical care for transplant patients. Note: If a qualified tissue/organ transplant is medically necessary and performed at one of the transplant network facilities, you may be eligible for reimbursement of some expenses for travel and lodging 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. Reimbursement is subject to IRS regulations. Note: Receipts are required for reimbursement of travel and lodging costs. See Section 5(b), *Organ/tissue transplants* for the Plan's Organ/Tissue transplants benefit.

	Contact the Plan at 800-593-2354 for more information. We are available to assist you Monday-Friday from 6:00 a.m. - 5:00 p.m. Mountain Standard Time (MST).
Livongo – remote diabetes monitoring program*	Livongo is a remote diabetes monitoring program powered by Livongo Health that empowers those with diabetes to live a better life. Livongo provides personalized support through a cellular enabled meter, mobile app, and personalized interventions to help you make better decisions about diabetes management. Candidates will be contacted and asked to participate in the program based on claims data. Participation is voluntary. The participant and his/her physician or healthcare professional remain in charge of the participant's treatment plan. The program provides: • Unlimited blood glucose test strips and lancets • A glucose meter that tracks strip usage and prompts members to reorder supplies • Real-time interventions by Certified Diabetes Educators for members with dangerous (high and/or low) blood sugar levels Note: The Livongo for Diabetes Program offers an advanced blood glucose meter that uses cellular technology to upload blood glucose readings automatically and provides real-time insights in the United States. Due to the unique cellular network infrastructure in certain countries, the Livongo advanced blood glucose meter may have limited cellular connectivity. Blood glucose readings may not upload automatically, real-time insights may not be received, and other features linked to connectivity may be limited. Members still receive the blood glucose meter, unlimited test strips, and coaching at no cost. Note: The Livongo advanced blood glucose meter will not have cellular connectivity in the following countries: British Indian Ocean Territory, Central African Republic, Cote D'Ivoire, Cuba, Djibouti, East Timor, Eritrea, Ethiopia, Federated States of Micronesia, Grenada, Japan, Lebanon, Liberia, Mauritius, Palau, Singapore, South Korea, Suriname, Togo, Turkmenistan. For more information visit get.livongo.com/FSBP or call 800-945-4355. *Participation in this Program can earn you a Healthy Action Incentive in the Simple Steps to Living Well Together Program (condition specific). See this Section, *Simple Steps to Living Well Together Program and Wellness Incentives*.
Livongo – remote hypertension monitoring program*	Livongo for hypertension provides support to members living with high blood pressure through remote hypertension monitoring. Remote hypertension monitoring combines technology to empower members living with high blood pressure with evidence based digital clinical interventions. Candidates will be contacted and invited to participate in the Program based on claim data. Participation is voluntary. The participant and his/her physician or healthcare professional remain in charge of the participant's treatment plan. The program provides: • A connected blood pressure monitor • Counseling by Livongo's clinical coaching team • Livongo mobile app that provides real-time readings The hypertension cuff and monitor are Bluetooth enabled. With each blood pressure reading, you receive instant in-app feedback and coaching to drive you closer to your goal. In addition, you have access to Livongo's clinical coaching team who provide counseling on ways to keep your blood pressure well controlled, adhere to your medications and generally manage your hypertension through lifestyle changes. Note: The Livongo mobile app is available only on the U.S. Apple Store or U.S. Google Play Store. For more information visit get.livongo.com/FSBP or call contact 800-945-4355. *Participation in this Program can earn you a Healthy Action Incentive in the Simple Steps to Living Well Together Program (condition specific). See this Section, *Simple Steps to Living Well Together Program and Wellness Incentives*.

Special feature	Description
Express Scripts Specialist Pharmacists Program	For those who need the highest degree of clinical support, Express Scripts enables members and their caregivers to engage with highly trained specialist pharmacists and nurses. The specialist pharmacists specialize in caring for patients with the most complex and costly conditions, including cardiovascular disease, diabetes, cancer, HIV, asthma, depression, and many rare and specialty conditions. For direct access to a specialist pharmacist, call 800-818-6717 or log on to express-scripts.com and send your question via secure email.
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@aetna.com. If your diagnosis qualifies for this program, you will be asked to submit medical history information and answer questions specific to the diagnosis. You also may need to gather information from your local physician or hospital, such as pathology (biopsy) slides or X-rays and mail them to the Plan as instructed. The appropriate physician will review the medical history and original tests before rendering a second opinion. You will be notified by e-mail within three to five days that the opinion is ready and can be viewed online at a secure website. Once a second opinion is obtained, you may proceed with the treatment that was originally recommended by your own physician or you may decide you want to seek another opinion or arrange care with another physician.
Aetna's secure member website – web based customer service – and Aetna Health℠ App	**Aetna's secure member website - web based customer service** Access **Aetna's secure member website** through our link at www.AFSPA.org/FSBP, select the "Helpful Links" tab and then click on "Aetna's secure member website". This provides you secure access to a broad range of your personal health information after you register. **Aetna's secure member website** 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 range, health care provider etc. • **Explanation of benefits (EOBs)** — You can access and print your EOBs. • **Decision support tools** — You can check the average cost of medical procedures or view hospital quality information before you receive care. • **Health information** — You can obtain health information and news that is relevant to you. • **Interactive health tools** — You can assess, understand, and manage conditions and health risks. Easy to use content helps members navigate common, but sometimes complex conditions. • **KidsHealth Library** — You can access an online resource that educates families and helps them make informed decisions about children's health. KidsHealth is an engaging way to encourage preventive behaviors and motivate kids and teens to become more involved in their health. **Aetna Health℠ App** You can use the Aetna Health app to: • Find doctors and facilities using location and see maps for directions • Locate urgent care - walk-in clinics, urgent care clinics, emergency rooms • View claims and claim details

