Panama Canal Area Benefit Plan

http://www.axa-assistance.com.pa

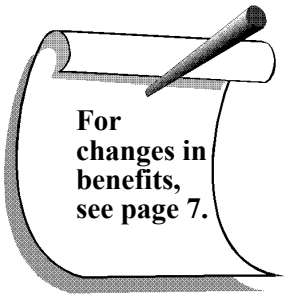
2009

A Managed fee-for-service plan with a point of service option

Sponsored and administered by: *The Association of Retirees of the Panama Canal Area (AJAC)*

Who may enroll in this Plan: *Annuitants (retirees and/or survivors) who are eligible for coverage under the Federal Employees Health Benefits Program, who reside in Panama and who become a member of the Association.*

To become a member of the Association: You become a member of the Association when you enroll in the Panama Canal Area Benefit Plan



Enrollment codes for this Plan:

431 – Self Only
432 – Self and Family

Authorized for distribution by the:

United States
Office of Personnel Management

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

RI 72-004

Important Notice from the Panama Canal Area Benefit Plan About Our Prescription Drug Coverage and Medicare

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

However, if you choose to enroll in Medicare Part D, you can keep your FEHB coverage and your FEHB plan will coordinate benefits with Medicare.

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

Please be advised

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

Medicare's Low Income Benefits

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

You can get more information about Medicare prescription drug coverage from these places:

Visit www.medicare.gov for personalized help,

Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

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Introduction

This brochure describes the benefits of The Panama Canal Area Benefit Plan (PCABP) under our contract (CS 1066) with the United States Office of Personnel Management, as authorized by the Federal Employees Health Benefits law. The address for the Panama Canal Area Benefit Plan administrative offices is:

Panama Canal Area Benefit Plan at AXA Assistance, Via España, Edificio Via España 120, Planta Baja, Panama City, Republic of Panama

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

If you are enrolled in this Plan, you are entitled to the benefits described in this brochure. If you are enrolled in Self and Family coverage, each eligible family member is also entitled to these benefits. You do not have a right to benefits that were available before January 1, 2009, unless those benefits are also shown in this brochure.

OPM negotiates benefits and rates with each plan annually. Benefit changes are effective January 1, 2009, and changes are summarized on page 7. Rates are shown at the end of this brochure.

Plain Language

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

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

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

Stop Health Care Fraud!

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

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

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

- Do not give your plan identification (ID) number over the telephone or to people you do not know, except for your health care provider, authorized health benefits plan, or OPM representative.
- Let only the appropriate medical professionals review your medical record or recommend services.
- Avoid using health care providers who say that an item or service is not usually covered, but they know how to bill us to get it paid.
- Carefully review explanations of benefits (EOBs) statements that you receive from us.
- Do not ask your doctor to make false entries on certificates, bills or records in order to get us to pay for an item or service.

- If you suspect that a provider has charged you for services you did not receive, billed you twice for the same service, or misrepresented any information, do the following:

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

  If the provider does not resolve the matter, call our Fraud and Abuse Hotline at 312-935-3296 in the United States and explain the situation.

  If we do not resolve the issue:

CALL - THE HEALTH CARE FRAUD HOTLINE

202-418-3300

OR WRITE TO:

United States Office of Personnel Management

Office of the Inspector General Fraud Hotline

1900 E Street NW Room 6400

Washington, DC 20415-1100

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

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

  Your child over age 22 (unless he/she is disabled and incapable of self support).

- If you have any questions about the eligibility of a dependent, check with your personnel office if you are employed, with your retirement office (such as OPM) if you are retired, or with the National Finance Center if you are enrolled under Temporary Continuation of Coverage.
- You can be prosecuted for fraud and your agency may take action against you if you falsify a claim to obtain FEHB benefits or try to obtain services for someone who is not an eligible family member or who is no longer enrolled in the Plan.

Preventing medical mistakes

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

1.Ask questions if you have doubts or concerns.

