FOREIGN SERVICE BENEFIT PLAN: High Option

Coverage Period: 01/01/17-12/31/17

Summary of Benefits and Coverage for: Self Only, Self Plus One or Self and Family | Plan Type: Network providers

This is only a summary. Please read the FEHB Plan brochure (RI 72-001) that contains the complete terms of this plan. **All benefits are subject to the definitions, limitations, and exclusions set forth in the FEHB Plan brochure.** Benefits may vary if you have other coverage, such as Medicare. You can get the FEHB Plan brochure at www.AFSPA.org/FSBP or by calling 202-833-4910.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	In-network: $300 Self Only; $600 Self Plus One and Self & Family; Out-of-network: $400 Self Only; $800 Self Plus One and Self & Family; Doesn't apply to in-network preventive care, inpatient hospital, surgery and medication.	You must pay all the costs up to the **deductible** amount before this plan begins to pay for certain covered services you use. **Copayments** and **coinsurance** amounts do not count toward your **deductible**, which generally starts over January 1st. When a covered service or supply is subject to a **deductible**, only the Plan allowance for the service or supply counts toward the **deductible**. See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible** and for which services are subject to the **deductible**.
Are there other deductibles for specific services?	No. There are no other deductibles.	You must pay all of the costs for these services up to the specific **deductible** amount before this plan begins to pay for these services.
Is there an out–of–pocket limit on my expenses?	In-network only: $5,000 Self Only; $7,000 Self Plus One and Self & Family ($5,000 per covered individual) In-network and out-of-network: $7,000 Self Only; $9,000 Self Plus One and Self & Family ($7,000 per covered individual)	The **out-of-pocket limit,** or catastrophic maximum, is the most you could pay during the year for your share of the cost of covered services. This limit helps you plan for health care expenses. The "per covered individual" amount is the most that any one member would have to pay, regardless of whether the individual is enrolled in Self Plus One, or Self and Family.
What is not included in the out–of–pocket limit?	Premiums, balance-billed charges, dental, penalties and non-covered health care.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.
Is there an overall annual limit on what the plan pays?	No. There is no overall annual limit on what the plan pays.	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. For a list of in-network providers, see www.AFSPA.org/FSBP or call 202-833-4910.	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. We use the term **in-network** for **providers** in our **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	No	You can see the **specialist** you choose without permission from the plan.
Are there services this plan doesn't cover?	Yes	Some of the services this plan doesn't cover are listed on page 4. See this plan's FEHB brochure for additional information about **excluded services**.

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- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use in-network **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider or Provider Outside the 50 United States	Your Cost If You Use an Out-of-network Provider (plus you may be balance billed)	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	10% coinsurance	30% coinsurance	Deductible applies.
	Specialist visit	10% coinsurance	30% coinsurance	Deductible applies.
	Other practitioner office visit	Chiropractic, acupuncture, massage therapy: No charge up to $60/visit	Chiropractic, acupuncture, massage therapy: No charge up to $60/visit	Max 40 visits per person per calendar year. Deductible doesn't apply.
	Preventive care/ screening/ immunization	No charge	30% coinsurance	Deductible applies for out-of-network providers.
If you have a test	Diagnostic test (x-ray, blood work)	10% coinsurance	30% coinsurance	Deductible applies.
	Imaging (CT, PET, and SPECT scans; MRIs)	10% coinsurance	30% coinsurance	Deductible applies. Preauthorization required in US.
	Quest Diagnostic Lab	No Charge (US only)	Not available	US only.

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider or Provider Outside the 50 United States	Your Cost If You Use an Out-of-network Provider (plus you may be balance billed)	Limitations & Exceptions
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.AFSPA.org/FSBP	Generic drugs	Retail: $10 copay in US; 10% coinsurance outside US; Mail: $15 copay	100% of cost	Retail: 30 day max supply; Mail: 90 day max supply. 1 year if posted or traveling outside US (mailing restrictions may apply). Deductible doesn't apply.
	Preferred Brand Name drugs	Retail: 25% coinsurance ($30 min) in US; 10% coinsurance outside US; Mail: $60 copay	100% of cost	Retail: 30 day max supply; Mail: 90 day max supply. 1 year if posted or traveling outside US (mailing restrictions may apply). Deductible doesn't apply.
	Non-Preferred Brand Name drugs	Retail: 35% coinsurance ($60 min) in US; 10% coinsurance outside US; Mail: 35% coinsurance ($80 min; $500 max)	100% of cost	Retail: 30 day max supply; Mail: 90 day max supply. 1 year if posted or traveling outside US (mailing restrictions may apply). Deductible doesn't apply.
	Specialty drugs	Retail in US: Generic & Preferred Brand 25% coinsurance; Non-Preferred Brand 35%; 10% coinsurance outside US. Mail: Generic 25% coinsurance($150 max); Preferred Brand 25% coinsurance ($200 max); Non-Preferred Brand 35% coinsurance ($300 max)	100% of cost	Retail: 30 day max supply, no coverage for chronic RX (mail only); Mail: 90 day max supply. 1 year if posted or traveling outside US (mailing restrictions may apply). Pre-authorization required. Deductible doesn't apply.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% coinsurance	30% coinsurance	Deductible applies.
	Physician/surgeon fees	10% coinsurance	30% coinsurance	Deductible doesn't apply.