	• View benefits and balances • Track out-of-pocket dollars • View ID card information • Store ID card offline • Get cost estimates before you receive care • View your Health History • Share your opinion (feedback) The app can be downloaded for free onto your mobile device. Text "**Aetna**" to 90156 to receive a link to download the Aetna Health app (message and date rates may apply).
Express Scripts (ESI) – prescription benefits web based customer service and mobile app	**Express Scripts web based customer service** Access the Plan's website tool for managing your Prescription benefits (see Section 5(f), *Prescription drug benefits*) through our link at www.AFSPA.org/FSBP. Click on the "Prescription" tab on the right. This provides you secure access to the Express Scripts Pharmacy and a broad range of prescription management tools. Services such as the following are available: • Refill and renew home delivery prescriptions; • Verify home delivery prescription status; • View retail and home delivery prescription claim histories, expenses, and balances; • Locate a pharmacy including Smart90® 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; • 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. **Express Scripts Mobile App** You can use the Express Scripts Mobile App to: • Register for online access directly (no need to already have an account at Express-Scripts.com in order to use the app); • Order refills and renewals and check delivery status on home delivery prescriptions; • Locate a pharmacy including Smart90® pharmacies; • Access *Price a Medication* to find and compare medication costs; • Transfer existing prescriptions to home delivery; • Find all your detailed drug information by medication name, dosage condition or drug category and see potential side effects, drug interactions, pill images, proper usage; • Set dosage and refill reminders; and • Receive pharmacy care alerts. The app can be downloaded for free onto your mobile device.

Special feature	Description
Aexcel Designated Providers	**A guide to the Aexcel specialist performance designation** Aexcel is our designation for high-performing specialty physicians and physician groups in 12 medical specialty areas: • Cardiology • Cardiothoracic surgery • Gastroenterology • General surgery • Neurology • Neurosurgery • Obstetrics and gynecology • Orthopedics • Otolaryngology/ENT • Plastic surgery • Urology • Vascular surgery Physicians with the Aexcel specialist designation have met added standards for volume, clinical performance, and efficiency. Aetna evaluates these providers using specific standards and, based on the results, gives them the Aexcel specialty designation. Visit www.fsbphealth.com, select "Find a Provider" and look for the blue star next to the provider's name for an Aexcel designated provider. If a specialist does not have a blue star, this does not mean the physician does not provide quality services. It could be that Aetna does not have enough information available to evaluate a particular physician or the physician's specialty is not one of the 12 specialty categories. The Aexcel information is only a guide. There are many ways to evaluate doctor practices. You should talk with your primary care physician and the specialist you are considering before making a decision. Please note that ratings have a chance for error. An Aexcel designation is not a guarantee of service quality or treatment outcome. Therefore, the Aexcel designation should not be the only reason for choosing a specialty doctor.

Non-FEHB Benefits Available to Plan Members

The benefits in this Section are not part of the FEHB contract or premium **and you cannot file an FEHB disputed claim about them**. Fees you pay for these services do not count toward FEHB deductibles, copayments or catastrophic protection out-of-pocket maximums. These programs and materials are the responsibility of the American Foreign Service **Protective Association (AFSPA)** and all appeals must follow their guidelines. For additional information, contact the Plan at 202-833-4910 or visit our website at www.AFSPA.org.

Dental Insurance	**AFSPA** offers four (4) dental plans, including a true international plan. Dependent children are covered up to age 26.
Discount Care Programs	Save on dental, vision, and LASIK services. Available to U.S. Residents only. **This plan is not insurance**.
Hearing Aid Discounts	Save 30-60% on digital hearing aids and batteries. **Complimentary service** for all **AFSPA** members. **This plan is not insurance**.
Life Insurance	**AFSPA** offers three (3) life insurance options: • Accidental Death & Dismemberment (AD&D) protects worldwide, up to $600,000, against loss due to accidental injury or death. • Group Enhanced Life (GEL) is a term life plan that covers up to $600,000. A portion of your benefit may be used while living including assistance with long term care costs. • For select agencies only, the Immediate Benefit Plan (IBP) covers immediate expenses, upon an employee's death. This term life plan pays the beneficiary within 48 hours of AFSPA's notification.
Group Disability Income Protection Insurance	**AFSPA**'s two (2) disability plans pay 60% of your salary (up to $5,000/month), if you cannot work for an extended period, due to illness or injury.
Members of Household Insurance	**AFSPA** offers three travel medical insurance plans for members of your household who are traveling outside of their home country and are not eligible for FEHB.
Professional Services	Receive discounted legal, taxes, long term care, and financial planning advice.
Travel Insurance	**AFSPA** offers travel insurance that covers pre-trip, medical, and travel assistance benefits including medical evacuation, repatriation of remains, trip cancellation, baggage loss, etc.
	Enroll/Apply at any time for all of the above programs. No Open Season is required. Learn more at www.AFSPA.org/AIP.
Institutes of Excellence™ (IOE) Infertility Providers	Access infertility providers with proven outcomes through Aetna's Institutes of Excellence (IOE) Infertility network. Learn more at www.aetnainfertilitycare.com.