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

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

- Bring the actual medicines or give your doctor and pharmacist a list of all the medicines that you take, including non-prescription (over-the-counter) medicines.
- Tell them about any drug allergies you have.

- Ask about any risks or side effects of the medication and what to avoid while taking it. Be sure to write down what your doctor or pharmacist says.
- Make sure your medicine is what the doctor ordered. Ask the pharmacist about your medicine if it looks different than you expected.
- Read the label and patient package insert when you get your medicine, including all warnings and instructions.
- Know how to use your medicine. Especially note the times and conditions when your medicine should and should not be taken.
- Contact your doctor or pharmacist if you have any questions.

3.Get the results of any test or procedure.

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

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

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

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

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

  Exactly what will you be doing?
  About how long will it take?
  What will happen after surgery
  How can I expect to feel during recovery?

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

Visit these Web sites for more information about patient safety

- www.ahrq.gov/path/beactive.htm. The Agency for Healthcare Research and Quality makes available a wide-ranging list of topics not only to inform consumers about patient safety but to help choose quality health care providers and improve the quality of care you receive.
- www.npsf.org. The National Patient Safety Foundation has information on how to ensure safer health care for you and your family.
- www.talkaboutrx.org. The National Council on Patient Information and Education is dedicated to improving communication about the safe, appropriate use of medicines.
- www.leapfroggroup.org. The Leapfrog Group is active in promoting safe practices in hospital care.
- www.ahqa.org. The American Health Quality Association represents organizations and health care professionals working to improve patient safety.
- www.quic.gov/report. Find out what federal agencies are doing to identify threats to patient safety and help prevent mistakes in the nation's health care delivery system.

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

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

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

We have a Point of Service (POS) option available to Plan members who reside in the Republic of Panama:

Our fee-for-service plan offers POS benefits. This means you can get better benefits at less cost by signing up with us for the POS program, selecting a contracted primary care physician (PCP), and letting the PCP manage your care. We offer the POS program in the following area: *The Republic of Panama.*

Contact us for the names of POS providers and to verify their continued participation. You can also go to our Web page at http://www.axa-assistance.com.pa. Do not call OPM or your agency for our provider directory.

The FFS benefits are the standard benefits of this Plan. POS benefits apply only when you use a POS provider. Provider networks may be more extensive in some areas than others. We cannot guarantee the availability of every specialty in all areas. If you select the POS option but choose a FFS provider, the standard FFS benefits apply.

How we pay providers

Panama POS: We have contracted with individual physicians, hospitals, and providers within the Republic of Panama to provide you with all of your health care needs. These POS providers have agreed to accept our negotiated rates as payment in full. If you reside within the Republic of Panama and you select the POS option and comply with the obligations required of you under this option, we will reimburse point-of-service providers directly for the medical services provided to you. If you select the POS option and use the point-of-service providers, you will usually have to pay your copayments described in this brochure and your prescription drug and dental claims.

If you live in Panama and select the Fee-for-Service (FFS) option, or if you live anywhere outside of Panama, you will usually have to pay for the medical services provided to you and then we will reimburse you according to the benefits described in this brochure. However, if the provider agrees to file the claim directly to the plan, he/she should send a completed Claim Form and the itemized bills to the Panama Canal Area Benefit Plan at AXA Assistance, PO Box 31-0940, Miami Florida 33231-0940 (if services were provided anywhere outside of Panama) or to the Panama Canal Area Benefit Plan at AXA Assistance, Via España, Edificio Via España 120, Panama City, Republic of Panama (if services were provided in Panama).

For claims incurred in the United States or any country outside of Panama, we will reimburse you at the coinsurance stated in this brochure based on the INGENIX (HIAA) fee schedule at the 75th percentile.

