

# Panama Canal Area Benefit Plan

1997

**A Managed Fee-for-Service Plan  
with a Preferred Provider Organization**



**Sponsored by the Group Insurance Board (Panama Canal Area)**

**Who may enroll in this Plan:** An active member of the Group Insurance Board (Panama Canal Area) residing in Panama who is eligible for coverage under the Federal Employees Health Benefits Program. A retired member of this Plan who transfers to another FEHB Plan may not renew his membership in the Panama Canal Area Benefit Plan.

**Enrollment code for this Plan:**

**431 Self Only**

**432 Self and Family**

Authorized for distribution by the:



**United States  
Office of  
Personnel  
Management**



# The Group Insurance Board

## c/o Panama Canal Commission, APO AA 34011

The Group Insurance Board (Panama Canal Area) has entered into Contract No. CS 1066 with the Office of Personnel Management (OPM) to provide a health benefits plan authorized by the Federal Employees Health Benefits (FEHB) law. The Plan is underwritten by the Pan-American Life Insurance Company, New Orleans, Louisiana, which administers this Plan on behalf of the Carrier and is referred to as Carrier in this brochure and which has issued to the Group Insurance Board (Panama Canal Area) Group Policy No. G-16522, which policy forms a part of the contract between the Group Insurance Board (Panama Canal Area) and OPM. The FEHB contract specifies the manner in which it may be modified or terminated.

This brochure is based on text incorporated into the contract between OPM and the Carrier as of January 1, 1997. This brochure is based on the certified text and is intended to be a complete statement of benefits available to FEHB members. It describes the benefits, exclusions, limitations, and maximums of the Panama Canal Area Benefit Plan for 1997 and until amended by future benefit negotiations between OPM and the Carrier. It also describes procedures for obtaining benefits. You should use this brochure to determine your entitlement to benefits. However, if conflicts are discovered between the language of this brochure and the contract, the contract will control. Oral statements cannot modify the benefits described in this brochure.

An enrollee does not have a vested right to receive the benefits in this brochure in 1998 or later years, and does not have a right to benefits available prior to 1997 unless those benefits are contained in this brochure.

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## Inspector General Advisory: Stop Health Care Fraud!

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Fraud increases the cost of health care for everyone. Anyone who intentionally makes a false statement or a false claim in order to obtain FEHB benefits, or in order to increase the amount of benefits, is subject to prosecution for FRAUD which may result in CRIMINAL PENALTIES.

Please review all medical bills, medical records and claims statements carefully. If you find that a provider, such as a doctor, hospital, pharmacy, etc., charged your Plan for services you did not receive, billed for the same service twice, or misrepresented any other information, take the following actions:

- Call the provider (doctor, hospital, etc.) and ask for an explanation - sometimes the problem is a simple error.
- If the provider does not resolve the matter, or if you remain concerned, call your Carrier at United States 504/566-3501 and Panama 263-8711 and explain the situation.
- If the matter is not resolved after speaking to your Carrier (and you still suspect fraud has been committed), call or write:

### THE HEALTH CARE FRAUD HOTLINE

202/418-3300

The Office of Personnel Management  
Office of the Inspector General Fraud Hotline  
1900 E Street, N.W., Room 6400  
Washington, D.C. 20415

The inappropriate use of membership identification cards, e.g., to obtain or obtaining benefits for a person who is not an eligible family member or after you are no longer enrolled in the Plan, is also subject to review by the Inspector General and may result in an adverse administrative action by your agency.

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## Using This Brochure

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The **Table of Contents** will help you find the information you need to make the best use of your benefits. To get the best value for your money, you should read **Facilities and Other Providers**. It will help you understand how your choice of doctors and hospitals will affect how much you pay for services under this Plan.

This brochure explains all of your benefits. It's important that you read about your benefits so you will know what to expect when a claim is filed. Most of the benefit headings are self-explanatory. **Other Medical Benefits** and **Additional Benefits**, on the other hand, both include a variety of unrelated benefits. What is different about these benefits is how they are paid: **Other Medical Benefits** are payable up to Calendar Year maximums and **Additional Benefits** do not apply to your Outpatient benefit maximums of \$650 for Self Only and \$1,500 for Family Enrollment.

You will find that some benefits are listed in more than one section of the brochure. This is because how they are paid depends on which provider bills for the service. For example, physical therapy is paid one way if it is billed by an inpatient facility and paid another way when it is billed by a doctor, physical therapist or outpatient facility.

The last part of the brochure contains information useful to you under certain circumstances. For example, if you have to go to the hospital you need to read **Precertification**; hospital stays **must** be precertified for all payable benefits to apply. If you are enrolled in Medicare, take a look at **This Plan and Medicare**. And, the **Enrollment Information** section tells you about several FEHB enrollment requirements that could affect your future coverage.

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# How This Plan Works

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## Help Contain Costs

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### You can help

FEHB plans are expected to manage their costs prudently. All FEHB plans have cost containment measures in place. All fee-for-service plans include two specific provisions in their benefits packages: precertification of all inpatient admissions and the flexible services option. Some include managed care options, such as PPO's, to help contain costs.

As a result of your cooperative efforts, the FEHB Program has been able to control premium costs. Please keep up the good work and continue to help keep costs down.

### Precertification

Precertification evaluates the medical necessity of proposed admissions and the number of hospital days required to treat your condition. You are responsible for ensuring that the precertification requirement is met. You or your doctor must check with your Plan before being admitted to the hospital. If that doesn't happen, your Plan will reduce benefits by \$500. Be a responsible consumer. Be aware of your Plan's cost containment provisions. You can avoid penalties and help keep premiums under control by following the procedures specified on pages 22, 23 and 24 of this brochure.

### Flexible benefits option

Under the flexible benefits option, the Carrier has the authority to determine the most effective way to provide services. The Carrier may identify medically appropriate alternatives to traditional care and coordinate the provision of Plan benefits as a less costly alternative benefit. Alternative benefits are subject to ongoing review. The Carrier may decide to resume regular contract benefits at its sole discretion. Approval of an alternative benefit is not a guarantee of any future alternative benefits. The decision to offer an alternative benefit is solely the Carrier's and may be withdrawn at any time. It is not subject to OPM review under the disputed claims process.

### PPO

This Plan offers most of its members the opportunity to reduce out-of-pocket expenses by choosing providers who participate in the Plan's preferred provider organization (PPO). Consider the PPO cost savings when you review Plan benefits and check with the Carrier to see whether PPO providers are available in your area.

This Plan has established preferred provider organization (PPO) arrangements in Panama. You can receive covered services from PPO providers at a reduced cost. Be sure to look at the PPO cost savings when you review the benefits described in this brochure and check with the Plan to see whether PPO providers are available in your area. The Plan is solely responsible for the selection of PPO providers and any questions regarding PPO providers should be directed to the Plan (see page 17 for more information).

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## Facilities and Other Providers

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### Covered facilities

#### Clinic

A place, other than a hospital, licensed to provide treatment or diagnosis and staffed by one or more doctors.

#### Hospice

A public or private agency or organization which:

- 1) administers and provides hospice care; and
- 2) is either:
  - a) licensed or certified as such by the state in which it is located;
  - b) certified (or is qualified and could be certified) to participate as such under Medicare;
  - c) accredited as such by the Joint Commission on the Accreditation of Health Care Organizations; or
  - d) meets the standards established by the National Hospice Organization.

#### Hospital

- 1) An institution which is accredited as a hospital under the Hospital Accreditation Program of the Joint Commission on Accreditation of Health Care Organizations or
- 2) Any other institution which is operated pursuant to law under the supervision of a staff of doctors and with 24-hour-a-day nursing service, and which is primarily engaged in providing:

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## Facilities and Other Providers *continued*

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- a) general patient care and treatment of sick or 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 an institution or part thereof which:

- 1) is used principally as a convalescent facility, rest facility, nursing facility, or facility for the aged;
- 2) furnishes primarily domiciliary or custodial care, including training in the routine of daily living; or
- 3) is operated as a school.

### **Skilled nursing facility**

A facility that is primarily engaged in providing skilled nursing care and other therapeutic services. The facility must be licensed by the state in which it is located and be an eligible provider of Medicare and Medicaid nursing care services.

### **Covered providers**

#### **Doctor**

A licensed doctor of medicine (M.D.) or osteopathy (D.O.); a licensed specialist in his/her specialty; or, for certain specified services covered by this Plan, a licensed dentist.

Other covered providers include a qualified clinical psychologist, clinical social worker, optometrist, nurse midwife, nurse practitioner/clinical specialist and nursing school administered clinic. For purposes of this FEHB brochure, the term "doctor" includes all of these providers when the services are performed within the scope of their license or certification.

#### **Coverage in medically underserved areas**

Within States designated as medically underserved areas, any licensed medical practitioner will be treated as a covered provider for any covered services performed within the scope of that license. For 1997, the States designated as medically underserved are: Alabama, Louisiana, Mississippi, New Mexico, North Dakota, South Carolina, South Dakota, West Virginia and Wyoming.

#### **Independent consulting doctor**

An independent consulting doctor is a specialist who:

- 1) is certified by the American Board of Medical Specialists in a field related to the proposed surgery;
- 2) is independent of the doctor who first advised the surgery;
- 3) does not perform the surgery for the insured person;
- 4) makes a personal exam of the insured person; and
- 5) sends the Carrier a written report.

### **PPO arrangements**

Benefits under this Plan are available from facilities, such as hospitals, and from providers, doctors, and other health care personnel, who provide covered services. This Plan covers two types of facilities and providers (1) those who participate in a preferred provider organization (PPO) and (2) those who do not. Who these health care providers are, and how benefits are paid for their services, are explained below. In general, it works like this:

PPO facilities and providers have agreed to provide services to Plan members at a lower cost than you'd usually pay for a non-PPO provider. Although PPOs are not available in all locations or for all services, when you use these providers you help contain health care costs and reduce what you pay out of pocket. The selection of PPO providers is solely the Carrier's responsibility; continued participating of any specific provider cannot be guaranteed. While PPO providers agree with the Carrier to provide covered services, final decisions about health care are the sole responsibility of the doctor and patient and are independent of the terms of the insurance contract.

PPO benefits apply only when you use a PPO provider. If no PPO provider is available, or you do not use a PPO provider, the standard non-PPO benefits apply.

When you use a PPO hospital, keep in mind that the professionals who provide services to you in the hospital, such as radiologists, anesthesiologists and pathologists, may not all be preferred providers. If they are not, they will be paid by this Plan as non-PPO providers.

Non PPO facilities and providers do not have special agreements with the Carrier. The Plan makes its regular payments toward the bills, and you're responsible for any balance.

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# Cost Sharing

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## Deductibles

A deductible is the amount of expense an individual must incur for covered services and supplies before the Plan starts paying benefits for the expense involved. A deductible is not reimbursable by the Plan and benefits paid by the Plan do not count toward a deductible. When a benefit is subject to a deductible, only expenses allowable under that benefit count toward the deductible.

### Prescription drug deductible

The calendar year deductible is the amount of covered expenses an individual must incur each calendar year before the Plan pays certain benefits. There is a \$400 deductible per member per calendar year for prescription drugs. The Catastrophic protection clause does not apply.

### Inpatient hospital deductible

There is a \$125 deductible per person per confinement for hospital room and board.

### Carryover

If you changed to this Plan during open season from a plan with a deductible and the effective date of the change was after January 1, any expenses that would have applied to that plan's deductible in the prior year will be covered by your old plan if they are for care you got in January before the effective date of your coverage in this Plan. If you have already met the deductible in full, your old plan will reimburse these covered expenses. If you have not met it in full, your old plan will first apply your covered expenses to satisfy the rest of the deductible and then reimburse you for any additional covered expenses. The old plan will pay these covered expenses according to this year's benefits; benefit changes are effective on January 1.

This Plan does not have a family limit deductible. Each deductible is per person.

## Family limit Coinsurance

Coinsurance is the stated percentage of covered charges you must pay after you have met any applicable deductible. For instance, when a Plan pays 80 percent of reasonable and customary charges for a covered service, you are responsible for 20 percent of the reasonable and customary charges, i.e., the coinsurance. In addition, you may be responsible for any excess charge over the Plan's reasonable and customary allowance. For example, if the provider ordinarily charges \$100 for a service but the Plan's reasonable and customary allowance is \$95, the Plan will pay 80 percent of the allowance (\$76). You must pay the 20 percent coinsurance (\$19), plus the difference between the actual charge and the reasonable and customary allowance (\$5), for a total member responsibility of \$24. Remember, if you use preferred providers, your share of covered charges (after meeting the deductible) is limited to the stated coinsurance amount. In Panama, if you use preferred providers, participating clinics and hospitals, for outpatient benefits, your share of covered charges is limited to the stated amounts, refer to page 16.