Section 6. General Exclusions – Services, Drugs and Supplies We Do Not Cover

The exclusions in this Section apply to all benefits. There may be other exclusions and limitations listed in Section 5 of this brochure. **Although we may list a specific service as a benefit, we will not cover it unless we determine it is medically necessary to prevent, diagnose, or treat your illness, disease, injury, or condition.** The fact that a covered provider has prescribed, recommended or approved a service or supply does not make it medically necessary or eligible for coverage under this Plan. For information on obtaining precertification or prior approval for services such as, but not limited to: chemotherapy, radiology imaging procedures, radiation oncology, gender reassignment surgery, transplants, skilled nursing facility admissions, mental health and substance use disorder treatment, and certain prescription drugs, see Section 3, *How you get care* under *Other services*.

We do not cover the following:

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

- Services, drugs, or supplies furnished by yourself, immediate relatives, or household members, such as spouse, parents, children, brothers, or sisters by blood, marriage, or adoption.
- Services, drugs, or supplies not specifically listed as covered.
- Charges that we determine are over our Plan allowance.

Listed below are examples of some of our exclusions:

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

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

Section 7. Filing a Claim for Covered Services

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

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

How to claim benefits

To obtain claim forms, visit our website at www.AFSPA.org/FSBP. To obtain claim filing advice or answers about our benefits, contact us by e-mail through our secure Member Portal at www.myafspa.org. Submit your claims by mail to the **Foreign Service Benefit Plan**, 1620 L Street, NW, Suite 800, Washington, DC 20036-5629 or through the secure Member Portal. Login to the Member Portal with your username and password. Once inside the portal, select "Submit A Claim" under the "Secure Forms" tab. Follow the screen prompts to upload your PDF claim documents. You have the options to include questions or comments and send your secure claims to a specific customer service representative. **Please ensure your name and member ID number appear on the claim. Make sure the image quality of your electronic documents is clear and legible. Any unclear or illegible supporting documentation may cause your claim to be delayed or denied.** In addition, you may contact us by phone (M-F 8:30 a.m. - 5:30 p.m. ET) at 202-833-4910 (members) or 202-833-5751 (health care providers).

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

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

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

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

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

In addition:

- Generally, you need to fill out only one claim form per year. You should fill out a claim form if you submit a claim due to accidental injury, you have changed your address, or if the member's other insurance/Medicare status has changed.
- If another health plan is your primary payor, you must send a copy of the explanation of benefits (EOB) form you received from your primary payor (such as the Medicare Summary Notice (MSN)) with your claim.
- Claims for massage therapy must include an itemized bill and the provider's Federal Tax I.D. Number and/or Massage Therapy License Number (if a United States provider).

- Bills for private duty nursing care must show that the nurse is a Registered Nurse (R.N.) or Licensed Practical Nurse (L.P.N.). You also should include the initial history and physical, treatment plan indicating expected duration and frequency from your attending physician or other health care professional and the nurse's notes from the nurse.
- Claims for rental or purchase of durable medical equipment must include the purchase price, a prescription, and a statement of medical necessity including the diagnosis and estimated length of time needed.
- Claims for dental services must include a copy of the dentist's itemized bill (including the information required on the previous page) and the dentist's Federal Tax ID Number. We do not have separate dental claim forms.

Post-service claims procedures

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

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

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

Records

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

We will provide you with a record of expenses you submit and benefits we paid for each claim that you file (explanation of benefits (EOB)). You are responsible for keeping these. We will not provide duplicate or year-end statements. If you need duplicate copies, please refer to Section 5(h), *Wellness and other Special Features* under *Aetna's secure member website (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 by December 31 of the year after the year you receive the service. If you could not file on time because of Government administrative operations or legal incapacity, you must submit your claim as soon as reasonably possible. We void uncashed reimbursement checks two years from the date they were issued. Once we pay benefits, there is a three-year limitation on the reissuance of uncashed checks.

Overseas Claims

The **Foreign Service Benefit Plan** pays claims for providers outside the 50 United States at the same in-network coinsurance rate as in-network providers in the 50 United States, except in Guam which is part of the Plan's network and subject to in- and out-of-network benefits.

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

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

You do not need to file overseas claims on CMS-1500 or UB-04 forms; **however, the information referenced below still is required to receive reimbursement.**

When filing a claim for services rendered by an overseas provider, bills and receipts should be itemized and show:

- Patient's name, date of birth, address, phone number and relationship to enrollee
- Patient's Plan identification number
- Full name and address of the provider, including city, postal code and country
- Dates that services or supplies were furnished
- Diagnosis/reason for visit

- Type of each service or supply
- Charge for each service or supply

Note: Canceled checks, cash register receipts, or balance due statements are not acceptable substitutes for itemized bills. Submissions of only a credit card or cash register receipt will result in a request for additional information. In addition, the Plan cannot accept a claim from you as an e-mail attachment. You may submit claims through our secure Member Portal as described below.