Your Rights

OPM requires that all FEHB plans provide certain information to their FEHB members. You may get information about us, our networks, and our providers. OPM's FEHB Web site (www.opm.gov/insure) lists the specific types of information that we must make available to you. Some of the required information is listed below. The Association of Retirees of the Panama Canal Area is a legal Panamanian entity incorporated in June 1999. Before this date the Association (Panama Canal Area) was the Group Insurance Board which came into effect in 1960 as an entity appointed by the Panama Canal Commission to administer Federal Employees Health Benefits Contract CS 1066 (the Panama Canal Area Benefit Plan). All members of the Association (Panama Canal Area) have the right to review the by-laws of the Association.

If you want more information about us, call 507-204-9200 in Panama, and 1-800-424-8196 or 312-935-3671 in the United States.

You may visit our Web site at http://www.axa-assistance.com.pa.

Your medical and claims records are confidential

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

Section 2. How we change for 2009

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

Program-wide changes

- In Section 3, under **Covered providers**, Illinois has been added to the list of medically underserved areas for 2009.

Changes to this Plan

- Your share of the non-Postal premium will increase by 3% for Self only and for Self and Family. See page 73.
- We extended hearing service benefits to FFS enrollees with 50% coinsurance. See page 26.
- We added coverage for routine screening, testing, diagnostic evaluations and treatment once each five years for adults. See page 26.
- We added a $1000 lifetime maximum benefit for hearing aids for adults enrolled in POS and FFS options. See page 26.
- We added a $5000 annual prescription out-of-pocket limit (for Self Only and Self and Family enrollments). See page 48.

Clarifications

- We clarify that enrollees should use specialty hospitals in the United States for highly specialized procedures. See page 52.
- We clarify that the 90 day filing limit applies only to POS contracted providers. See page 55.
- We clarify that FFS enrollees' claims may be submitted to the plan directly by the providers. See pages 6 and 43.
- We clarify when POS enrollees will be reimbursed at the POS level of benefits when getting medical attention outside of Panama. See page 43.
- We clarify that the $50 copayment for outpatient hospital or ambulatory surgical center applies only for the use of the operating room. See page 39.
- We clarify that physical and occupational therapies have an annual benefit limit of $300 for POS and $250 for FFS. See page 25.
- We clarify that enrollees who need mental health or substance abuse services must contact the medical department for preauthorization. See page 46.
- We clarify that medications not FDA approved or not FDA equivalent are not covered. See page 48.
- We clarify that annual gynecological examinations and pap tests are covered for adults and young women after menarche. See page 21.
- We clarify that outpatient and inpatient surgeries must be precertified. See page 32.
- We clarify that requests for a second opinion or surgical procedure to be rendered outside of Panama for a Panama POS enrollee must be preauthorized prior to the enrollee leaving Panama by the medical department. See pages 32 and 36.

Section 3. How you get care

Identification cards

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

If you do not receive your ID card within 30 days after the effective date of your Enrollment, or if you need replacement cards, call us at 507-204-9200 in Panama, and 1-800-424-8196 or 312-935-3671 in the United States. You may also request replacement cards through our Web site: http://www.axa-assistance.com.pa

Where you get covered care

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

- **Covered providers**

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

For purposes of this Plan, covered providers include: a licensed doctor of medicine (M.D.) or a licensed doctor of osteopathy (D.O.); a licensed specialist in his/her specialty. Other covered providers include: a licensed doctor of podiatry (D.P.M.); a licensed dentist (D.D.S. or D.M.D.); licensed chiropractor (D.C.); licensed registered physical, occupational, or speech therapist (R.P.T., R.O.T. R.S.T) practicing within the scope of their license. Other covered providers include a qualified clinical psychologist, clinical social worker, optometrist, nurse midwife, nurse practitioner/clinical specialist, nursing school administered clinic and nutritionists/licensed dieticians**.** For purpose 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.

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

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 Plan a written report.

Primary Care Physician – a licensed medical doctor whose practice is devoted to internal medicine, family/general practice or pediatrics.

Medically underserved areas. Note: We cover any licensed medical practitioner for any covered service performed within the scope of that license in the states OPM determines are "medically underserved". For 2009, the states are: Alabama, Arizona, Idaho, Illinois, Kentucky, Louisiana, Mississippi, Missouri, Montana, New Mexico, North Dakota, South Carolina, South Dakota and Wyoming.