You are required to pay the following coinsurance on benefits under this Plan: 20% for Other charges under Inpatient Hospital and hospital room and board and other charges under Mental Conditions and Substance Abuse Benefits; 50% for Prescription drugs; and 25% for Outpatient benefits from non-participating hospitals and clinics under Other Medical Benefits. A special 50% coinsurance applies to surgical procedures/exams performed without the required precertification and second surgical opinion. Please refer to the Catastrophic protection clause on page 22.

### If provider waives coinsurance

If a provider routinely waives (does not require you to pay) the coinsurance for services rendered, the Plan is not obligated to pay the full percentage of the amount of the provider's original charge it would otherwise have paid. A provider or supplier who routinely waives copayments or deductibles is misstating the actual charge. This practice may be in violation of the law. The Plan will base its percentage on the fee actually charged. For example, if the provider ordinarily charges \$100 for a service but routinely waives the 20% coinsurance, the actual charge is \$80. The Plan will pay \$64 (80% of the actual charge of \$80).

### When hospital charges are limited by law

When inpatient claims are paid according to a Diagnostic Related Group (DRG) limit (for instance, for admissions of certain retirees who do not have Medicare - see page 9), the Plan will pay 30% of the total covered amount as room and board charges and 70% as other charges and will apply your coinsurance accordingly.

## Lifetime maximums

Under Additional Benefits, benefits for smoking cessation are limited to \$100 for completion of one smoking cessation program per member per lifetime.

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# General Limitations

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All benefits are subject to the definitions, limitations and exclusions in this brochure and are payable when determined by the Carrier to be medically necessary. Coverage is provided only for services and supplies that are listed in this brochure. **No oral statement of any person shall modify or otherwise affect the benefits, limitations and exclusions of this brochure, convey or void any coverage, increase or reduce any benefits under the Plan or be used in the prosecution or defense of a claim under the Plan.** This brochure is based on text included in the contract between OPM and the Plan and is intended to be the complete statement of benefits available to FEHB members. You should use this brochure to determine your entitlement to benefits. However, if conflicts are discovered between the language of this brochure and the contract, the contract will control.

## Other sources of benefits

### Medicare

This section applies when you or your family members are entitled to benefits from a source other than this Plan. You must disclose information about other sources of benefits to the Carrier and complete all necessary documents and authorizations requested by the Carrier.

If you or a covered family member is enrolled in this Plan and Part A, Part B or Parts A and B of Medicare, the coordination of benefits with Medicare provisions described on pages 24 & 25 apply.

### Group health insurance and automobile insurance

Coordination of benefits (double coverage) applies when a person covered by this Plan also has, or is entitled to benefits from any other group health coverage, or is entitled to the payment of medical and hospital costs under no-fault or other automobile insurance that pays benefits without regard to fault. Information about the other coverage must be disclosed to this Carrier.

When there is double coverage, one plan normally pays its benefits in full as the primary payer, and the other plan pays a reduced benefit as the secondary payer. When this Plan is the secondary payer, it will pay the lesser of (1) its benefits in full, or (2) a reduced amount that, when added to the benefits payable by the other coverage, will not exceed 100% of this Plan's reasonable and customary charges.

The determination of which plan is primary (pays its benefits first) is made according to guidelines provided by the National Association of Insurance Commissioners (NAIC). When benefits are payable under automobile insurance including no-fault, the automobile insurer is primary (pays its benefits first) if it is legally obligated to provide benefits for health care expenses without regard to other health benefits coverage the enrollee may have.

This provision applies whether or not a claim is filed under the other coverage. When applicable, authorization must be given to this Carrier to obtain information about benefits or services available from the other coverage, or to recover overpayments from other coverages.

### CHAMPUS

If you are covered by both this Plan and the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS), this Plan will pay benefits first.

### Medicaid

If you are covered by both this Plan and Medicaid, this Plan will pay benefits first.

### Workers' compensation

The Plan will not pay for benefits or services required as the result of occupational disease or injury that medical benefits are determined by the Office of Workers Compensation Programs (OWCP) to be payable under workers' compensation (under section 8103 of title 5, U.S.C.) or by a similar agency under another Federal or State law. This provision also applies when a third party injury settlement or other similar proceeding provides medical benefits in regard to a claim under workers' compensation or similar laws. If medical benefits provided under such laws are exhausted, medical benefits may be provided for services or supplies covered by this Plan. The Plan is entitled to be reimbursed by OWCP (or the similar agency) for benefits paid by the Plan that were later found to be payable by OWCP (or the agency).

### DVA facilities, DoD facilities, and Indian Health Service

Facilities of the Department of Veterans Affairs, Department of Defense, and the Indian Health Service are entitled to seek reimbursement from the Plan for certain services and supplies provided to you or a family member to the extent that reimbursement is required under the Federal statutes governing such facilities.

### Other Government agencies

The Plan will not provide benefits for services and supplies paid for directly or indirectly by any other local, State, or Federal Government agency.

### Liability insurance and third party actions

Subrogation applies when you are sick or injured as a result of the act or omission of another person or party.

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## General Limitations *continued*

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Subrogation means the Plan has the right to request a refund of payments made by it under the following conditions:

The Plan will be subrogated to any claim you or your family member has against a third party provided:

- 1) You or your family member was injured or became ill due to the act or omission of the third party, and
- 2) The Plan paid benefits under the FEHB contract for such injury or illness.

The Plan can only seek repayment of the amount of benefits it paid.

If you or your family member collects any sums for damages from the third party, the person collecting the sums (whether you or your family member) will be liable to the Plan for benefits paid. If you or your family member sues to recover expenses, the Plan can join in the suit. If you or your family member does not sue, the Plan can do so in the name of the person who received the benefits.

You and your family members are obligated to:

- 1) Avoid doing anything that would prejudice the Plan's right of subrogation, and
- 2) Execute any documents required to enforce the Plan's right.

Benefits are payable only for expenses incurred while you or your family member are entitled to coverage under this Plan. If you need more information about subrogation, the plan will provide you with its subrogation procedures.

### Overpayments

The Carrier will make reasonably diligent efforts to recover benefit payments made erroneously but in good faith and may apply subsequent benefits otherwise payable to offset any overpayments.

### Limit on your costs if you're age 65 or older and don't have Medicare

The information in the following paragraphs applies to you when 1) you are **not** covered by either **Medicare Part A** (hospital insurance) or **Part B** (medical insurance), or both, 2) you are enrolled in this Plan as an annuitant or as a former spouse or family member covered by the family enrollment of an annuitant or former spouse, and 3) you are not employed in a position which confers FEHB coverage.

#### Inpatient hospital care

If you are not covered by **Medicare Part A**, are age 65 or older or become age 65 while receiving inpatient hospital services, and you receive care in a Medicare participating hospital, the law (5 U.S.C. 8904(b)) requires the Plan to base its payment on an amount equivalent to the amount Medicare would have allowed if you had Medicare Part A. This amount is called the equivalent Medicare amount. After the Plan pays, the law prohibits the hospital from charging you more for covered services than any deductibles, coinsurance, or copayments you owe under the Plan. Any coinsurance you owe will be based on the equivalent Medicare amount, not the actual charge.

#### Physician services

Claims for physician services provided for retired FEHB members age 65 or older who do not have Medicare Part B are also processed in accordance with 5 U.S.C. 8904(b). This law mandates the use of Medicare Part B limits for covered physician services for those members who are not covered by Medicare Part B.

The Plan is required to base its payment on the Medicare-approved amount (which is the Medicare fee schedule for the service), or the actual charge, whichever is lower. If your doctor is a member of the Plan's preferred provider organization (PPO) and participates with Medicare, the Plan will base its payment on the lower of these two amounts and you are responsible only for any deductible and the PPO copayment or coinsurance.

If you go to a PPO doctor who does not participate with Medicare, you are responsible for any deductible and the copayment or coinsurance. In addition, unless the doctor's agreement with the Carrier specifies otherwise, you must pay the difference between the Medicare-approved amount and the limiting charge (115% of the Medicare-approved amount).

If your physician is not a Plan PPO doctor but participates with Medicare, the Plan will base its regular benefit payment on the Medicare-approved amount. For instance, under this Plan's high option medical benefit, the Plan will pay 75% of the Medicare-approved amount. You will only be responsible for any deductible and coinsurance equal to 25% of the Medicare-approved amount.

If your physician does not participate with Medicare, the Plan will still base its payment on the Medicare-approved amount. However, in most cases you will be responsible for any deductible, the coinsurance or copayment amount, and any balance up to the limiting charge amount that a provider who does not participate with Medicare is legally permitted to bill under Medicare law (115% of the Medicare-approved amount).

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## General Limitations *continued*

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Since a physician who participates with Medicare is only permitted to bill you up to the Medicare fee schedule amount even if you do not have Medicare Part B, it is generally to your financial advantage to use a physician who participates with Medicare.

The Carrier's explanation of benefits (EOB) will tell you how much the hospital or physician can charge you in addition to what the Plan paid. If you are billed more than the hospital or physician is allowed to charge, ask the hospital or physician to reduce the bill. If you have already paid more than you have to pay, ask for a refund. If you cannot get a reduction or refund, or are not sure how much you owe, ask the Carrier for guidance.

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## General Exclusions

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These exclusions apply to more than one or to all benefit categories. Exclusions that are primarily identified with a single benefit category are listed along with that benefit category, but may apply to other categories. Therefore, please refer to the specific benefit sections as well to assure that you are aware of all benefit exclusions.

Benefits are provided only for services and supplies that are medically necessary (see definition). The Carrier reserves the right to determine medical necessity. The fact that a covered provider has prescribed, recommended, or approved a service or supply does not, in itself, make it medically necessary.

### **Benefits will not be paid for services and supplies when:**

- No charge would be made if the covered individual had no health insurance coverage
- Furnished without charge (except as described on page 8), while in active military service; or required for illness or injury sustained on or after the effective date of enrollment (1) as a result of an act of war within the United States, its territories or possessions, or within the Republic of Panama or (2) during combat
- Furnished by immediate relatives or household members, such as spouse, parent, child, brother or sister by blood, marriage or adoption
- Furnished or billed by a provider or facility that has been barred from the FEHB Program
- Furnished or billed by a noncovered facility, except that medically necessary prescription drugs are covered
- For or related to sex transformation, sexual dysfunction or sexual inadequacy
- Not specifically listed as covered
- Investigational or experimental
- Not provided in accordance with accepted professional medical standards in the United States and/or Panama

### **Benefits will not be paid for:**

- Any portion of a provider's fee or charge that is ordinarily due from the enrollee but has been waived. If a provider routinely waives (does not require the enrollee to pay) a deductible or coinsurance, the Carrier will calculate the actual provider fee or charge by reducing the fee or charge by the amount waived
- Charges the enrollee or Plan has no legal obligation to pay, such as: excess charges for an annuitant age 65 or older who is not covered by Medicare Parts A and/or B (see page 9), doctor charges exceeding the amount specified by the Department of Health and Human Services when benefits are payable under Medicare (limiting charge) (see page 9), or State premium taxes however applied
- Expenses incurred while not covered by this Plan
- Private duty nursing care services, in or out of hospital
- Expenses to the extent they exceed the reasonable and customary charges for the service or supply
- Home visits or home treatments
- Weight control or any treatment of obesity, except surgery for morbid obesity
- Any facility not included in the definition of hospital or clinic
- Services of any practitioner not included in the definition of covered provider, with the exception of a therapist
- Eye refractions, eyeglasses and contact lenses

### **Circumstances beyond Plan control**

In the event of major disaster, riot, or civil disturbance, the Plan will make a good faith effort to pay all legitimate claims timely. However, the Plan will not be responsible for the failure to pay claims for which records necessary to support the claim(s) have been destroyed and cannot be reconstructed.

# Benefits

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## Inpatient Hospital Benefits

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### What is covered

#### Precertification

The Plan pays for inpatient hospital services as shown below.

The medical necessity of your hospital admission **must** be precertified for you to receive full Plan benefits. Emergency admissions not precertified must be reported within two business days following the day of admission even if you have been discharged. Otherwise, the benefits payable will be reduced by \$500. See page 22 for details.

#### Waiver

This precertification requirement does not apply to persons whose primary coverage is Medicare Part A, or another health insurance policy, or when the hospital admission is outside the United States and Puerto Rico. For information on when Medicare is primary, see page 24. If you are hospitalized outside of Panama, see pages 24 & 25.