Note: We will provide translation and currency conversion services for claims for overseas (foreign) services.

Note: Members receiving services in countries under sanction by the Office of Foreign Assets Control (OFAC) of the U.S. Department of the Treasury may be requested to provide additional information. For more information see https://www.treasury.gov/resource-center/sanctions/pages/default.aspx.

We use the following methods to process your foreign claims:

- We will translate your claim, if you do not provide a translation.
- We will use the U.S. dollar exchange rate, benchmarked against the rate reported by Oanda (www.oanda.com), applicable on the date the service was incurred, if you do not supply us with a currency exchange rate supported by documentation.
  - If you receive services from a provider who is part of our Direct Billing Arrangements, we will use the exchange rate on the date the service was incurred if the provider does not supply us with a currency exchange rate.
  - Generally, you do not pay a provider in our Direct Billing Arrangement. We must reimburse the provider directly for any covered expenses. You are responsible, however, for any deductible and coinsurance, which we do not reimburse.
  - If you have paid a direct billing provider prior to your claim submission, we request that you provide us with a copy of your paid receipt along with the exchange rate you used to convert the currency.

We have **Direct Billing Arrangements** with providers in many countries, including China, Colombia, France, Germany, Great Britain, Italy, Japan, Korea, Panama, Russia, Switzerland and Turkey. In addition, overseas Seventh-day Adventist Hospitals and Clinics participate in our Direct Billing Arrangement. Please see our website (www.AFSPA.org/FSBP) for the most up-to-date information.

The Plan provides a secure electronic method for you to submit claims to us via the Internet. Visit our secure Member Portal (www.myafspa.org**), enter your username and password.** Once inside the portal, select “Submit A Claim” under the "Secure Forms" tab. Follow the screen prompts to upload your PDF claim documents. You have the options to include questions or comments and send your secure claims to a specific customer service representative. **Please ensure your name and member ID number appear on the claim**. **Make sure the image quality of your electronic documents is clear and legible. Any unclear or illegible supporting documentation may cause your claim to be delayed or denied.** In addition, you may correspond with us via secure e-mail through this process.

If you are unable to submit your claim electronically via the secure Member Portal, you may send your claim via mail to **Foreign Service Benefit Plan, 1620 L Street, NW, Suite 800, Washington, DC 20036-5629**.

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

Plan telephone numbers (M-F 8:30 a.m. - 5:30 p.m. ET): 202-833-4910 (members); 202-833-5751 (health care providers)

When we need more information

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

Authorized Representative

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

Notice Requirements

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

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

Section 8. The Disputed Claims Process

You may appeal directly to the Office of Personnel Management (OPM) if we do not follow required claims processes. For more information or to make an inquiry about situations in which you are entitled to immediately appeal to OPM, including additional requirements not listed in Sections 3, 7 and 8 of this brochure, please call your plan's customer service representative at the phone number found on your enrollment card, plan brochure, or plan website.

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

To help you prepare your appeal, you may arrange with us to review and copy, free of charge, all relevant materials and Plan documents under our control relating to your claim, including those that involve any expert review(s) of your claim. To make your request, please contact our Customer Service Department by writing **Foreign Service Benefit Plan**, 1620 L Street, NW, Suite 800, Washington, DC 20036-5629 or through our secure Member Portal at www.myafspa.org (login to the Member Portal with your username and password), or by calling 202-833-4910 (M-F 8:30 a.m. - 5:30 p.m. ET).

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

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

Our reconsideration will not take into account the initial decision. The review will not be conducted by the same person, or his/her subordinate, who made the initial decision.

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

Step	Description
1	Ask us in writing to reconsider our initial decision. You must: a) Write to us within 6 months from the date of our decision; and b) Send your request to us at: **Foreign Service Benefit Plan**, 1620 L Street, NW, Suite 800, Washington, DC 20036-5629; and c) Include a statement about why you believe our initial decision was wrong, based on specific benefit provisions in this brochure; and d) Include copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms. e) Include your email address (optional for member), if you would like to receive our decision via email. Please note that by giving us your email, we may be able to provide our decision more quickly. We will provide you, free of charge and in a timely manner, with any new or additional evidence considered, relied upon, or generated by us or at our direction in connection with your claim and any new rationale for our claim decision. We will provide you with this information sufficiently in advance of the date that we are required to provide you with our reconsideration decision to allow you a reasonable opportunity to respond to us before that date. However, our failure to provide you with new evidence or rationale in sufficient time to allow you to timely respond shall not invalidate our decision on reconsideration. You may respond to that new evidence or rationale at the OPM review stage described in step 4.