- **Covered facilities**

Covered facilities include:

- 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 Healthcare 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:

    1. General patient care and treatment of sick or injured persons through medical, diagnostic and major surgical facilities, all of which must be provided on its premises or under its control; or

    2. 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 or

    3. In Panama, authorized by the Ministry of Health to operate as such.

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, 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.

Rehabilitation Facility—An institution that: (1) meets the "hospital" definition as stated; or (2) provides a program for the treatment of alcohol or drug abuse and meets one of the following requirements: (a) is affiliated with a hospital under a contractual agreement with an established patient referral system; (b) is licensed, certified or approved as an alcohol or drug abuse rehabilitation facility by the State; or (c) is accredited as such a facility by the Joint Commission on Accreditation of Healthcare Organizations.

Skilled Nursing Facility—An institution that (1) is operated pursuant to law and primarily engaged in providing the following services for patients recovering from an illness or injury: room, board and 24-hour-a-day nursing service by professional nurses; (2) is under the full-time supervision of a doctor or registered nurse (R.N.); (3) maintains adequate medical records; and (4) has the services of a doctor available under an established agreement for 24 hours a day, if not supervised by a doctor.

What you must do to get covered care

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

- **Primary care**

If you have enrolled in the Point of Service option in Panama you must select a primary care physician. Your primary care physician will provide or coordinate most of your health care. If you want to change your primary care physician call us in Panama at 507-204-9200.

- **Specialty care**

If you have enrolled in the Point of Service option in Panama your primary care physician will refer you to a specialist for needed care. You must receive a referral form from your primary care physician and present it to the specialist for Point of Service benefits to be applicable. Your primary care physician must provide or authorize follow up care. Do not go to the specialist for return visits unless your primary care physician gives you a referral.

- **Transitional care**

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

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

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

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

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

We pay for covered services from the effective date of your enrollment. However, if you are in the hospital when your enrollment in our Plan begins, call our customer service department immediately at 507-204-9200 in Panama, and 1-800-424-8196 or 312-935-3671 in the United States. If you are new to the FEHB Program, we will reimburse you for your covered services while you are in the hospital beginning on the effective date of your coverage.

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

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

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

How to get approval for…

- **Your hospital stay**

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

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

Warning:

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

How to precertify an admission

We require both FFS and POS Plan members to precertify all admissions to evaluate the medical necessity of your proposed admission and the number of hospital days you will need.

- You, your representative, your doctor, or your hospital must call us at 507-204-9200 in Panama, and 1-800-424-8196 or 312-935-3671 in the United States at least 24 hours before admission.
- If you have an emergency admission due to a condition that you reasonably believe puts your life in danger or could cause serious damage to bodily function, you, your representative, the doctor, or the hospital must telephone us within two business days following the day of the emergency admission, even if you have been discharged from the hospital.
- Provide the following information:
  - Enrollee's name and Plan identification number;
  - Patient's name, birth date, and phone number;
  - Reason for hospitalization, proposed treatment, or surgery;
  - Name and phone number of admitting doctor;
  - Name of hospital or facility; and
  - Number of planned days of confinement.
- We will then tell the doctor and/or hospital the number of approved inpatient days and we will send written confirmation of our decision to you, your doctor, and the hospital.

Maternity care

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

If your hospital stay needs to be extended:

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

What happens when you do not follow the precertification rules

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

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

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

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

- For the part of the admission that was medically necessary, we will pay inpatient benefits, but

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

Exceptions :

You do not need precertification in these cases:

- You are admitted to a hospital outside the United States, and Panama.
- You have another group health insurance policy that is the primary payer for the hospital stay.
- Medicare Part A is the primary payer for the hospital stay. Note: If you exhaust your Medicare hospital benefits and do not want to use your Medicare lifetime reserve days, then we will become the primary payer and you **do** need precertification.