#### Room and board

- Semiprivate room accommodations, general nursing care, meals and special diets. If a private room is used, only the hospital's average semiprivate room rate will be considered a covered expense. If the hospital does not have semiprivate rooms, payment will be based on the average, semiprivate room rate in the geographic area.
- The **\$125** per confinement deductible will be waived if the following conditions are met during the entire confinement: (a) the room and board charge is **\$75** or less per day; and (b) ward accommodations are used (three or more beds in a room).
- Service in an intensive care unit as defined on page 31.

#### Non-PPO benefit

After a **\$125** deductible per confinement, the Plan pays - **100%** of reasonable and customary charges, for hospital room and board up to the average semiprivate room rate per day, not to exceed 365 days for any one period of confinement.

#### PPO benefit

Plan pays 100% of the negotiated per diem for certain medical conditions when available when confined in a PPO hospital. The **\$125** per confinement deductible will be waived.

#### Other charges

The following other charges are covered when incurred while hospital room and board benefits are payable.

Operating room	Oxygen
Electrocardiograms	X-rays
Blood and blood plasma	Basal metabolism tests
Drugs and medicine used during the hospital stay	Physical therapy
Surgical dressings and casts	Laboratory service
Anesthetics (but not administration of anesthetics)	Radioisotope studies and therapy
Intravenous injections and hypodermics (for sedative purposes only)	Medically necessary occupational therapy
	Cardio-pulmonary pump

#### Non-PPO benefit

Plan pays 80% of reasonable and customary charges. Please refer to the Catastrophic Protection clause on page 22.

#### PPO benefit

Plan pays 100% of the negotiated per diem.

### Limited benefits

#### Diagnostic testing

Benefits paid for diagnostic testing while hospitalized are limited to the specific laboratory profile directly related to the admitting diagnosis. See precertification requirements for certain diagnostic tests on page 17.

#### Hospitalization for dental work

The Plan pays hospital benefits as stated above for covered room and board and covered hospital services for hospitalization in connection with dental procedures only when a non-dental physical impairment exists which makes hospitalization necessary to safeguard the health of the patient.

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## Inpatient Hospital Benefits *continued*

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### Weekend admissions

Benefits will not be paid for a hospital admission on Friday or Saturday, except in case of a medical emergency or if weekend surgery is scheduled.

### Related benefits

#### Professional charges

Doctor's, other than the operating surgeon, charges up to **\$35** per day for the first five days, and **\$30** per day thereafter, for hospital visits while hospital room and board benefits are payable, not to exceed one visit per day per doctor.

#### Critical care physician attention

The Plan pays **100%** of the reasonable and customary charges for nonsurgical medical attention provided by a single attending doctor in the intensive care unit or other critical care unit of a hospital to a covered individual within 72 hours after the onset of a medical emergency as defined on page 31. In order to qualify for reimbursement under this provision, the severity of the medical emergency must be such that prolonged doctor attention is required in the critical care unit.

#### Take-home items

The Plan does not pay for take home items except when they are specifically stated in this brochure.

### What is not covered

- Custodial care, as defined on page 30
- Hospital room and board and inpatient doctor care when in the Plan's judgement, a hospital admission or portion of an admission is not medically necessary, i.e., the medical services did not require the acute hospital inpatient (overnight) setting, but could have been provided in a doctor's office, the outpatient department of a hospital or some other setting
- Hospital admission for inpatient diagnostic testing when such testing can be performed on an outpatient basis
- Personal comfort services, such as radio and television, air conditioners, beauty and barber services

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## Services rendered by a U.S. Gov't Hospital in the Republic of Panama

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### Precertification waiver

Inpatient hospital admission precertification is not required for confinements in a U.S. Government hospital in Panama.

### Inpatient

After a \$125 deductible per confinement, the **Plan pays** covered charges up to **\$400** per day, for all expenses, including surgery, incurred while confined in a hospital operated by the U.S. Government or any instrumentality thereof; benefits for the treatment of mental conditions/substance abuse are limited to **\$320** per day for 90 days for all expenses.

Any Federal subsidy you may receive is considered other coverage and applied in the Coordination of Benefits provision (see page 24).

### Outpatient

**Plan pays** - covered charges up to a maximum of **\$60** per visit for services and supplies provided by the outpatient department of a hospital operated by the U.S. Government or any instrumentality thereof. Benefits for U.S. Government Hospital outpatient treatment of mental conditions and substance abuse are limited to **\$30** per outpatient session, up to a calendar year limit of **\$600** per person.

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## Surgical Benefits

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### What is covered

The Plan pays for the following services:

#### Hospital inpatient

Plan pays - **100%** of reasonable and customary charges for surgical procedures performed as an inpatient. Certain procedures are subject to precertification and second surgical opinion, as explained below and on pages 22 & 23 of this brochure.

#### Outpatient

Plan pays - **100%** of reasonable and customary outpatient charges for all surgical procedures and directly related covered services received on the day of surgery, if the surgery is performed on an OUTPATIENT basis and, if second surgical opinion is obtained.

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## Surgical Benefits *continued*

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### Multiple surgical procedures

Maximum benefits payable for surgical operations (including dental surgery and dental treatment described on pages 18 and 19) performed during the course of the same operative procedure and by the same surgical approach, or in the same operative field, shall not exceed the amount for the most expensive operation performed.

When surgical operations (other than dental surgery and treatment) performed during the course of the same operative procedure are not by the same surgical approach or in the same operative field, payment shall be made for the most expensive operation performed plus one-half of the amount that would otherwise have been payable for any other operation performed.

### Second surgical opinion

For all hospital surgical procedures not related to the original diagnosis for which precertification was obtained, a second surgical opinion will be required. All elective (non-emergency) surgical procedures require second surgical opinion by the Plan. Failure to comply with this requirement will limit the surgical benefit to **50%** of reasonable and customary charges. The cost of the second surgical opinion will be borne by the Plan. No second surgical opinion is required if this Plan is secondary carrier.

### Anesthesia

For each administration of anesthetics, the Plan will pay actual charges up to **40%** of the surgical benefit payable for the surgical procedure performed. The precertification limitations shown above also apply to anesthesia.

### Organ/tissue transplants and donor expenses

Transplant surgery means transfer of body organ(s) from the donor to the recipient.

#### What is covered

- Cornea, heart, kidney, liver, pancreas, heart/lung, single lung and double lung transplants
- Bone marrow and stem cell support as follows:

Allogeneic bone marrow transplants for acute lymphocytic or non-lymphocytic leukemia; advanced Hodgkin's lymphoma; advanced non-Hodgkin's lymphoma; advanced neuroblastoma; and testicular, mediastinal, retroperitoneal and ovarian germ cell tumors.

Autologous bone marrow transplants (autologous stem cell support) and autologous peripheral stem cell support for acute lymphocytic or non-lymphocytic leukemia; advanced Hodgkin's lymphoma; advanced non-Hodgkin's lymphoma; advanced neuroblastoma; breast cancer; multiple myeloma; epithelial ovarian cancer; and testicular, mediastinal, retroperitoneal and ovarian germ cell tumors.

- Related medical hospital expenses of the donor are covered when the recipient is covered by the Plan. Recipient means an insured person who undergoes an operation to receive an organ transplant. Donor means a person who undergoes an operation for the purpose of donating an organ for transplant surgery.

#### What is not covered

Benefits for body organ transplants are not payable for:

- any expenses when approved alternative remedies are available;
- any animal organ or mechanical equipment device or organ(s);
- any financial consideration to the donor other than for a covered expense which is incurred in the performance of or in relation to transplant not mentioned above;
- any transplant not listed as covered.

### Oral and maxillofacial surgery

See Oral surgery under Dental Benefits on page 18.

### Reconstructive surgery

Reconstructive surgery will be covered (see *Definition*).

### Limited benefits

The Plan limits benefits for surgical procedures requiring second surgical opinion to **50%** of reasonable and customary charges for hospital and doctor services and supplies that are related to the surgery if second surgical opinion is not obtained. The Catastrophic Protection Benefit will not apply if second surgical opinion is not obtained.

### Designated outpatient surgical procedures

- Arthroscopy (internal exam of a joint)
- Breast biopsy
- Bronchoscopy (internal exam of lung), adult, with or without biopsy
- Cataract removal

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## Surgical Benefits *continued*

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- Cystourethroscopy (internal exam of urinary bladder and urethra)
- Digestive tract endoscopy (internal exam of esophagus, stomach, colon or rectum)
- Dilation and curettage of uterus (D&C)
- Excision of pilonidal cyst, simple
- Laparoscopy (internal exam of abdomen) with or without tubal ligation (female sterilization)
- Laryngoscopy and tracheoscopy (internal exam of larynx and windpipe)
- Myringotomy (puncture of the membrane in ear)
- Prostate biopsy
- Reduction of nasal fracture, open or closed
- Vasectomy (male sterilization)

If Designated OUTPATIENT surgical procedures are performed on an INPATIENT basis, the Plan limits benefits to **50%** of reasonable and customary charges for all covered services including hospital, doctor and other medical services and supplies which are related to the surgery. The **\$125** per admission deductible will apply, as well as any surgical precertification and second surgical opinion requirements. The Catastrophic Protection Benefit will not apply if precertification and second surgical opinion are not obtained.

However, if it is medically necessary that an insured person be hospitalized for the surgical procedures, the regular Plan benefits for all covered services will be payable if the hospitalization has been precertified.

### What is not covered

- Cosmetic surgery (as defined on page 29)
- Expenses for surgery in excess of the reasonable and customary charges
- Radial keratotomy or similar surgery done in treating myopia (except for cornea graft)
- Services of an assistant surgeon or assistant anesthesiologist
- Charges for normal postoperative care by the doctor who performs surgery are considered to be part of the surgical charge and no separate benefit is payable for such charges.

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## Maternity Benefits

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### What is covered

The Plan pays the same benefits for hospital, surgery (delivery), laboratory tests and other medical expenses as for illness or injury.

#### Inpatient hospital

##### Precertification

The medical necessity of your hospital admission must be precertified for you to receive full Plan benefits. Unscheduled or emergency admissions not precertified must be reported within two business days following the day of admission even if you have been discharged. Newborn confinements that extend beyond the mother's discharge must also be precertified. If any of the above are not done, the benefits payable will be reduced by \$500. See pages 22, 23 & 24 for details.

#### Room and board

##### Non-PPO benefit

After you pay **\$125** deductible per confinement, the Plan pays **100%** of reasonable and customary charges for hospital room and board up to the average semiprivate room rate per day, not to exceed 365 days for any one period of confinement.

Bassinets or nursery charges on days in which mother and child are both confined are considered hospital room and board expenses of the mother and not expenses of the child.

##### PPO benefit

Plan pays 100% of the negotiated per diem if available.

#### Other charges

Covered under Inpatient Hospital Benefits on page 11.

#### Obstetrical care

The professional services of a surgeon in or out of a hospital are covered under Surgical Benefits. Doctor's, other than the operating surgeon, charges up to **\$35** per day for the first five days, and **\$30** per day thereafter, for hospital visits while hospital room and board benefits are payable, not to exceed one visit per day per doctor.

The professional services rendered to newborns while in the hospital will be reimbursed as expenses of the mother.

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## Maternity Benefits *continued*

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### Related benefits

**Contraceptive drugs** Covered under Prescription drugs benefit on page 18.

**Diagnosis and treatment of infertility** Covered under Other Medical Benefits on page 16.

**Voluntary sterilization** Covered under Surgical Benefits on page 14.

### For whom

Benefits are payable under Self Only enrollments and for family members under Self and Family enrollments.

### What is not covered

- Charges related to abortions, except when the life of the mother would be endangered if the fetus were carried to term.
- Expenses of the newborn if the child is not covered by a Self and Family enrollment.
- Contraceptive devices.
- Routine sonograms to determine fetal age and/or size.
- Reversal of voluntary surgical sterilization.
- Assistive Reproductive Technology (ART) procedures that enable a woman with otherwise untreatable infertility to become pregnant through any artificial conception procedures such as artificial insemination, in vitro fertilization, embryo transfer and GIFT, as well as services and supplies related to ART procedures are not covered.

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## Mental Conditions/Substance Abuse Benefits

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### What is covered

The Plan pays for the following services:

#### Inpatient care

After a **\$125** deductible per confinement, the Plan pays **80%** of reasonable and customary room and board charges, for up to a maximum of 90 days per calendar year.

#### Precertification

The Plan pays for inpatient hospital services as shown below:

The medical necessity of your admission to a hospital or other covered facility **must** be precertified for you to receive full Plan benefits. Emergency admissions must be reported within two business days following the day of admission even if you have been discharged. Otherwise, the benefits payable will be reduced by **\$500**. See pages 22, 23 & 24 for details.