Step	Description
2	In the case of a post-service claim, we have 30 days from the date we receive your request to: a) Pay the claim; or b) Write to you and maintain our denial; or c) Ask you or your provider for more information. You or your provider must send the information so that we receive it within 60 days of our request. We will then decide within 30 more days. If we do not receive the information within 60 days we will decide within 30 days of the date the information was due. We will base our decision on the information we already have. We will write to you with our decision.
3	If you do not agree with our decision, you may ask OPM to review it. You must write to OPM within: • 90 days after the date of our letter upholding our initial decision; or • 120 days after you first wrote to us – if we did not answer that request in some way within 30 days; or • 120 days after we asked for additional information. Write to OPM at: United States Office of Personnel Management, Healthcare and Insurance, Federal Employee Insurance Operations, FEHB 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.
4	OPM will review your disputed claim request and will use the information it collects from you and us to decide whether our decision is correct. OPM will send you a final decision within 60 days. There are no other administrative appeals. If you do not agree with OPM's decision, your only recourse is to file a lawsuit. If you decide to sue, you must file the suit against OPM in Federal court by December 31 of the third year after the year in which you received the disputed services, drugs, or supplies or from the year in which you were denied precertification or prior approval. This is the only deadline that may not be extended.

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

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

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

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

Section 9. Coordinating Benefits with Medicare and Other Coverage

When you have other health coverage

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

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

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

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

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

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

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

- **TRICARE and CHAMPVA**

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

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

- **Workers' Compensation**

We do not cover services that:

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

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

- **Medicaid**

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

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

When other Government agencies are responsible for your care

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

When others are responsible for injuries

Our subrogation and reimbursement rights are both a condition of, and a limitation on, the benefit payments that you are eligible to receive from us. By accepting Plan benefits, you agree to the terms of this provision.

If you receive (or are entitled to) a monetary recovery from any source as the result of an injury or illness, you are required to reimburse us out of that recovery for any and all of our benefits paid to diagnose and treat that illness or injury to the full extent of the benefits paid or provided. The Plan's right of reimbursement extends to all benefit payments for related treatment incurred up to and including the date of settlement or judgement, regardless of the date that those expenses were submitted to the Plan for payment. Additionally, if your representatives (heirs, estate, administrators, legal representatives, successors, or assignees) receive (or are entitled to) a monetary recovery from any source as a result of an injury or illness to you, they are required to reimburse us out of that recovery. This is known as our reimbursement right.

We may also, at our option, pursue recovery as successor to the rights of the enrollee or any covered family member who suffered an illness or injury, which includes the right to file suit and make claims in your name, and to obtain reimbursement directly from the responsible party, liability insurer, first party insurer, or benefit program. This is known as our subrogation right.

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

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

- When you are entitled to the payment of healthcare expenses under automobile insurance, including no-fault insurance and other insurance that pays without regard to fault, your automobile insurance is the primary payor and we are the secondary payor;
- Third party liability coverage;
- Personal or business umbrella coverage;
- Uninsured and underinsured motorist coverage;
- Workers' Compensation benefits;
- Medical reimbursement or payment coverage;
- Homeowners or property insurance;
- Payments directly from the responsible party; and
- Funds or accounts established through settlement or judgment to compensate injured parties.

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

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

We enforce our reimbursement right by asserting a first priority lien against any and all recoveries you receive by court order or out-of-court settlement, insurance or benefit program claims, or otherwise, regardless of whether medical benefits are specifically designated in the recovery and without regard to how it is characterized (for example as “pain and suffering"), designated, or apportioned. Our subrogation or reimbursement interest shall be paid from the recovery before any of the rights of any other parties are paid.

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

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

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

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

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

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

Some FEHB plans already cover some dental and vision services. When you are covered by more than one vision/dental plan, coverage provided under your FEHB plan remains as your primary coverage. FEDVIP coverage pays secondary to that coverage. When you enroll in a dental and/or vision plan on BENEFEDS.com or by phone at 877-888-3337, TTY 877-889- 5680, you will be asked to provide information on your FEHB plan so that your plans can coordinate benefits. Providing your FEHB information may reduce your out-of-pocket cost.

Clinical trials

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

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

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

- Research costs – costs related to conducting the clinical trial such as research physician and nurse time, analysis of results, and clinical tests performed only for research purposes are considered research costs. These costs are generally covered by the clinical trials. This Plan does not cover these costs.

When you have Medicare

For more detailed information on "What is Medicare?" and "Should I Enroll in Medicare?" please contact Medicare at 1-800-MEDICARE (1-800-633-4227), (TTY 1-877-486-2048) or at www.medicare.gov.

- **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, prior approval, or concurrent review when Medicare Part A and/or Part B is the primary payor. Precertification, prior approval, 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, prior approval, prior authorization, and concurrent review procedures.