- **Other services**

Some services require a referral, precertification, or prior authorization. *These services are as follows:*

- All surgeries, both inpatient and outpatient must be precertified.
- For all elective (non-emergency) surgical procedures, we may require a second surgical opinion. If you fail to comply with this requirement, we will limit our payment to 50% of our Plan allowance for these surgery charges.
- For all in hospital surgical procedures not related to the original diagnosis for which you obtained precertification, we may require you to get a second surgical opinion. If you fail to comply with this requirement, we will limit our payment to 50% of our Plan allowance for these surgery charges if medical necessity can be determined.
- Growth hormone therapy (GHT)
- If designated outpatient surgical procedures (see page 33 for a complete listing) are performed on an inpatient basis, we will limit our payment to 50% of our Plan allowance. However, if it is medically necessary that you be hospitalized for the surgical procedure, we will pay our regular benefits if you have precertified your admission.
- We require you to obtain precertification 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, MRIs, Nuclear Medicine Studies (e.g. Thallium Cardiac Studies), certain Arteriographies, Genetic Studies and other similar procedures. If you fail to comply with this requirement, we will limit our payment for outpatient services to 50% of our Plan allowance and impose a $500 penalty for inpatient charges.

Section 4. Your costs for covered services

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

Copayments

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

Example: When you see a participating physician you pay a copayment of $10 per visit and when you go to a participating hospital, you pay $50.00 per admission if you belong to the POS plan. If you are a FFS member, or are a POS member and choose to go to a non-participating hospital, you pay $125.00 per admission.

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

Cost-sharing

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

Deductible

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

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

Note: This plan does not have any deductibles

Coinsurance

Coinsurance is the percentage of our allowance that you must pay for your care. Coinsurance doesn't begin until you meet your deductible.

Example: FFS members pay a 50% coinsurance for all medical services.

If your provider routinely waives your cost

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

For example, in the US, if your physician ordinarily charges $100 for a service but routinely waives your 50% coinsurance, the actual charge is $50. We will pay $25 (50% of the actual charge of $50).

Waivers

In some instances, a Panama Canal Area Benefit Plan provider may ask you to sign a "waiver" prior to receiving care. This waiver may state that you accept responsibility for the total charge for any care that is not covered by your health plan. If you sign such a waiver, whether you are responsible for the total charge depends on the contracts that the Plan has with its providers. If you are asked to sign this type of waiver, please be aware that, if benefits are denied for the services, you could be legally liable for the related expenses. If you would like more information about waivers, please contact us at 507-204-9200 in Panama, and 1-800-424-8196 or 312-935-3671 in the United States

Fee-For-Service Outpatient Maximum

Most Fee-for-Service outpatient benefits 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. If an enrollee has Self and Family enrollment, the $1,500 outpatient maximum can be reached by one or more family members.

Differences between our allowance and the bill

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

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

- **POS providers** agree to limit what they will bill you. Because of that, when you use a POS provider, your share of covered charges consists only of your copayment. Here is an example about copayment: You see a POS physician who charges $50, but our allowance is $30. You are only responsible for your copayment amount. That is, you pay just -- $10 of our $30 allowance. Because of the agreement, your POS physician will not bill you for the $20 difference between our allowance and his bill.
- **FFS providers**, on the other hand, have no agreement to limit what they will bill you. When you use a FFS provider, you will pay your coinsurance -- **plus** any difference between our allowance and charges on the bill. Here is an example: You see a FFS physician who charges $50 and our allowance is again $30. You are responsible for your coinsurance, so you pay 50% of our $30 allowance ($15). Plus, because there is no agreement between the FFS physician and us, the physician can bill you for the $20 difference between our allowance and his/her bill.

The following table illustrates the examples of how much you have to pay out-of-pocket for services from a POS physician vs. a FFS physician. The table uses our example of a service for which the physician charges $50 and our allowance is $30. The table shows the amount you pay.