#### Other charges

Other hospital charges for the treatment of, and related services for, mental conditions and substance abuse are payable at **80%** of reasonable and customary charges, up to a maximum of **\$700** per year.

#### Inpatient visits

Doctor's charges up to **\$35** per day for the first five days, and **\$30** per day thereafter, for hospital visits while hospital room and board benefits are payable, not to exceed one visit per day per doctor.

#### Outpatient care

Psychiatric treatment sessions with a licensed psychiatrist, clinical psychologist, clinical social worker, and up to two sessions per calendar year for psychological evaluation by a licensed psychologist. Charges for psychiatric treatment sessions and two evaluations by a psychologist are payable at **80%**, not to exceed **\$30** per session, with a limit of **\$600** per calendar year. No other benefits are payable for these services. (These services are covered even when billed for by a hospital or provided by hospital personnel.)

### What is not covered

- Marital, family, or other counseling or training services.
- Specialized treatment for mental retardation and/or learning disabilities.
- All charges for chemical aversion therapy, condition reflex treatments, narcotherapy or any similar aversion treatments and all related charges (including room and board).

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## Other Medical Benefits

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### What is covered

#### Outpatient benefits

The Plan pays for the following services and supplies furnished at a doctor's office, clinic or the outpatient department of a hospital:

In participating clinics and hospitals, the Plan pays **100%** of the negotiated limit, per outpatient visit, not to exceed **\$60**, according to the Plan's agreement with the health care provider. This reimbursement includes the charge for the physician's services, as well as all routine laboratory examinations and X-rays. An additional amount is payable for certain laboratory and X-ray procedures equal to **75%** of the reasonable and customary charge for these procedures, which include pap smears, EKG's and any other services specified in the agreement with the health care provider.

In participating clinics and hospitals with whom the Plan has established an agreement for radiology and laboratory services only, the plan will pay 100% of the negotiated limit per covered radiology and laboratory service performed, according to the Plan's agreement with the health care provider.

**IN NONPARTICIPATING CLINICS AND HOSPITALS, THE PLAN PAYS 75% OF REASONABLE AND CUSTOMARY CHARGES.**

Benefits paid to both participating and nonparticipating providers are subject to the Outpatient benefit maximums of **\$650** for Self Only enrollment and **\$1,500** for Self and Family enrollment per calendar year, regardless of where the services are provided.

The maximum benefits apply to the following covered expenses:

- Sickness—Diagnosis and treatment (except drugs, medicines, injections, and hypodermics).
- Blood lead level screening for children.
- Physical and occupational therapy—For the services of a registered physical or occupational therapist practicing within the scope of their license for administration of medically necessary therapy in accordance with a doctor's specific instructions as to type, frequency and duration, the Plan pays **75%** up to **\$250** per calendar year.
- Chiropractic services—The Plan pays **75%** up to **\$250** per calendar year.

NOTE: The **\$250** limits for the physical and occupational therapy and for chiropractic services are additional inside limits included in the outpatient benefit limitation, (**\$650/\$1,500** calendar year maximums).

#### Diagnosis and treatment of infertility

Any expense or charge for the promotion of fertility including (but not limited to):

- 1) fertility tests, including initial diagnostic tests;
- 2) any attempts to cause pregnancy by hormone therapy.

### What is not covered

- Spare contact lenses
- Eye exercises, vision training and vision therapy
- Weight control or any treatment of obesity, except surgery for morbid obesity
- Orthopedic shoes and other supportive devices for the feet, crutches, canes, orthopedic beds, and any other orthopedic devices
- Prosthetic appliances such as, artificial eyes and limbs
- Speech, occupational, recreational, educational or milieu therapy, or forms of nonmedical self-care and self-help training, and any related diagnostic testing
- Out-of-hospital supplies, except as provided under Prescription drugs, Accidental injury, Dread disease, Cancer treatment and therapy, or Renal dialysis
- Chelation therapy, except for acute arsenic, gold, mercury, or lead poisoning
- Chemotherapy drugs which have not been approved by the USFDA (United States Food and Drug Administration)
- Routine physical examinations that are not necessary for medical reasons, such as those required for obtaining or continuing employment, insurance, or governmental licensing
- Home health care
- Durable medical equipment

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## Additional Benefits

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### Accidental injury

Plan pays, within 72 hours of an accidental injury, **100%** of reasonable and customary charges for outpatient services, treatment, surgery, and/or supplies provided by a doctor, clinic or hospital (excluding orthopedic devices, dental surgery or treatment, ambulance service and physical therapy).

### Ambulance service

Plan pays **100%** of the reasonable and customary charge up to **\$100** per incident which results in admission to, or discharge from, a hospital.

Professional medical treatment and supplies (not first aid) furnished during the transportation of the patient when an ambulance service charge is authorized, will be reimbursed by the Plan at 100% of reasonable and customary charges.

### Hospice care

Plan pays up to a maximum of **\$5,000** of reasonable and customary charges for hospice care provided by an Independent Hospice Administration for a terminally ill patient in the final stages of that illness when such care is recommended by a doctor. This benefit does not apply to services shown as covered under any other provisions of this Plan.

### PPO arrangements

**For specific PPO arrangements on inpatient and outpatient medical treatments in Panama, you must call 263-8711 or 263-8721.**

#### How to obtain a list of participating providers

Send your request in writing to:

The Group Insurance Board  
Panama Canal Commission  
Unit 2300  
APO AA 34011-2300

### Well child care

6 Annual Visits to age 1; 2 Annual Visits ages 1 to 2; 1 Annual Visit ages 3 to 13 (subject to the Outpatient Maximum). The following immunizations are covered at 100% of reasonable and customary charges (not subject to the Outpatient Maximum) for dependent children under 22: DPT (diphtheria, tetanus, pertussis vaccine); OPV (oral polio vaccine); Hepatitis B vaccine; Haemophilis influenzae type b vaccine (flu shot); MMR (measles, mumps, rubella vaccine); and Td (tetanus diphtheria toxoid booster).

### Non-Routine services

The Plan pays 100% of reasonable and customary charges for specifically designated, non-routine diagnostic procedures performed on an outpatient basis if precertification is obtained. These tests include Cat-scans, MRI's, Nuclear Medicine Studies (e.g., Thallium Cardiac Studies), Arteriographies, Genetic Studies and other similar procedures that are high cost, involve high technology or that may be over-utilized. These benefits are not subject to the Outpatient benefit maximums (**\$650/\$1,500** per calendar year). Failure to obtain precertification will result in a **50%** reduction in benefits.

The Plan pays 100% of all reasonable and customary charges for the following services and supplies furnished at a doctor's office, clinic or the outpatient department of a hospital, which are not otherwise covered by this Plan. These charges are not subject to the Outpatient benefit maximums (**\$650/\$1,500** per calendar year).

- Dread disease—Diagnosis and treatment of poliomyelitis, scarlet fever, diphtheria, smallpox, or cerebral meningitis, encephalitis, hemophilia, and rabies (including suspected rabies).
- Cancer treatment and therapy—Treatment of malignancy (such as X-ray and chemotherapy)
- Renal dialysis—In connection with dialysis, if precertification is obtained. Precertification is not required if patient is eligible for Medicare.
- Contact lenses—The first pair of contact lenses to correct an impairment caused by intraocular surgery, when prescribed by the surgeon who performed the operation

### Routine services

In addition to coverage on page 16 of diagnostic X-ray, laboratory and pathological services and machine diagnostic tests, the following routine (screening) services are covered as preventive care:

#### Breast cancer screening

Mammograms are covered for women age 35 and older as follows:

- From age 35 through 39, one mammogram screening during this five year period.
- From age 40 through 49, one mammogram screening every two consecutive calendar years.
- From age 50 through 64, one mammogram screening every calendar year.
- At age 65 and older, one mammogram screening every two consecutive calendar years.

In addition to diagnostic mammograms that are covered as diagnostic X-rays, the Plan pays **80%** of the reasonable and customary charges for routine screening mammograms. Mammogram benefits will not be subject to the Outpatient benefit maximums of **\$650** for Self Only enrollment and **\$1,500** for Self and Family enrollment.

## Additional Benefits *continued*

<b>Cervical cancer screening</b>	Annual coverage of one pap smear for women age 18 and older.
<b>Colorectal cancer screening</b>	Annual coverage of one fecal occult blood test for members age 40 and older.
<b>Prostate cancer screening</b>	Annual coverage of one PSA (Prostate Specific Antigen) test for men age 40 and older.  The Plan will pay 75% of reasonable and customary charges for these procedures. These benefits are not subject to the Outpatient benefit maximums of <b>\$650</b> for Self Only enrollment and <b>\$1,500</b> for Self and Family enrollment.
<b>Other services</b>	The following (screening) services are covered as preventive care: <ul style="list-style-type: none"> <li>• Pregnancy Risk Management Programs</li> <li>• Group B streptococcus infection screening of pregnant women</li> </ul> The Plan will pay 75% of reasonable and customary charges for these procedures. These benefits are not subject to the Outpatient benefit maximums of <b>\$650</b> for Self Only enrollment and <b>\$1,500</b> for Self and Family enrollment.

### Limited benefits

<b>Smoking cessation benefit</b>	The Plan will pay up to <b>\$100</b> for enrollment in one smoking cessation program per member per lifetime.  This benefit will not be subject to the Outpatient benefit maximums ( <b>\$650/\$1,500</b> per calendar year). This benefit must be approved by the Plan prior to the member enrolling.
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## Prescription Drug Benefits

<b>What is covered</b>	After a <b>\$400</b> deductible per member per calendar year has been met, the Plan pays <b>50%</b> of covered expenses.  You may purchase the following medications and supplies prescribed by a doctor from either a pharmacy or by mail: <ul style="list-style-type: none"> <li>• Drugs that by Federal law of the United States require a doctor's prescription for their purchase</li> <li>• Insulin</li> <li>• Needles and syringes for the administration of covered medications</li> </ul>
<b>What is not covered</b>	<ul style="list-style-type: none"> <li>• Medical supplies such as dressings and antiseptics</li> <li>• Norplant is not covered</li> </ul> The <b>\$400</b> deductible does not apply toward the Catastrophic Protection Benefit

## Dental Benefits

<b>What is covered</b>	Plan Pays - <b>100%</b> up to the scheduled amounts as shown for covered dental surgery and treatment received from a dentist or surgeon regardless of where the services are provided:
<b>Preventive care</b>	<ul style="list-style-type: none"> <li>• Oral prophylaxis (limited to two per calendar year), other than sodium fluoride prophylaxis, for prevention of dental cavities. . . . . \$ 20</li> </ul>
<b>Oral and maxillofacial surgery</b>	<ul style="list-style-type: none"> <li>• Extraction of impacted teeth, including X-rays . . . . . \$100</li> <li>• Apicoectomy . . . . . \$ 85</li> <li>• Removal of tumors and cysts . . . . . \$ 40</li> <li>• Lancing of erupting tooth . . . . . \$ 70</li> </ul>
<b>Periodontics</b>	<ul style="list-style-type: none"> <li>• Periodontal treatments* . . . . . \$ 60</li> </ul>
<b>Endodontics</b>	<ul style="list-style-type: none"> <li>• Root canal treatment, including devitalization and removal of pulp, root canal filling, and X-rays (4 canals). Including intraoral drainage of abscess* . . . . . \$210</li> </ul>
	*Prior to treatment, you must submit a completed dentist Pre-Treatment Estimate form to obtain approval of benefits for the work to be performed. If approval is not obtained, the Plan will limit benefits to <b>50%</b> of the scheduled amounts.

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## Dental Benefits *continued*

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### Related benefits

#### Accidental dental injury

Plan pays - **80%** of reasonable and customary charges for covered dental work required as a result of accidental injury, that are incurred within 52 weeks after the accident, up to a maximum payment of **\$250** for each person for any one accident. Expense must be incurred while the member is under this Plan.

For repair of accidental injury to sound natural teeth or supporting bone or tissue, this Plan will pay benefits, as covered above, for:

- Dental surgery (including anesthetics) and dental treatment specified above
- Tooth extraction (including anesthetics)
- Restoration and replacement of teeth.

#### What is not covered

- Realignment of teeth (orthodontia) or treatment for cosmetic purposes
- Repair of cavities
- Repair or replacement of teeth except as covered above. Masticating (chewing) incidents are not considered to be accidental injuries
- Tooth extraction not specified as covered above
- X-rays not specified as covered above
- Dental surgery, appliances or adjustments of occlusion for temporomandibular joint syndrome (TMJ)
- Dental services and supplies (other than necessary hospitalization) which are not specifically covered under Accidental dental injury.