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

Claims process when you have the Original Medicare Plan – Send us a copy of your Medicare Card when we are secondary to Medicare. We need this information in order to start electronic crossover of your claims. Electronic crossover is a process that assures, in most cases, you do not have to file a claim when Medicare is primary. Call us at 202-833-4910 or contact us through our secure Member Portal at www.myafspa.org. Login to the Member Portal with your username and password to find out if your claims are being electronically filed or you have questions about the process described 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 insurance provider – 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 admissions.
  - If you are enrolled in Medicare Part B, we will waive the deductible and coinsurance for outpatient hospital, ambulatory surgical center, and ambulance.
- **Services provided by facilities and providers covered under Emergency services/ accidents in Section 5(d).**
  - If you are enrolled in Medicare Part B, we will waive the deductible, coinsurance and copay.
- **Services provided by mental health and substance use disorder 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 admissions.
  - If you are enrolled in Medicare Part B, we will waive the deductible and coinsurance.
- **Services provided under Prescription benefits in Section 5(f).**
  - If you are enrolled in Medicare Part B and Medicare Part B is primary, the Plan will coordinate benefits and waive the deductible, coinsurance, and/or copayment for prescription drugs covered under Medicare Part B that you purchase only at Network pharmacies.
  - If you are enrolled in Medicare Part B and Medicare Part B is primary, the Plan will coordinate benefits and waive the deductible, coinsurance and/or copayment for colostomy, ostomy, and diabetic supplies covered under Medicare Part B that you purchase from any Medicare Part B provider.
- **Services provided under Dental benefits in Section 5(h).**
  - We do **not** waive the coinsurance under Dental benefits.

Please review the table on the next page. It illustrates your cost share if you are enrolled in Medicare Part B. If you purchase Medicare Part B, your provider is in our network and participates in Medicare, then we waive some costs because Medicare will be the primary payor.

Benefit Description	High Option You pay without Medicare	High Option You pay without Medicare	High Option You pay with Medicare Part B	High Option You pay with Medicare Part B
	In-Network	Out-of-Network	In-Network	Out-of-Network
Deductible	$300 self only/ $600 family	$400 self only/ $800 family	$0	$0
Catastrophic Protection **Out-of-Pocket Maximum**	$5,000 self only/ $7,000 family	$7,000 self only/ $9,000 family	$5,000 self only/ $7,000 family	$7,000 self only/ $9,000 family
Part B Premium Reimbursement Offered	N/A	N/A	N/A	N/A
Primary Care Physician	10% of the Plan allowance	30% of the Plan allowance and any difference between our allowance and the billed amount	$0	$0
Specialist	10% of the Plan allowance	30% of the Plan allowance and any difference between our allowance and the billed amount	$0	$0
Inpatient Hospital	$0	$200 per admission and 20% of the Plan allowance and any difference between our allowance and the billed amount	$0	$200 per admission and 20% of the Plan allowance and any difference between our allowance and the billed amount
Outpatient Hospital	10% of the Plan allowance	30% of the Plan allowance and any difference between our allowance and the billed amount	$0	$0
Incentives offered	N/A	N/A	N/A	N/A

- **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**

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

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

- **Medicare Advantage (Part C)**

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

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

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

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

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

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

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

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

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

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

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

See Medicare publication 11037 at www.medicare.gov/Pubs/pdf/11037-Medicare-Coverage-Outside-United-Stat.pdf for details.

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

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

If you:

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

Then, for your inpatient hospital care:

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

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

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

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

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.

Physicians Who Opt-Out of Medicare

A physician may have opted-out of Medicare and may or may not ask you to sign a private contract agreeing that you can be billed directly for services ordinarily covered by Original Medicare. This is different than a non-participating doctor, and we recommend you ask your physician if he or she has opted-out of Medicare. Should you visit an opt-out physician, the physician will not be limited to 115% of the Medicare approved amount. You may be responsible for paying the difference between the billed amount and our regular in-network/out-of-network benefits.

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, you pay nothing for covered charges.

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

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

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

Section 10. Definitions of Terms We Use in This Brochure

Admission

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

Assignment

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

Calendar year

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

Cardiac rehabilitation

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

Clinical trials cost categories

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

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

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

Coinsurance

See Section 4, *Coinsurance*.

Copayment

See Section 4, *Copayment*.

Cost-Sharing

See Section 4, *Cost-sharing*.

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

See Section 4, *Deductible*.

Effective date

The date the benefits described in this brochure become effective:

1. January 1 for all continuing enrollments;
2. The first day of the first full pay period of the new year if you change plans or options or elect FEHB coverage during the Open Season for the first time; or
3. The date determined by your employing or retirement system if you enroll during the calendar year, but not during the Open Season.

Expense

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

1. For a service or supply that is not medically necessary; or
2. That is in excess of the Plan's allowance for the service or supply.

Experimental or investigational service

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

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

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

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

Genetic counseling

A process of communication between you and trained professionals intended to provide you with information about a genetic disease, or risk of such a disease, and its effect on you and your family.

Genetic screening

The diagnosis, prognosis, management, and prevention of genetic disease for those patients who have no current evidence or manifestation of a genetic disease and have an inheritable risk of genetic disease.

Genetic testing

The diagnosis and management of genetic disease or those patients with current signs and symptoms and for those who have an inheritable risk of genetic disease.

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.

Intensive day treatment

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

Medical Foods

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

Medically necessary

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

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

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

Mental health conditions/substance use disorder

Conditions and diseases listed in the most recent edition of the International Classification of Diseases (ICD) as mental, behavioral, and neurodevelopmental disorders.