EXAMPLE	POS physician	FFS physician
Physician's charge	$50	$50
Our allowance	We set it at: 30	We set it at: 30
We pay	Allowance less copay: 20	50% of our allowance: 15
You owe: Coinsurance	$10 copayment: 10	50% of our allowance: 15
+Difference up to charge?	No: 0	Yes: 20
TOTAL YOU PAY	$10	$35

Your FFS catastrophic protection out-of-pocket maximum for coinsurance

After your FFS out-of-pocket expenses for the 50% coinsurance for inpatient hospital room and board and other charges reach $2,500 in a calendar year, we will then pay the remaining hospital inpatient room and board and other charges at 100% of Plan allowance.

Out-of-pocket expenses applicable to this benefit are limited to the 50% coinsurance you pay for hospital room and board and other inpatient charges.

The following are not counted toward out-of-pocket expenses:

- Expenses in excess of our Plan allowances and 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 10-12); and
- The $125 copayment per person per admission 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 received in January before your effective date of coverage in this Plan. If you have already met your old plan's catastrophic protection benefit level in full, it will continue to apply until the effective date of your coverage in this Plan. If you have not met this expense level in full, your old plan will first apply your covered out-of-pocket expenses until the prior year's catastrophic level is reached and then apply the catastrophic protection benefit to covered out-of-pocket expenses incurred from that point until the effective date of your coverage in this Plan. Your old plan will pay these covered expenses according to this year's benefits; benefit changes are effective January 1.
If we overpay you	We will make diligent efforts to recover benefit payments we made in error but in good faith. We may reduce subsequent benefit payments to offset overpayments.
When Government facilities bill us	Facilities of the Department of Veteran Affairs, the Department of Defense, and the Indian Health Service are entitled to seek reimbursement from us for certain services and supplies they provide to you or a family member. They may not seek more than their governing laws allow.

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

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

If you…

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

Then, for your inpatient hospital care,

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

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

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

If your physician…	**Then you are responsible for…**
Participates with Medicare	your coinsurance or copayments, and any balances up to the Medicare approved amount.
Does not participate with Medicare,	Your coinsurance or copayments, and any balance up to 115% of the Medicare approved amount.

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

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

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

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

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

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

- If your physician **accepts** Medicare assignment, then you pay nothing for covered charges.
- If your physician **does not accept** Medicare assignment, then you pay the difference between the "limiting charge" or the physician's charge (whichever is less) and our payment combined with Medicare's payment.

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

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

Section 5. Benefits

(See page 7 for how our benefits changed this year and page 68 for a benefits summary.)

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

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- If you are a FFS member, almost all outpatient benefits are applied to an outpatient maximum of $650 under the self only option and $1500 under the self and family option. We added No outpatient maximum to show when the calendar year outpatient maximum does not apply.
- The FFS benefits are the standard benefits of this Plan. POS benefits apply only when you use a POS provider. When no POS provider is available, FFS benefits apply.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works, with special sections for members who are age 65 or over. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

Benefit Description	You Pay
Note: The outpatient maximum applies to almost all FFS benefits. We say (No outpatient maximum) when it does not apply.	
Diagnostic and treatment services	
Professional services of physicians • In physician's office • Office medical consultations • Physician home visits	POS: $10 copayment FFS Panama: 50% of the Panama POS Fee schedule amount and any difference between the POS Fee schedule and the billed amount FFS US: 50% of the US FFS Plan allowance (see pg 64 describing how we derive our US FFS allowance) and any difference between our allowance and the billed amount.
Professional services of physicians • In an urgent care center • Initial examination of a newborn child covered under a family enrollment • Second surgical opinion (No outpatient maximum) • In a skilled nursing facility (No outpatient maximum)	POS: Nothing FFS Panama: 50% of the Panama POS Fee schedule amount and any difference between the POS Fee schedule and the billed amount FFS US: 50% of the US FFS Plan allowance and any difference between our allowance and the billed amount
Inpatient Physician Hospital Visit Note: Under the FFS option this benefit is limited to $ 35 per day per doctor	POS: Nothing FFS Panama: Nothing up to $35 per doctor per day and all charges thereafter FFS US: Nothing up to $35 per doctor per day and all charges thereafter (No outpatient maximum)