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## How to Claim Benefits

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### Claim forms and identification cards

If you do not receive your identification card(s) within 60 days after the effective date of your enrollment, call the Carrier (in Panama 263-8711 or 263-8721, in the United States 504-566-3501) to report the delay. In the meantime, use your copy of the SF 2809 enrollment form or your annuitant confirmation letter from OPM as proof of enrollment when you obtain services. This is also the number to call for claim forms or advice on filing claims.

If you made your open season change by using Employee Express and have not received your new ID card by the effective date of your enrollment, call the Employee Express HELP number to request a confirmation letter. Use that letter to confirm your new coverage with providers.

### How to file claims

**Claims filed by your doctor that include an assignment of benefits to the doctor are to be filed on the form HCFA-1500, Health Insurance Claim Form.** Claims submitted by enrollees may be submitted on the HCF 1500 or a claim form that includes the information shown below. Bills and receipts should be itemized and show:

- Name of patient and relationship to enrollee
- Plan identification number of the enrollee
- Name and address of person or firm providing the service or supply
- Dates that services and supplies were furnished
- Type of each service or supply and the charge
- Diagnosis

In addition:

- A copy of the explanation of benefits (EOB) from any primary payer (such as Medicare) must be sent with your claim.
- Bills for private duty nurses must show that the nurse is a registered or licensed practical nurse and must include nursing notes.
- Claims for rental or purchase of durable medical equipment, private duty nursing, and physical, occupational and speech therapy require a written statement from the doctor specifying the medical necessity for the service or supply and the length of time needed.
- Claims for prescription drugs and medicines that are not ordered through the mail order drug program must include receipts that include the prescription number, name of drug, prescribing doctor's name, date and charge.
- Claims for overseas (foreign) services should include an English translation. Charges should be converted to U.S. dollars using the exchange rate applicable at the time the expense was incurred.

Cancelled checks, cash register receipts or balance due statements are not acceptable.

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## How to Claim Benefits *continued*

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After completing a claim form and attaching proper documentation, send claims to:

**For claims incurred in Panama:**

Pan-American Life Insurance Co.  
Apartado Postal 4533  
Panama 5, Republic of Panama

**For claims incurred in the United States:**

Group Insurance Board  
Panama Canal Commission     or  
Unit 2300  
APO AA 34011-2300

Pan American Life  
Panama Canal Area  
601 Poydras St., 19th Floor  
New Orleans, LA 70130

### 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. The Carrier will not provide duplicate or year end statements.

### Submit claims promptly

Claims must be filed within 90 days promptly after the expense for which claim is being made was incurred. The Plan is not required to honor a claim submitted after the 90-day period unless timely filing was prevented by administrative operations of Government or legal incapacity, provided the claim was submitted as soon as reasonably possible.

To avoid the possibility of denial, submit your claims within the 90-day period. The underwriter (Pan-American Life) has the contractual right to investigate any claim prior to processing.

### Direct payment to hospital or provider of care

Normally, you must pay the hospital, doctor, or other provider of service and file a claim for **Hospital or Provider Care** reimbursement with Pan-American Life. This claim must be supported by all bills for covered services and supplies. Payment of benefits will be made directly to you.

However, at the discretion of the Group Insurance Board (Panama Canal Area), the underwriter may accept an assignment of your benefits so that they will be paid directly to the hospital, doctor, or other provider of service.

Call telephone number 263-8711 or visit the Pan-American Life Insurance Company in Panama for information concerning covered charges, benefits, and if an assignment of benefits will be accepted. Members in the United States can call (504) 566-3501 for the same information.

Pan-American Life has the right, through its medical examiner, to examine any claimant during the pendency of a claim to determine if the furnished services and supplies were medically necessary.

### When more information is needed

Reply promptly when the Carrier requests information in connection with a claim. If you do not respond, the Carrier may delay processing or limit the benefits available.

### Confidentiality

Medical and other information provided to the Carrier, including claim files, is kept confidential and will be used only: 1) by the Carrier and its subcontractors only for internal administration of the Plan, coordination of benefit provisions with other plans, and subrogation of claims; 2) by law enforcement officials with authority to investigate and prosecute alleged civil or criminal actions; or 3) by OPM to review a disputed claim or perform its contract administration functions; 4) by OPM and the General Accounting Office when conducting audits as required by the FEHB law; or 5) for bona fide medical research or education. Medical data that does not identify individual members may be disclosed as a result of the bona fide medical research or education.

### Disputed claims review

#### Reconsideration

If a claim for payment is denied by the Carrier, you must ask the Carrier, in writing and, within six months of the date of the denial, to reconsider its decision before you request a review by OPM. (This time limit may be extended if you show you were prevented by circumstances beyond your control from making your request within the time limit.) OPM will not review your request unless you demonstrate that you gave the Carrier an opportunity to reconsider your claim. Before you ask the Carrier to reconsider, you should first check with your provider or facility to be sure that the claim was filed correctly. For instance, did they use the correct procedure code for the service(s) performed (surgery, laboratory test, X-ray, office visit, etc.)? Indicate any complications of any surgical procedure(s) performed. Include copies of an operative or procedure report, or other documentation that supports your claim. Your written request to the Carrier must state why, based on specific benefit provisions in this brochure, you believe the denied claim for payment should have been paid.

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## How to Claim Benefits *continued*

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Within 30 days after receipt of your request for reconsideration, the Carrier must affirm the denial in writing to you, pay the claim, or request additional information that is reasonably necessary to make a determination. If the Carrier asks a provider for information it will send you a copy of this request at the same time. The Carrier has 30 days after receiving the information to give its decision. If this information is not supplied within 60 days, the Carrier will base its decision on the information it has on hand.

### OPM review

If the Carrier affirms its denial, you have the right to request a review by OPM to determine whether the Carrier's actions are in accordance with the terms of its contract. You must request the review within 90 days after the date of the Plan's letter affirming its initial denial.

You may also ask OPM for a review if the Carrier fails to respond within 30 days of your written request for reconsideration or 30 days after you have supplied additional information to the Carrier. In this case, OPM must receive a request for review within 120 days of your request to the Carrier for reconsideration or of the date you were notified that the Carrier needed additional information, either from you or from your doctor or hospital.

This right is available only to you or the executor of a deceased claimant's estate. Providers, legal counsel, and other interested parties may act as your representative only with your specific written consent to pursue payment of the disputed claim. OPM must receive a copy of your written consent with their request for review.

Your written request for an OPM review must state why, based on specific benefit provisions in this brochure, you believe the Carrier should have paid the denied claim. Refer to specific benefit provisions in this brochure. If the Carrier has reconsidered and denied more than one unrelated claim, clearly identify the documents for each claim.

Your request must include the following information or it will be returned by OPM:

- A copy of your letter to the Carrier requesting reconsideration;
- A copy of the Carrier's reconsideration decision (If the Carrier failed to respond, provide instead (a) the date of your request to the Carrier, or (b) the dates the Carrier requested and you provided additional information to the Carrier);
- Copies of documents that support your claim (such as doctors' letters, operative reports, bills, medical records, explanation of benefit (EOB) forms); and
- Your daytime phone number.

Medical documentation received from you or the Carrier during the review process becomes a permanent part of the disputed claim file, subject to the provisions of the Freedom of Information Act and the Privacy Act.

Send your request for review to: Office of Personnel Management, Retirement and Insurance Service, Office of Insurance Programs, Insurance Contracts Division, P.O. Box 436, Washington, DC 20044.

You (or a person acting on your behalf) may not bring a lawsuit to recover benefits on a claim for treatment, services, supplies or drugs covered by this Plan until you have exhausted the OPM review procedure, established at section 890.105, title 5, Code of Federal Regulations (CFR). If OPM upholds the Carrier's decision on your claim, and you decide to bring a lawsuit based on the denial, the lawsuit must be brought no later than December 31 of the third year after the year in which the services or supplies upon which the claim is predicated were provided. Pursuant to section 890.107, title 5, CFR, such a lawsuit must be brought against the Office of Personnel Management in Federal court.

Federal law exclusively governs all claims for relief in a lawsuit that relates to this Plan's benefits or coverage or payments with respect to those benefits. Judicial action on such claims is limited to the record that was before OPM when it rendered its decision affirming the Carrier's denial of the benefit. The recovery in such a suit is limited to the amount of benefits in dispute.

**Privacy Act statement**—If you ask OPM to review a denial of a claim for payment or service, OPM is authorized by chapter 89 of title 5, U.S.C., to use the information collected from you and the Carrier to determine if the Carrier has acted properly in denying you the payment or service, and the information so collected may be disclosed to you and/or the Carrier in support of OPM's decision on the disputed claim.

# Other Information

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## Protection Against Catastrophic Costs

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### Catastrophic protection

After a person's out-of-pocket expenses for the 20% coinsurance for Inpatient Hospital other charges reach \$1,000 in a calendar year, the Plan will then pay the remaining other charges at 100%.

Out-of-pocket expenses for the purposes of this benefit are:

- The 20% you pay for Inpatient Hospital other charges.

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

- Expenses in excess of reasonable and customary charges or maximum benefit limitations;
- Expenses for mental conditions, substance abuse, dental care or prescription drugs;
- Any amounts you pay because benefits have been reduced for non-compliance with this Plan's cost containment requirements (see pages 11, 22, 23 & 24); and
- The \$125 deductible per person per confinement for hospital room and board.

### Carryover

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

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## Precertification

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### Precertify before admission

Precertification is not a guarantee of benefit payments. Precertification of an inpatient admission is a predetermination that, based on the information given, the admission meets the medical necessity requirements of the Plan. **It is your responsibility to ensure that precertification is obtained.** If precertification is not obtained and benefits are otherwise payable, benefits for the admission will be reduced by \$500.

To precertify a scheduled admission:

- If a resident of Panama with services to be performed in a Panama hospital, you must have your physician contact the Plan's medical consultant at the hospital where the services are to be performed. If the hospital does not have a Plan's medical consultant or if your physician is not able to contact the Plan's medical consultant, you, your representative, or your physician must call 263-8711 or 263-8721.
- If a resident of Panama with services to be performed in a non-Panama hospital, you, your representative, your doctor, or your hospital must call 263-8711 or 263-8721 prior to your departure.
- If a resident of the United States, you, your representative, your doctor, or your hospital must call 1-800/222-3711.
- For those Plan members who do not reside either in Panama or the United States, call 504/566-3501.
- The following information must be provided: enrollee's name and Plan Identification Number; patient's name, birth date and phone number; reason for hospitalization, proposed treatment or surgery; name of hospital or facility; name and phone number of admitting doctor; and number of planned days of confinement.

When the above requirements are met, the Plan's precertification vendor will tell the doctor and hospital the number of approved days of confinement for the care of the patient's condition. Written confirmation of the Carrier's certification decision will be sent to you, your doctor, and the hospital. If the length of stay needs to be extended, follow the procedures below.

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## Precertification *continued*

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### **Need additional days?**

A review coordinator will contact your doctor before the certified length of stay ends to determine if you will be discharged on time or if additional inpatient days are medically necessary. If the admission is precertified but you remain confined beyond the number of days certified as medically necessary, the Plan will not pay for charges incurred on any extra days that are determined not to be medically necessary by the Carrier during the claim review.

### **You don't need to certify an admission when**

- Medicare Part A, or another group health insurance policy, is the primary payer for the hospital confinement (see page 24). Precertification is required, however, when Medicare hospital benefits are exhausted prior to using lifetime reserve days.
- You are confined in a hospital outside the United States, Puerto Rico, and Panama.
- Hospital confinement is in a U.S. Government operated hospital in Panama (see page 12).

### **Maternity or emergency admissions**

When there is an unscheduled maternity admission or an emergency admission due to a condition that puts the patient's life in danger or could cause serious damage to bodily function, you, your representative, the doctor, or the hospital must telephone in Panama 263-8711 or 263-8721, in the United States 1-800/222-3711 within two business days following admission, even if the patient has been discharged from the hospital. Otherwise, inpatient benefits otherwise payable for the admission will be reduced by \$500.

Newborn confinements that extend beyond the mother's discharge date must also be certified. You, your representative, the doctor or hospital must request certification for the newborn's continued confinement within two business days following the day of the mother's discharge.

### **Other precertification requirements**

- For all elective (non-emergency) surgical procedures, a second surgical opinion will be required. Failure to comply with this requirement, will limit benefits to 50% of reasonable and customary charges for all covered services.
- For all in hospital surgical procedures not related to the original diagnosis for which precertification was obtained, a second surgical opinion will be required. Failure to comply with this requirement will limit the surgical benefit to 50% of reasonable and customary charges.
- If Designated outpatient surgical procedures are performed on an inpatient basis, the Plan limits benefits to 50% of reasonable and customary charges for all covered services.