Observation Care

Observation care is a well-defined set of specific, clinically appropriate services, which include ongoing short term treatment, assessment, and reassessment, that are provided while a decision is being made regarding whether a patient will require further treatment as a hospital inpatient or whether a patient will be able to be discharged from the hospital. Observation services are commonly ordered for a patient who presents to the emergency room department and who then requires a significant period of treatment or monitoring in order to make a decision regarding their inpatient admission or discharge. Some hospitals will bill for observation room status (hourly) and hospital incidental services. See pages 61 and 62 for more information.

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

Plan allowance

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

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

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

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

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

Providers outside the 50 United States (does not include Guam) – We generally do not reduce claims from providers outside the 50 United States to a Plan allowance, that is, our Plan allowance is the amount billed by the provider or as part of our Direct Billing Arrangements. However, we reserve the right to request information from you or your provider that will enable us to determine medical necessity or an allowance on charges that we deem to be excessive.

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

Post-service claims

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

Pre-service claims

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

Routine preventive services and immunizations

We cover preventive services, counseling, screenings and vaccinations recommended under the ACA and the U.S. Preventive Services Task Force (USPSTF). A complete list of preventive care services, recommended under the USPSTF is available online at: www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/.

Also visit:

- HHS: www.healthcare.gov/preventive-care-benefits/
- CDC: www.cdc.gov/vaccines/schedules/index.html
- www.healthcare.gov/preventive-care-women/

For a complete list of the American Academy of Pediatrics Bright Futures Guidelines go to brightfutures.aap.org/Pages/default.aspx

For additional information: healthfinder.gov/myhealthfinder/default.aspx

If our preventive services, counseling and screenings benefits are more generous than the ACA or USPSTF, we pay under the appropriate benefit without cost sharing when delivered by an in-network provider (including Guam) or provider outside the 50 United States.

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 determine whether or not a claim is an urgent care claim by applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine. If you believe your claim qualifies as an urgent care claim, please contact the Plan through our Customer Service Department at the **Foreign Service Benefit Plan**, 1620 L Street, NW, Suite 800, Washington, DC 20036-5629, by phone at 202-833-4910 (M-F 8:30 a.m. - 5:30 p.m. ET), or e-mail through our secure Member Portal at www.myafspa.org. Login to the Member Portal with your username and password. We also have a fax number: 202 833-4918. 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.

Index

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

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Summary of Benefits for the High Option of the Foreign Service Benefit Plan - 2021

Do not rely on this chart alone. This is a summary. All benefits are subject to the definitions, limitations, and exclusions in this brochure. Before making a final decision, please read this FEHB brochure. You can also obtain a copy of our Summary of Benefits and Coverage as required by the Affordable Care Act at http://www.afspa.org/2021-FSBP-SBC.

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 for in-network providers (including Guam) and providers outside the 50 United States or $400 for out-of-network providers (including Guam). And, after we pay, you generally pay any difference between our allowance and the billed amount if you use an out-of-network physician or other health care professional.

High Option Benefits	You pay	Page
Medical services provided by physicians:		
• Diagnostic and treatment services provided in the hospital and office	In-network (includes Guam): 10% of our allowance* Out-of-network (includes Guam): 30% of our allowance and any difference between our allowance and the billed amount* Providers outside the 50 United States (does not include Guam): 10% of our allowance*	31-35
Surgical and Anesthesia Services provided by physicians:	In-network (includes Guam): 10% of our allowance Out-of-network (includes Guam): 30% of our allowance and any difference between our allowance and the billed amount Providers outside the 50 United States (does not include Guam): 10% of our allowance	51-60
Services provided by a hospital:		
• Inpatient	In-network (includes Guam): Nothing Out-of-network (includes Guam): $200 per hospital admission and 20% of charges and any difference between our allowance and the billed amount Providers outside the 50 United States (does not include Guam): Nothing	62-63
• Outpatient	Surgical: In-network (includes Guam): 10% of our allowance* Out-of-network (includes Guam): 30% of our allowance and any difference between our allowance and the billed amount* Providers outside the 50 United States (does not include Guam): 10% of our allowance* Medical: In-network (includes Guam): 10% of our allowance* Out-of-network (includes Guam): 30% of our allowance and any difference between our allowance and the billed amount* Providers outside the 50 United States (does not include Guam): 10% of our allowance*	63