Benefit Description	You Pay
Lab, X-ray and other diagnostic tests	
Tests, such as: • Blood tests • Urinalysis • Non-routine pap tests • Pathology • X-rays • Non-routine Mammograms • CAT Scans/MRI • Ultrasound • Electrocardiogram and EEG	POS: Nothing FFS Panama: 50% of the Panama POS Fee schedule amount and any difference between the POS Fee schedule and the billed amount FFS US: 50% of the US FFS Plan allowance and any difference between our allowance and the billed amount Note: If your POS provider uses a FFS lab or radiologist, we will pay FFS benefits for those lab and X-ray charges.
Preventive care, adult	
Routine Medical Check-up by your Primary Care Physician (two check-ups per calendar year) Note: These routine check-ups include toe nail clipping for diabetics, and annual digital prostate exam (rectal exam) for men age 40 and over. Visit to a nutritionist or licensed dietician with a referral from your Primary Care Physician.	POS: Nothing FFS Panama: All charges FFS US: All charges
Routine screenings, limited to: • Total Blood Cholesterol-once every three years or fasting lipoprotein profile, once every five years • Abdominal Aortic Aneurysm Screening-ultrasonography, one between the age of 65 and 75, for men with history of smoking. • Chlamydial infection • Colorectal Cancer Screening, including - Fecal occult blood test, once annually - Sigmoidoscopy, screening – every five years starting at age 50 • Colonoscopy and Double contrast barium enema (DCBE), once every five years beginning at age 50 • One routine osteoporosis screening for women 65 and older. • One routine osteoporosis screening, beginning at age 60 for women who are at increased risk	POS: Nothing FFS Panama: 50% of the Panama POS Fee schedule amount and any difference between the POS Fee schedule and the billed amount (No outpatient maximum) FFS US: 50% of the US FFS Plan allowance and any difference between our allowance and the billed amount (No outpatient maximum)
Routine Prostate Specific Antigen (PSA) test – one annually for men age 40 and older	POS: Nothing FFS Panama: 50% of the Panama POS Fee schedule amount and any difference between the POS Fee schedule and the billed amount (No outpatient maximum) FFS US: 50% of the US FFS Plan allowance and any difference between our allowance and the billed amount (No outpatient maximum)

Preventive care, adult - continued on next page

Benefit Description	You Pay
Preventive care, adult (cont.)	
Routine mammogram – covered for women age 35 and older, as follows: • From age 35 through 39, one during this five year period • From age 40 through 64, one every calendar year • At age 65 and older, one every two consecutive calendar years Routine annual gynecological examination, including pap test for Adults and young women after menarche.	POS: Nothing FFS Panama: 50% of the Panama POS Fee schedule amount and any difference between the POS Fee schedule and the billed amount (No outpatient maximum) FFS US: 50% of the US FFS Plan allowance and any difference between our allowance and the billed amount (No outpatient maximum)
Adult routine immunizations endorsed by the Centers for Disease Control and Prevention (CDC): • Tetanus, diphtheria and pertussis (Tdap) vaccine – with booster once every 10 years, ages 19 to 64. • Tetanus-diphtheria (Td) booster – once every 10 years, ages 65 and over (except as provided for under Childhood immunizations) • Influenza vaccine, annually, for pregnant women, for men and women age 50 and older, for individuals with compromised immune systems and for those likely to transmit influenza to persons at high risk. • Pneumococcal vaccine, every 5 years, age 65 and older • Varicella (Chickenpox) vaccine, ages 19 to 49.	POS: Nothing FFS Panama: Not a covered benefit. You pay all billed charges. FFS US: Not a covered benefit. You pay all billed charges.
Preventive care, children	
• Childhood immunizations for dependent children under the age of 22 as follows: TDap (diphtheria, tetanus, pertussis vaccine); OPV (oral polio vaccine); Hepatitis B Vaccine; Haemophilus influenza type b vaccine (flu shot); MMR (measles, mumps, rubella vaccine); and Td (tetanus diphtheria toxoid booster). • Hepatitis A vaccine, for all infants ages 12 to 23 months. • Meningoccoal vaccine, at 11 to 12 years of age, entry to high school or 15 years of age, and for college freshmen who live in a dormitory.	POS: Nothing FFS Panama: 50% of the Panama POS Fee schedule amount and any difference between the POS Fee schedule and the billed amount (No outpatient maximum) FFS US: 50% of the US FFS Plan allowance and any difference between our allowance and the billed amount (No outpatient maximum)
• Examinations, limited to: - Examinations for amblyopia and strabismus – limited to one screening examination (ages 2 through 6) - Examinations done on the day of immunizations (ages 3 up to age 22)	POS: Nothing FFS Panama: 50% of the Panama POS Fee schedule amount and any difference between the POS Fee schedule and the billed amount (No outpatient maximum) FFS US: 50% of the US FFS Plan allowance and any difference between our allowance and the billed amount (No outpatient maximum)