However, if it is medically necessary that an insured person be hospitalized for the surgical procedures, the regular Plan benefits for all covered services will be payable if the hospitalization has been precertified.

- Precertification is required on both an inpatient and outpatient basis for specifically designated, non-routine diagnostic procedures that are high cost, involve high technology or that may be over-utilized. These tests include Cat Scans, MRI's, Nuclear Medicine Studies (e.g. Thallium Cardiac Studies), certain Arteriographies, Genetic Studies and other similar procedures. Failure to comply with this requirement will result in a 50% reduction in the benefit payable for outpatient charges and a \$500 reduction in benefits payable for inpatient charges.

Follow the steps outlined above to obtain precertification for these procedures.

### **Other considerations**

An early determination of need for confinement (precertification of the medical necessity of inpatient admission) is binding on the Carrier unless the Carrier is misled by the information given to it. After the claim is received, the Carrier will first determine whether the admission was precertified and then provide benefits according to all of the terms of this brochure.

### **If you do not precertify**

If precertification is not obtained before admission to the hospital (or within two business days following the day of a maternity or emergency admission or, in the case of a newborn, the mother's discharge), a medical necessity determination will be made at the time the claim is filed. If the Carrier determines that the hospitalization was not medically necessary the inpatient hospital benefits will not be paid. However, medical supplies and services otherwise payable on an outpatient basis will be paid.

If the claim review determines that the admission was medically necessary, any benefits payable according to all of the terms of this brochure will be reduced by \$500 for failing to have the admission precertified.

If the admission is determined to be medically necessary, but part of the length of stay was found not to be medically necessary, inpatient hospital benefits will not be paid for the portion of the confinement that was not medically necessary. However, medical services and supplies otherwise payable on an outpatient basis will be paid.

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## Precertification *continued*

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### Written confirmation

Either a registered nurse or a medical consultant will be in contact with you and your doctor regarding the hospitalization, surgical procedure, diagnostic test, services or supplies. The proposed plan of treatment will be reviewed and coordinated with the Plan's benefits. Admission review will certify the appropriate hospital stay or recommended alternative settings or outpatient treatment. Admission review may also recommend pre-admission testing to shorten an approved inpatient stay.

Written confirmation of the Plan's precertification decision will be sent to you. If it is determined that the length of stay needs to be extended, follow the procedures listed below. If the admission is precertified but you remain confined beyond the number of days certified as medically necessary, the Plan will not pay for charges incurred on any extra days that are not determined by the Plan during the claim review to be medically necessary.

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## This Plan and Medicare

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### Coordinating benefits

The following information applies only to enrollees and covered family members entitled to benefits from both this Plan and Medicare. You must disclose information about Medicare coverage, including your enrollment in a Medicare prepaid plan, to this Carrier; this applies whether or not you file a claim under Medicare. You must also give this Carrier authorization to obtain information about benefits or services denied or paid by Medicare when they request it. It is also important that you inform the Carrier about other coverage you may have as this coverage may affect the primary/secondary status of this Plan and Medicare (see pages 8, 19 and 20).

This Plan covers most of the same kinds of expenses as Medicare Part A, hospital insurance, and Part B, medical insurance, except that Medicare does not cover prescription drugs.

The following rules apply to enrollees and their family members who are entitled to benefits from both an FEHB plan and Medicare.

### This Plan is primary if:

- 1) You are age 65 or over, and have Medicare Part A (or Parts A and B), and are employed by the Federal Government;
- 2) Your covered spouse is age 65 or over and has Medicare Part A (or Parts A and B) and you are employed by the Federal Government;
- 3) The patient (you or a covered family member) is within the first 18 months of eligibility to receive Medicare Part A benefits due to End Stage Renal Disease (ESRD) except when Medicare was the patient's primary payer on the day before he or she became eligible for Medicare Part A due to ESRD; or
- 4) The patient (you or a covered family member) is under age 65 and eligible for Medicare solely on the basis of disability, and you are employed by the Federal Government.

For purposes of this section, "employed by the Federal Government" means that you are eligible for FEHB coverage based on your current employment and that you do not hold an appointment described under Rule 6 of the following "Medicare is primary" section.

### Medicare is primary if:

- 1) You are an annuitant age 65 or over, covered by Medicare Part A (or Parts A and B) and are not employed by the Federal Government;
- 2) Your covered spouse is age 65 or over and has Medicare Part A (or Parts A and B) and you are not employed by the Federal Government;
- 3) You are age 65 or over and (a) you are a Federal judge who retired under title 28, U.S.C., (b) you are a Tax Court judge who retired under Section 7447 of title 26, U.S.C., or (c) you are the covered spouse of a retired judge described in (a) or (b);
- 4) You are an annuitant not employed by the Federal Government, and either you or a covered family member (who may or may not be employed by the Federal Government) is under age 65 and eligible for Medicare on the basis of disability;
- 5) You are enrolled in Part B only, regardless of your employment status;
- 6) You are age 65 or over and employed by the Federal Government in an appointment that excludes similarly appointed nonretired employees from FEHB coverage, and have Medicare Part A (or Parts A and B);
- 7) You are a former Federal employee receiving workers' compensation and the Office of Workers Compensation has determined that you are unable to return to duty;
- 8) The patient (you or a covered family member) has completed the 18-month ESRD coordination period and is still eligible for Medicare due to ESRD; or
- 9) The patient (you or a covered family member) becomes eligible for Medicare due to ESRD after Medicare assumed primary payer status for the patient under rules 1) through 7) above.

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## This Plan and Medicare *continued*

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### When Medicare is primary

When Medicare is primary, all or part of your Plan deductibles and coinsurance will be waived as follows:

**Inpatient Hospital Benefits:** If you are enrolled in Medicare Part A, the Plan will waive the deductible and coinsurance.

**Surgical Benefits:** If you are enrolled in Medicare Part B, this Plan will waive the deductible and coinsurance applicable to surgical care.

**Other Medical Benefits:** If you are enrolled in Medicare Part B, this Plan will waive the deductible and coinsurance applicable to medical care.

**Additional Benefits:** If you are enrolled in Medicare Part B, this Plan will waive the deductible and coinsurance applicable to medical care.

**Mental Conditions and Substance Abuse:** If you are enrolled in Medicare Part A, this Plan will waive the deductible and coinsurance applicable to inpatient mental conditions and substance abuse care.

**Dental Benefits:** If you are enrolled in Medicare Part B, this Plan will waive the deductible and coinsurance applicable to dental care.

When Medicare is the primary payer, this Plan will pay the lesser of (1) its benefits in full, or (2) a reduced amount that, when added to the benefits payable by Medicare, will not exceed 100% of reasonable and customary expenses or, for doctor services, the amount specified by Medicare as described on page 9.

### When you also enroll in a Medicare prepaid plan

When you are enrolled in a Medicare prepaid plan while you are a member of this Plan, you may continue to obtain benefits from this Plan. If you submit claims for services covered by this Plan that you receive from providers that are not in the Medicare plan's network, the Plan will not waive any deductibles or coinsurance when paying these claims.

### Medicare's payment and this Plan

If you are covered by Medicare Part B and it is primary, you should be aware that your out-of-pocket costs for services covered by both this Plan and Medicare Part B will depend on whether your doctor accepts Medicare assignment for the claim.

Medicare-participating doctors accept assignment; that is, they have agreed not to bill you for more than the Medicare-approved amount for covered services. Some non-Medicare-participating doctors accept assignment on certain claims. If you use a doctor who accepts Medicare assignment for the claim, the doctor is permitted to bill you after the Plan has paid only in those instances where the Medicare and Plan payments combined do not total the Medicare-approved amount.

Non-Medicare-participating doctors do not need to accept assignment. When they do not accept assignment on a claim, they can bill you for more than the Medicare-approved amount — up to a limit set by the Medicare law (the Social Security Act, 42 U.S.C.) called the limiting charge. The limiting charge is 115 percent of the Medicare-approved amount. If you use a doctor who does not accept assignment for the claim, the doctor is permitted to bill you after the Plan has paid only if the Medicare and Plan payments combined do not total the limiting charge set by the Medicare law for non-Medicare-participating doctors. Neither you nor your FEHB Plan is liable for any amount in excess of the Medicare limiting charge for charges of a non-participating Medicare doctor. The Medicare Explanation of Benefits (EOB) form will have more information about this limit.

### How to claim benefits

In most cases, when services are covered by both Medicare and this Plan, Medicare is the primary payer if you are an annuitant and this Plan is the primary payer if you are an employee. When Medicare is the primary payer, your claims should first be submitted to Medicare. After Medicare has paid its benefits, the Carrier will consider the balance of any covered expenses. To be sure your claims are processed by this Carrier, you must submit the EOB form from Medicare and duplicates of all bills along with a completed claim form. The Carrier will not process your claim without knowing whether you have Medicare and, if you do, without receiving the Medicare EOB.

### Medicare coverage charges incurred outside the U.S.

Generally Medicare does not cover charges incurred outside the United States, the Commonwealth of Puerto Rico, the Virgin Islands, Guam and American Samoa.

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# Enrollment Information

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## If you are a new member

Use this brochure as a guide to coverage and obtaining benefits. There may be a delay before you receive your identification card and member information from the Carrier.

Until you receive your ID card, you may show your copy of the SF 2809 enrollment form or your annuitant confirmation letter from OPM to a provider as proof of enrollment in this Plan. If you do not receive your ID card within 60 days after the effective date of your enrollment, you should contact the Carrier. See “How to claim benefits” on page 19.

If you made your open season change by using Employee Express and have not received your new ID card by the effective date of your enrollment, call the Employee Express HELP number to request a confirmation letter. Use that letter to confirm your new coverage with Plan providers.

If you are a new member of this Plan, benefits and rates begin on the effective date of your enrollment, as set by your employing office or retirement system (see *Effective date* on page 30). Coverage under your new plan for a hospitalized member may be delayed if you are currently enrolled in another FEHB plan and you or a covered family member is hospitalized on the effective date of your enrollment - see *If you are hospitalized* below.

No FEHB plan may refuse to provide benefits for any condition you or a covered family member may have solely on the basis that it was a condition that existed before you enrolled in a plan under the FEHB Program, except as stated in any cosmetic surgery or dental benefits description in this brochure.

## If you are hospitalized

If you change plans or options, benefits under your prior plan or option cease on the effective date of your enrollment in your new plan or option unless you or a covered family member are confined in a hospital or other covered facility or are receiving medical care in an alternative care setting on the last day of your enrollment under the prior plan or option. In that case, the confined person will continue to receive benefits under the former plan or option until the earlier of (1) the day the person is discharged from the hospital or other covered facility (a move to an alternative care setting does not constitute a discharge under this provision), or (2) the day after the day all inpatient benefits have been exhausted under the prior plan or option, or (3) the 92nd day after the last day of coverage under the prior plan or option. However, benefits for other family members under the new plan will begin on the effective date. If your plan terminates participation in the FEHB Program in whole or in part, or if the Associate Director for Retirement and Insurance orders an enrollment change, this continuation of coverage provision does not apply; in such case, the hospitalized family member’s benefits under the new plan begin on the effective date of enrollment.

## Your responsibility

**It is your responsibility to be informed about your health benefits.** Your employing office or retirement system can provide information about when you may change your enrollment; who “family members” are; what happens when you transfer, go on leave without pay, enter military service, or retire; when your enrollment terminates; and the next open season for enrollment. Your employing office or retirement system will also make available to you an FEHB Guide, brochures and other materials you need to make an informed decision.

## Things to keep in mind

- The **benefits** in this brochure are effective on January 1 for those already enrolled in this Plan. If you changed plans or plan options, see “*If you are a new member*” above. In both cases, however, the Plan’s new **rates** are effective the first day of the enrollee’s first full pay period that begins on or after January 1 (January 1 for all annuitants).
- Generally, you must be continuously enrolled in the FEHB Program for the last five years before you retire to continue your enrollment for you and any eligible family members after you retire.
- The FEHB Program provides Self Only coverage for the enrollee alone or Self and Family coverage for the enrollee, his or her spouse, and unmarried dependent children under age 22. Under certain circumstances, coverage will also be provided under a family enrollment for a disabled child 22 years of age or older who is incapable of self-support.
- An enrollee with Self Only coverage who is expecting a baby or the addition of a child may change to a Self and Family enrollment up to 60 days after the birth or addition. The effective date of the enrollment change is the first day of the pay period in which the child was born or became an eligible family member. The enrollee is responsible for his or her share of the Self and Family premium for that time period.
- You will not be informed by your employing office (or your retirement system) or your Carrier when a family member loses eligibility.