High Option Benefits	You pay	Page
Emergency benefits:		
• Accidental injury: emergency room charges (ER) or urgent care facility charges, ER, urgent care physician's or other health care professional charges and ancillary services performed at the time of the ER visit or initial urgent care facility visit; **or** office visit and ancillary services performed at the time of the initial office visit	In-network (includes Guam): Nothing Out-of-network (includes Guam): Only the difference between our allowance and the billed amount Providers outside the 50 United States (does not include Guam): Nothing	66
• Medical emergency	In-network (includes Guam): 10% of our allowance* Out-of-network (includes Guam): 10% of our allowance and any difference between our allowance and the billed amount* Providers outside the 50 United States (does not include Guam): 10% of our allowance*	66
• Outpatient care in an urgent care facility because of a medical emergency	In-network (includes Guam): $35 copayment per occurrence Out-of-network (includes Guam): $35 copayment per occurrence and any difference between our allowance and the billed amount Providers outside the 50 United States (does not include Guam): $35 copayment per occurrence	67
Mental health and substance use disorder treatment:	In-network (includes Guam): Regular cost-sharing* Out-of-network (includes Guam): Regular cost-sharing* Providers outside the 50 United States (does not include Guam): Regular cost-sharing*	68-72
Prescription drugs:		
• Retail pharmacy **(NOTE: After two courtesy fills of non-specialty maintenance medication at network retail, you must use network home delivery or a Smart90® retail network pharmacy. See next page.)** **(NOTE: See Section 5(f) for restrictions on specialty drugs.)**	Network pharmacies in the 50 United States: Note – You must show your Plan ID card: • Tier I (Generic Drug): $10 copay for up to a 30-day supply • Tier II (Preferred Brand Name Drug): 25% ($30 minimum; $100 maximum) for up to a 30-day supply • Tier III (Non-Preferred Brand Name Drug): 35% ($60 minimum; $200 maximum) for up to a 30-day supply • Tier IV (Generic Specialty Drugs): 25% up to a maximum of $150 for up to a 30-day supply • Tier V (Preferred Brand Name Specialty Drugs): 25% up to a maximum of $200 for up to a 30-day supply • Tier VI (Non-Preferred Brand Name Specialty Drugs): 35% up to a maximum of $300 for up to a 30-day supply Out-of-network pharmacies in the 50 United States: 100% and cannot claim reimbursement from the Plan (no coverage) Retail pharmacies outside of the 50 United States: 10% (claim reimbursement from the Plan)	81

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Prescription drugs (cont.):		
• Network home delivery and Smart90 retail network pharmacy **(NOTE: After two courtesy fills of non-specialty maintenance medication at network retail, you must use network home delivery or a Smart90 retail network pharmacy.)**	Network home delivery through the Express Scripts Pharmacy℠ or through a Smart90 retail network pharmacy • Tier I (Generic Drug): $15 for up to a 90-day supply • Tier II (Preferred Brand Name Drug): $60 for up to a 90-day supply • Tier III (Non-Preferred Brand Name Drug): 35% ($80 minimum; $500 maximum) for up to a 90-day supply • Tier IV (Generic Specialty Drugs): 25% up to maximum of $150 for up to a 90-day supply • Tier V (Preferred Brand Name Specialty Drugs): 25% up to a maximum of $200 for up to a 90-day supply • Tier VI (Non-Preferred Brand Name Specialty Drugs): 35% up to a maximum of $300 for up to a 90-day supply	82
Dental care:		
• Routine preventive care and surgical procedures	The difference between our scheduled allowances and the actual billed amounts	87
• Orthodontics	50% of our allowance up to $1,000 per course of treatment, per person and 100% after our maximum payment of $1,000	87
Wellness and other special features:		
• Flexible benefits option • Electronic Funds Transfer (EFT) of claim reimbursements • Scanned claim submission via secure Internet connection • Electronic copies of Explanations of Benefits • 24-hour Nurse Advice Line and Healthwise Knowledgebase • FSBP 24-Hour Translation Line • Simple Steps to Living Well Together Program and Wellness Incentives • Mediterranean Wellness Program • Health Coaching Program • Healthy Pregnancy Program • Digital Coach Programs	• In Touch Care (ITC) Program • Cancer Support Program • TherapEase Cuisine • myStrength™ on-line mental health support program • AbleTo on-line treatment support • Pre-Diabetic Alert Program • Institutes of Excellence for tissue and organ transplants • Livongo remote diabetes monitoring program • Livongo remote hypertension monitoring program • Express Scripts Specialist Pharmacists Program • Overseas Second Opinion • Aetna's secure member website, web-based customer service/ Aetna Health℠ app • Express Scripts (ESI) Prescription benefits web based customer service and mobile app • Aexcel Designated Providers	88-101

High Option Benefits	You pay	Page
Protection against catastrophic costs (out-of-pocket maximum):	In-network only (including Guam): Nothing after $5,000 for Self Only enrollment and $7,000 for Self Plus One or Self and Family enrollment per year (includes prescriptions purchased at a network retail pharmacy and through network home delivery) In- and out-of-network (including Guam): Nothing after $7,000 for Self Only enrollment and $9,000 for Self Plus One or Self and Family enrollment per year (includes prescriptions purchased at a network retail pharmacy and through network home delivery) Providers outside the 50 United States: Nothing after $5,000 for Self Only enrollment and $7,000 for Self Plus One or Self and Family enrollment per year (includes prescriptions purchased outside the 50 United States and through network home delivery) Note: Benefit maximums still apply and some costs do not count toward this protection.	26-27

Notes

Notes

2021 Rate Information for the Foreign Service Benefit Plan

To compare your FEHB health plan options, please go to www.opm.gov/fehbcompare.

To review premium rates for all FEHB health plan options please go to www.opm.gov/FEHBpremiums or www.opm.gov/Tribalpremium.

2021 rates for this Plan follow. If you are in a special enrollment category, 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	$215.27	$71.75	$466.41	$155.47
High Option Self Plus One	403	$517.46	$178.73	$1,121.16	$387.25
High Option Self and Family	402	$532.52	$177.50	$1,153.79	$384.59