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider or Provider Outside the 50 United States	Your Cost If You Use an Out-of-network Provider (plus you may be balance billed)	Limitations & Exceptions
If you need immediate medical attention	Emergency room services	Accident: No charge; Medical emergency: 10% coinsurance	Accident: Charges over Plan allowance; Medical emergency: 10% plus amount over Plan allowance	Deductible applies for medical emergency.
	Emergency medical transportation	10% coinsurance	10% coinsurance	Deductible doesn't apply.
	Urgent care	Accident: No charge; Medical emergency: $35 copay	Accident: No charge; Medical emergency: $35 copay plus amount over Plan allowance	Deductible doesn't apply.
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge	$200 copay per admission plus 20% coinsurance	Precertification required in US.
	Physician/surgeon fee	10% coinsurance	30% coinsurance	Deductible doesn't apply.
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	10% coinsurance	30% coinsurance	Deductible applies; preauthorization required for partial hospitalization in US.
	Mental/Behavioral health inpatient services	No charge facility/ 10% coinsurance physician fee	$200 copay facility/ 30% coinsurance physician fee	Facility - precertification required in US; physician fee - deductible applies.
	Substance use disorder outpatient services	10% coinsurance	30% coinsurance	Deductible applies; preauthorization required for partial hospitalization in US.
	Substance use disorder inpatient services	No charge facility/ 10% coinsurance physician fee	$200 copay facility/ 30% coinsurance physician fee	Facility - precertification required in US; physician fee - deductible applies.

If you are pregnant	Prenatal and postnatal care	No charge	30% coinsurance	Deductible doesn't apply.
	Delivery and all inpatient services	No charge	30% coinsurance	Deductible doesn't apply.
If you need help recovering or have other special health needs	Home health care	10% coinsurance	30% coinsurance	Preauthorization required in US; 90 visit limit per year. If not preauthorized, 40 visit limit per year. No deductible.
	Rehabilitation services	10% coinsurance	30% coinsurance	125 visit limit (combined) per year; Deductible applies.
	Habilitation services	10% coinsurance	30% coinsurance	125 visit limit (combined) per year; Deductible applies.
	Skilled nursing care	Preauthorized: No charge up to 90 days	Preauthorized: No charge up to 90 days per year	Preauthorization required in the US If not preauthorized 20% coinsurance and 45 day limit per year.
	Durable medical equipment	10% coinsurance	30% coinsurance	Deductible applies.
	Hospice service	10% coinsurance	30% coinsurance	Deductible doesn't apply.
If your child needs dental or eye care	Eye exam	10% coinsurance	30% coinsurance	Routine eye exams not covered; Deductible applies.
	Glasses	10% coinsurance	30% coinsurance	Cover one pair of eyeglasses with standard frames and must be related to accidental injury, intraocular surgery, keratoconus or glaucoma; Deductible applies.
	Dental check-up	No charge for two preventive care exams per person per year	No charge for two preventive care exams per person per year	You pay all charges exceeding Plan's scheduled allowance for the service.

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check this plan's FEHB brochure for other excluded services.)

- Cosmetic surgery
- Custodial care
- Routine eye care
- Routine foot care
- Long-term care

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Other Covered Services (This isn't a complete list. Check this plan's FEHB brochure for other covered services and your costs for these services.)

- Acupuncture
- Bariatric surgery
- Chiropractic care
- Diabetic education
- Gender dysphoria services
- Hearing aids
- Infertility treatment
- Health coaching
- Massage therapy
- myStrength™ online mental health program
- Nutritional counseling
- Simple Steps to Living Well Together Wellness & Incentives
- Smoking cessation
- Telehealth
- Virtual Lifestyle Management
- Weight management program

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending on the circumstances, you may be eligible for a 31-day free extension of coverage, to convert to an individual policy, and to receive temporary continuation of coverage (TCC). Your TCC rights will be limited in duration and will require you to pay a **premium**, which may be significantly higher than the **premium** you pay while covered under the plan. An individual policy may also provide different benefits than you had while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, see the FEHB Plan brochure, contact your HR office/retirement system, contact your plan at 1-202-833-4910 or visit www.opm.gov.insure/health.

Your Appeal Rights:

If you are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal**. For information about your **appeal** rights please see Section 3, "How you get care," and Section 8 "The disputed claims process," in your plan's FEHB brochure. If you need assistance, you can contact: 1-202-833-4910.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **Coverage under this plan qualifies as minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

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

Language Access Services:

[Spanish (Español): Para obtener asistencia en Español, llame al 1-202-833-4910.]

[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-202-833-4910.]

[Chinese (中文): 如果需要中文的帮助，**请拨打这个号码** 1-202-833-4910.]

[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-202-833-4910.]

To see examples of how this plan might cover costs for a sample medical situation, see the next page.

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $7370
- **Patient pays** $170

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$0
Copays	$20
Coinsurance	$0
Limits or exclusions	$150
Total	**$170**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $4410
- **Patient pays** $990

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$300
Copays	$400
Coinsurance	$210
Limits or exclusions	$80
Total	**$990**

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

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