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## Enrollment Information *continued*

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- You must direct questions about enrollment and eligibility, including whether a dependent age 22 or older is eligible for coverage, to the employing office or retirement system. The Carrier does not determine eligibility and cannot change an enrollment status without the necessary information from the employing agency or retirement system.
- An employee, annuitant, or family member enrolled in one FEHB plan is not entitled to receive benefits under any other FEHB plan.
- Report additions and deletions, (including divorces) of covered family members to the Carrier promptly.
- If you are an annuitant or former spouse with FEHB coverage and you are also covered by Medicare Part B, you may drop your FEHB coverage and enroll in a Medicare prepaid plan when one is available in your area. If you later change your mind and want to reenroll in FEHB, you may do so at the next open season, or whenever you involuntarily lose coverage in the Medicare prepaid plan or move out of the area it serves.

Most Federal annuitants have Medicare Part A. If you do not have Medicare Part A, you may enroll in a Medicare prepaid plan, but you will probably have to pay for hospital coverage in addition to the Part B premium. Before you join the plan, ask whether they will provide hospital benefits and, if so, what you will have to pay.

You may also remain enrolled in this Plan when you join a Medicare prepaid plan. See page 25 for how this Plan's benefits are affected when you are enrolled in a Medicare prepaid plan.

Contact your local Social Security Administration (SSA) office for information on local Medicare plans (also known as Coordinated Care Plans or Medicare HMOs) or request it from SSA at 1-800-638-6833. Contact your retirement system for information on dropping your • FEHB enrollment and changing to a Medicare prepaid plan.

- Federal annuitants are not required to enroll in Medicare Part B (or Part A) in order to be covered under the FEHB Program nor are their FEHB benefits reduced if they do not have Medicare Part B (or Part A).

### Coverage after enrollment ends

When an employee's enrollment terminates because of separation from Federal service or when a family member is no longer eligible for coverage under an employee or annuitant enrollment, and the person is not otherwise eligible for FEHB coverage, he or she will generally be eligible for a free 31-day extension of coverage. The employee or family member may also be eligible for one of the following:

#### Former spouse coverage

When a Federal employee or annuitant divorces, the former spouse may be eligible to elect coverage under the spouse equity law. If you are recently divorced or anticipate divorcing, contact the employee's employing office (personnel office) or retiree's retirement system to get more facts about electing coverage.

#### Temporary continuation of coverage (TCC)

If you are an employee whose enrollment is terminated because you separate from service, you may be eligible to temporarily continue your health benefits coverage under the FEHB Program after separation. Ask your employing office for RI 79-27, which describes TCC, and for RI 70-5, the FEHB Guide for individuals eligible for (TCC). Unless you are separated for gross misconduct, TCC is available to you if you are not otherwise eligible for continued coverage under the Program. For example, you are eligible for TCC when you retire if you are unable to meet the five-year enrollment requirement for continuation of enrollment after retirement.

Your TCC begins after the initial free 31-day extension of coverage ends and continues for up to 18 months after your separation from service (that is, if you use TCC until it expires 18 months following separation, you will only pay for 17 months of coverage). Generally, you must pay the total premium (both the Government and employee shares) plus a 2 percent administrative charge. If you use your TCC until it expires, you are entitled to another free 31-day extension of when you may convert to nongroup coverage. If you cancel your TCC or stop paying premiums, the free 31-day extension of coverage and conversion option are not available.

Children or former spouses who lose eligibility for coverage because they no longer qualify as family members (and who are not eligible for benefits under the FEHB Program as employees or under the spouse equity law) also may qualify for TCC. They also must pay the total premium plus the 2 percent administrative charge. TCC for former family members continues for up to 36 months after the qualifying event occurs, for example the date the child reaches age 22 or the date of the divorce. This includes the free 31-day extension of coverage. When their TCC ends (except by cancellation or nonpayment of premium), they are entitled to another free 31-day extension of coverage when they may convert to nongroup coverage.

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## Enrollment Information *continued*

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**NOTE:** If there is a delay in processing the TCC enrollment, the effective date of the enrollment is still the 32nd day after regular coverage ends. The TCC enrollee is responsible for premium payments retroactive to the effective date, and coverage may not exceed the 18 or 36 month period noted above.

### **Notification and election requirements:**

- **Separating employees** — Within 61 days after an employee’s enrollment terminates because of separation from service, his or her employing office must notify the employee of the opportunity to elect TCC. The employee has 60 days after separation (or after receiving the notice from the employing office, if later) to elect TCC.
- **Children** — You must notify your employing office or retirement system when a child becomes eligible for TCC within 60 days after the qualifying event occurs, for example, the child reaches age 22 or marries.
- **Former spouses** — You or your former spouse must notify the employing office or retirement system of the former spouse’s eligibility for TCC within 60 days after the termination of the marriage. A former spouse may also qualify for TCC if, during the 36-month period of TCC eligibility, he or she loses spouse equity eligibility because of remarriage before age 55 or loss of the qualifying court order. This applies even if he or she did not elect TCC while waiting for spouse equity coverage to begin. The former spouse must contact the employing office within 60 days of losing spouse equity eligibility to apply for the remaining months of TCC to which he or she is entitled.

The employing office or retirement system has 14 days after receiving notice from you or the former spouse to notify the child or the former spouse of his or her rights under TCC. If a child wants TCC, he or she must elect it within 60 days after the date of the qualifying event (or after receiving the notice, if later). If a former spouse wants TCC, he or she must elect it within 60 days after any of the following events, the date of the qualifying event or the date he or she receives the notice, whichever is later; or the date he or she loses coverage under the spouse equity law because of remarriage before age 55 or loss of qualifying court order.

**Important:** The employing office or retirement system must be notified of a child’s or former spouse’s eligibility for TCC within the 60-day time limit. If the employing office or retirement system is not notified, the opportunity to elect TCC ends 60 days after the qualifying event in the case of a child and 60 days after the change in status in the case of a former spouse.

### **Conversion to individual coverage**

When none of the above choices is available — or chosen — when coverage as an employee or family member ends, or when TCC coverage ends (except by cancellation or nonpayment of premium), you may be eligible to convert to an individual, nongroup contract. You will not be required to provide evidence of good health and the plan is not permitted to impose a waiting period or limit coverage for preexisting conditions. If you wish to convert to an individual contract, you must apply in writing to the carrier of the plan in which you are enrolled within 31 days after receiving notice of the conversion right from your employing agency. A family member must apply to convert within the 31-day free extension of coverage that follows the event that terminates coverage, e.g., divorce or reaching age 22. Benefits and rates under the individual contract may differ from those under the FEHB Program.

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## Definitions

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### **Accidental injury**

An injury caused by an external force or element such as a blow or fall and which requires immediate medical attention. Also included are animal bites, poisonings and dental care required as a result of an accidental injury to sound natural teeth. Masticating (chewing) incidents will not be considered to be accidental injuries.

### **Admission**

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

### **Assignment (benefits)**

An authorization by an enrollee or spouse for the Carrier to issue payment of benefits directly to the provider. The Carrier reserves the right to pay the member directly for all covered services.

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## Definitions *continued*

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### **Assignment (disputed claims)**

For disputed claims purposes, written consent given by an enrollee to a covered provider or facility that transfers all of the rights of the enrollee to the provider for that particular claim for benefits under this Plan.

### **Calendar year**

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

### **Confinement**

An admission (or series of admissions separated by less than 60 days) to a hospital as an inpatient for any one illness or injury. There is a new confinement when an admission is for a cause entirely unrelated to the cause for the previous admission. All hospital admissions are considered one confinement unless (1) the enrollee returns to work for at least one full day before the next admission; or (2) for dependents or annuitants, there are 60 days between confinements.

### **Congenital anomaly**

A condition existing at or from birth which is a significant deviation from the common form or norm. For purposes of this Plan, congenital anomalies include protruding ear deformities, cleft lips, cleft palates, birthmarks, webbed fingers or toes and other conditions that the Carrier may determine to be congenital anomalies. In no event will the term congenital anomaly include conditions relating to teeth or intra-oral structures supporting the teeth.

### **Cosmetic surgery**

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.

### **Covered charge**

An actual charge up to the reasonable and customary charge.

### **Covered facilities**

#### **Clinic**

A place, other than a hospital, licensed to provide treatment or diagnosis and staffed by one or more doctors.

#### **Hospice**

A public or private agency or organization which:

- 1) administers and provides hospice care; and
- 2) is either:
  - a) licensed or certified as such by the state in which it is located;
  - b) certified (or is qualified and could be certified) to participate as such under Medicare;
  - c) accredited as such by the Joint Commission on the Accreditation of Health Care Organizations; or
  - d) meets the standards established by the National Hospice Organization.

### **Hospital**

- 1) An institution which is accredited as a hospital under the Hospital Accreditation Program of the Joint Commission on Accreditation of Health Care Organizations or
- 2) Any other institution which is operated pursuant to law under the supervision of a staff of doctors and with 24-hour-a-day nursing service, and which is primarily engaged in providing:
  - a) general patient care and treatment of sick or 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 an institution or part thereof which:

- 1) is used principally as a convalescent facility, rest facility, nursing facility, or facility for the aged;
- 2) furnishes primarily domiciliary or custodial care, including training in the routine of daily living; or
- 3) is operated as a school.

#### **Participating Hospital or Clinic**

One with which this Plan has, at the time an enrollee is treated, an agreement to render out-of-hospital care to members.

#### **Skilled nursing facility**

A facility that is primarily engaged in providing skilled nursing care and other therapeutic services. The facility must be licensed by the state in which it is located and be an eligible provider of Medicare and Medicaid nursing care services.

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## Definitions *continued*

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### **Covered providers**

#### **Doctor**

For purposes of this Plan, covered providers include:

A licensed doctor of medicine (M.D.) or osteopathy (D.O.); a licensed specialist in his/her specialty; or, for certain specified services covered by this Plan, a licensed dentist.

Other covered providers who may render services without the supervision of an M.D. but for whom the Plan provides benefits include a qualified clinical psychologist, clinical social worker, optometrist, nurse midwife, nurse practitioner/clinical specialist and nursing school administered clinic. For purposes of this FEHB brochure, the term "doctor" includes all of these providers when the services are performed within the scope of their license or certification. Within States designated as medically underserved areas, any licensed medical practitioner is covered. For 1997, the States designated as medically underserved are: Alabama, Louisiana, Mississippi, New Mexico, North Dakota, South Carolina, South Dakota, West Virginia and Wyoming.

#### **Independent consulting doctor**

An independent consulting doctor is a specialist who:

- 1) is certified by the American Board of Medical Specialists in a field related to the proposed surgery;
- 2) is independent of the doctor who first advised the surgery;
- 3) does not perform the surgery for the insured person;
- 4) makes a personal exam of the insured person; and
- 5) sends the Carrier a written report.

### **Custodial care**

Treatment or services, regardless of who recommends them or where they are provided, that could be rendered safely and reasonably by a person not medically skilled, or that are designed mainly to help the patient 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 the patient;
- 4) acting as companion or sitter;
- 5) supervising medication that can usually be self administered; or
- 6) treatment or services that any person may be able to perform with minimal instruction, including but not limited to recording temperature, pulse, and respirations, or administration and monitoring of feeding systems.

The Carrier determines which services are custodial care.

### **Durable medical equipment**

Equipment and supplies that:

- 1) are prescribed by your attending doctor;
- 2) are medically necessary;
- 3) are primarily and customarily used only for a medical purpose;
- 4) are generally useful only to a person with an illness or injury;
- 5) are designed for prolonged use; and
- 6) serve a specific therapeutic purpose in the treatment of an illness or injury.

### **Effective date**

The date the benefits described in this brochure are effective:

- 1) January 1 for continuing enrollments and for all annuitant enrollments;
- 2) the first day of the first full pay period of the new year for enrollees who change plans or options or elect FEHB coverage during open season for the first time; or
- 3) for new enrollees during the calendar year, but not during the open season, the effective date of enrollment as determined by the employing office or retirement system.

### **Elective surgery**

Any non-emergency surgical procedure requiring inpatient hospital confinement which may be scheduled at the patient's convenience without jeopardizing the patient's life or causing serious impairment to the patient's bodily functions.

### **Expense**

The cost incurred for a covered service or supply. A doctor must order or prescribe the service or supply. Expense is considered incurred on the date the service or supply is received.

Expense does not include any charge:

- 1) for a service or supply which is not medically necessary; or
- 2) which is in excess of the reasonable and customary charge for the service or supply.

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## Definitions *continued*

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### **Experimental or investigational drug, device and medical treatment or procedure**

A drug, device or medical treatment or procedure is experimental or investigational:

- 1) if the drug or device cannot be lawfully marketed without approval of the U.S. Food and Drug Administration and approval for marketing has not been given at the time the drug or device is furnished; or
- 2) if reliable evidence shows that the drug, device or medical treatment or procedure 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
- 3) if reliable evidence shows that the consensus of opinion among experts regarding the drug, device or medical treatment or procedure is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its efficacy or its efficacy as compared with the standard means of treatment or diagnosis.

Reliable evidence shall mean only 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.

### **Group health coverage**

Health care coverage that a member is eligible for because of employment, membership in, or connection with, a particular organization or group that provides payment for hospital, medical, or other 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.

### **Hospice care program**

A coordinated program of home and inpatient pain control and supportive care for the terminally ill patient and the patient's family provided by a medically supervised team under the direction of an independent Hospice Administration approved by the Carrier.

### **Intensive care unit**

A special segregated unit of a hospital in which patients are concentrated, by reason of serious illness, usually without regard to diagnosis. Special lifesaving techniques and equipment are regularly and immediately available within the unit, and patients are under continuous observation by a nursing staff specially trained and selected for the care of this type of patient. The unit is maintained on a continuing rather than an intermittent or temporary basis.

### **Medical emergency**

The sudden and unexpected onset of a condition requiring immediate medical care, that the covered person secures within 72 hours after the onset. The severity of the condition as revealed by the doctor's diagnosis, must be such as would normally require emergency care. Medical emergencies include heart attacks, cardiovascular accidents, poisonings, loss of consciousness or respiration, convulsions, and such other acute conditions as may be determined by the Plan to be medical emergencies.

### **Medically necessary**

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

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

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

### **Mental conditions/substance abuse**

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

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## **Definitions** *continued*

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### **Preferred provider organization (PPO) arrangement**

An arrangement between this Plan and doctors, hospitals, clinics, health care institutions, or other health care professionals in Panama to provide services to you at a reduced cost. The PPO provides members the opportunity to reduce their out-of-pocket expenses for care by selecting facilities and providers from among a specific group of health care providers. Although preferred providers are only available in Panama, your use of them whenever possible helps contain health care costs and reduces your out-of-pocket costs. The selection of PPO providers is solely the Plan's responsibility; continued participation of any specific PPO provider cannot be guaranteed.

### **Prosthetic appliance**

An artificial substitute for a missing body part such as an arm, eye, or leg. This appliance may be used for a functional or cosmetic reason or both.

### **Reasonable and customary**

The usual charge made by the providers for the service or supply in the absence of insurance. The charge may not be more than the general level of charges for illness or injury of comparable severity and nature made by other providers within a geographical area in which the service or supply is provided. This is determined by the use of prevailing health care charges developed statistically from actual claims received in your area, and are updated at least annually.

This Plan uses HIAA data for claims incurred in the United States, updated twice a year, at the 75th percentile to determine reasonable and customary charges for inpatient and outpatient surgical charges; other inpatient doctor services are paid on a fee schedule; hospital miscellaneous charges are paid at 80 percent; and medical outpatient charges are paid at 75 percent up to an annual maximum. In the Republic of Panama, reasonable and customary charges for inpatient and outpatient surgical charges and miscellaneous hospital charges are determined by applying the prevailing health care charges made by local providers for health care services or supplies in the absence of insurance. Other inpatient doctor services are paid on a fee schedule. For outpatient care, the Plan uses the cost of the medical attention negotiated with participating hospitals and clinics to determine the reasonable and customary charges for outpatient medical attention provided by nonparticipating hospitals, clinics, and doctors. Medical outpatient charges are paid at 75 percent up to an annual maximum.

### **Reconstructive surgery**

Reconstructive surgery is performed to correct a condition which has resulted in a functional defect or which has resulted from accidental injury or from surgery if the accident or surgery has produced a major effect on the member's appearance and the condition can reasonably be expected to be corrected by such surgery.

### **Sound natural tooth**

A tooth which is whole or properly restored is without impairment, periodontal or other conditions and is not in need of the treatment provided for any reason other than an accidental injury.

## *Notes*

# How the Panama Canal Area Benefit Plan Changes January 1997

Do not rely on this page; it is not an official statement of benefits.

## Benefit changes

There are no benefit changes for contract year 1997.

## Clarifications

The Plan will pay 75% of reasonable and customary charges for cervical cancer screening, colorectal cancer screening and prostate cancer screening.

The use of a Plan identification card to obtain benefits after you are no longer enrolled in the Plan is a fraudulent action subject to review by the Inspector General.

Medical data that does not identify individual members may be disclosed as a result of bona fide medical research or education.

PPO arrangements This section has been clarified to show that while PPO providers agree with the Plan to provide covered services, final decisions about health care from PPO providers are the sole responsibility of the doctor and patient and are independent of the terms of the insurance contract.

General Information When a family member is hospitalized on the effective date of an enrollment change and continues to receive benefits under the old plan, benefits under the new plan will begin for other family members on the effective date of the new enrollment.

An enrollee with Self Only coverage who is expecting a baby or the addition of a child may change to a Self and Family enrollment up to 60 days after the birth or addition.

Annuitants and former spouses with FEHB coverage, and who are covered by Medicare Part B, may join a Medicare prepaid plan if they do not have Medicare Part A, but they will probably have to pay for hospital coverage. They may also remain enrolled under an FEHB plan when they enroll in a Medicare prepaid plan.

Federal annuitants are not required to enroll in Medicare Part B (or Part A) in order to be covered under the FEHB Program nor are their FEHB benefits reduced if they do not have Medicare Part B (or Part A).

Temporary continuation of coverage (TCC) for employees or family members who lose eligibility for FEHB coverage includes one free 31-day extension of coverage and may include a second. How these are coordinated has been clarified; notification and election requirements have also been clarified.

“Conversion to individual coverage” does not require evidence of good health and the plan is not permitted to impose a waiting period or limit coverage for preexisting conditions; benefits and rates under the individual contract may differ from those under the FEHB Program.

The rules concerning whether this Plan or Medicare pays your claim first when you are entitled to benefits under both this Plan and Medicare have been clarified (see page 24).

This Plan is primary if you, the enrollee, are age 65 or over, have Medicare, and are employed by the Federal Government. If your covered spouse is age 65 or over, has Medicare, and is employed by the Federal Government and you, the enrollee, are not, Medicare is primary.

Medicare is primary if you are a former Federal employee receiving workers' compensation and the Office of Workers Compensation has determined that you are unable to return to duty.

Language on the non-FEHB page has been clarified to show that the cost of the benefits described on this page is not included in the FEHB premium.

## Other changes

The “Flexible services option” is not known as the “Flexible benefits option.”

Enrollees who change their FEHB enrollments using Employee Express may call the Employee Express HELP number to obtain a letter confirming that change if their ID cards do not arrive by the effective date of the enrollment change.

If you are eligible for Medicare, the information about Medicare coverage that you must disclose to the Carrier now includes your enrollment in a Medicare prepaid plan.

When you are enrolled in both this Plan and a Medicare prepaid plan, this Plan will waive any deductibles or coinsurance.

The fact that an enrollee does not have a vested right to receive the benefits in this brochure in 1998 or later years, nor to benefits for years prior to 1997 unless those benefits are in this brochure, is now stated under “General Limitations” as well as on page 2.

The Plan will not pay for services required as the result of occupational disease or injury for which any medical benefits are determined by the Office of Workers Compensation Programs (OWCP) to be payable under workers’ compensation or by a similar agency under another Federal or State law. The Carrier is entitled to be reimbursed by OWCP (or the similar agency) for services it paid that were later found to be payable by OWCP (or the agency).

Arkansas and Idaho are no longer designated as medically underserved states.

Disputed claims If your claim for payment or services is denied by the Carrier, and you decide to ask OPM to review that denial, you must first ask the Carrier to reconsider their decision. You must now request their reconsideration within six months of the denial (previously, you had one year to do this). This time limit may be extended if you show you were prevented by circumstances beyond your control from making your request within the time limit.

Providers, legal counsel, and other interested parties may act as your representatives in pursuing payment of a disputed claim only with your written consent. Any lawsuit to recover benefits on a claim for treatment, services, supplies or drugs covered by this Plan must be brought against the Office of Personnel Management in Federal court and only after you have exhausted the OPM review procedure.

This Plan will use the 75th percentile of HIAA instead of the 85th percentile.

## *Summary of Benefits for Panama Canal Area Benefit Plan - 1997*

**Do not rely on this chart alone.** All benefits are subject to the definitions, limitations, and exclusions set forth in the brochure. This chart merely summarizes certain important expenses covered by the Plan. If you wish to enroll or change your enrollment in this Plan, be sure to indicate the correct enrollment code on your enrollment form (codes appear on the cover of this brochure).

Benefits	Plan pays/provides	Page
<b>Inpatient care</b>	<b>Hospital</b>	<p><b>Non-PPO benefit:</b> 100% of reasonable and customary charges for room and board, up to the average semi private room rate for unlimited days after \$125 per admission deductible; 80% of reasonable and customary charges for Other charges . . . . . 11-12</p> <p><b>PPO benefit:</b> 100% of the negotiated per diem for certain medical conditions, when confinement is in a PPO hospital</p> <p><b>IN U.S. GOV'T HOSPITALS IN THE REPUBLIC OF PANAMA:</b> After you pay \$125 deductible per person per confinement, the Plan pays up to \$400 per day for all covered charges, including surgery . . . . . 12</p>
	<b>Surgical</b>	100% of reasonable and customary charges when precertification requirements are met . . . . 12-14
	<b>Medical</b>	80% of covered charges for each admission when precertified. . . . . 11-12
		<b>PPO benefit:</b> 100% of the negotiated charges for PPO hospital admissions, if available.
	<b>Maternity</b>	Same benefits as for illness or injury. . . . . 14-15
	<b>Mental Conditions/ Substance Abuse</b>	After \$125 deductible, 80% for the treatment of and related services for mental conditions/ substance abuse for a maximum of 90 days per calendar year when precertified, and up to \$700 per calendar year for miscellaneous hospital charges . . . . . 15
<b>Outpatient care</b>	<b>Hospital</b>	<p><b>Non-PPO benefit:</b> 75% of covered charges up to \$650 for Self Only and \$1,500 for Self and Family coverage per calendar year. . . . . 16</p> <p><b>PPO benefit:</b> 100% of the negotiated charges up to \$60 per visit plus 75% of reasonable and customary charges for certain specified procedures</p> <p><b>IN U.S. GOV'T HOSPITALS IN THE REPUBLIC OF PANAMA:</b> Plan pays covered charges up to \$60 per visit for covered services and supplies provided by the outpatient department of a hospital operated by the U.S. Government or any instrumentally thereof . . . . . 12</p> <p>Maximum benefits payable are \$650 for a Self Only enrollment, and \$1,500 for a Self and Family enrollment per calendar year regardless of where the services are rendered</p>
	<b>Surgical</b>	100% of reasonable and customary charges for surgical procedures performed as an outpatient. All procedures are subject to precertification and/or second surgical opinion . . . . . 12-14
	<b>Medical</b>	75% of reasonable and customary charges . . . . . 16
		<b>PPO benefit:</b> 100% up to \$60 per visit plus 75% of reasonable and customary charges for certain specified procedures, up to \$650 Self Only and \$1,500 Self and Family for covered services and supplies furnished at a doctor's office, clinic or outpatient department of a hospital
	<b>Maternity</b>	Same benefits as for illness or injury. . . . . 14-15
	<b>Home Health Care</b>	No current benefit
		<b>Mental Conditions/ Substance Abuse</b>
<b>Emergency care (accidental injury)</b>	100% of reasonable and customary charges within 72 hours of accidental injury . . . . . 17	
<b>Prescription drugs</b>	50% of covered expenses after a \$400 deductible per member per year . . . . . 18	
<b>Dental care</b>	100% of scheduled amounts for covered dental surgery and treatment . . . . . 18-19	
<b>Additional benefits</b>	Accidental injury; ambulance service; hospice care; PPO arrangements . . . . . 17-18	
<b>Protection against catastrophic costs</b>	After a person's out-of-pocket expenses for in-hospital miscellaneous charges reach \$1,000 per calendar year, the Plan will then pay the remaining charges at 100%. This benefit does not apply to Mental Conditions and Substance Abuse or prescription drugs . . . . . 22	