Preventive care, children - continued on next page

Benefit Description	You Pay
Preventive care, children (cont.)	
- Retinal screening exam performed by an ophthalmologist for infants with low birth weight (<1500 g) or gestational age of 32 weeks or less and infants weighing between 1500 g and 2000 g or gestational age of more than 32 weeks with an unstable clinical course	POS: Nothing FFS Panama: 50% of the Panama POS Fee schedule amount and any difference between the POS Fee schedule and the billed amount (No outpatient maximum) FFS US: 50% of the US FFS Plan allowance and any difference between our allowance and the billed amount (No outpatient maximum)
Maternity care	
Complete maternity (obstetrical) care, such as: • Prenatal care • Delivery • Postnatal care Note: Here are some things to keep in mind: • You do not need to precertify your normal delivery; however you must obtain precertification for other circumstances, such as extended stays for you or your baby. • You may remain in the hospital up to 48 hours after a regular delivery and 96 hours after a cesarean delivery. We will cover an extended stay if medically necessary . • We cover routine nursery care of the newborn child during the covered portion of the mother's maternity stay. We will cover other care of an infant who requires non-routine treatment if we cover the infant under a Self and Family Enrollment. Surgical benefits, not maternity benefits, apply to circumcision • Circumcision is covered under Surgery Benefits. (Section 5 (b)). • We pay hospitalization and surgeon services (delivery) the same as for illness and injury. See Hospital benefits (Section 5c) and Surgery benefits (Section 5(b))	POS: $10 copayment for all office visits FFS Panama: 50% of the Panama POS Fee schedule amount and any difference between the POS Fee schedule and the billed amount FFS US: 50% of the US FFS Plan allowance and any difference between our allowance and the billed amount.
Not covered: Routine sonograms to determine fetal age, size or sex	*All charges*

Benefit Description	You Pay
Family Planning	
A range of voluntary family planning services, limited to: • Voluntary sterilization (See Surgical procedures Section 5 (b)) (No outpatient maximum) • Surgically implanted contraceptives (No outpatient maximum) • Injectable contraceptive drugs (such as Depo provera) • Intrauterine devices (IUDs) (No outpatient maximum) • Diaphragms Note: We cover oral contraceptives under the prescription drug benefit (Section 5(f)).	POS: Nothing FFS Panama: 50% of the Panama POS Fee schedule amount and any difference between the POS Fee schedule and the billed amount FFS US: 50% of the US FFS Plan allowance and any difference between our allowance and the billed amount
Not covered: • *Reversal of voluntary surgical sterilization* • *Genetic counseling*	*All charges*
Infertility services	
Diagnosis and treatment of infertility including fertility drugs, except as shown in *Not covered.*	POS: $10 copayment per consultation FFS Panama: 50% of the Panama POS Fee schedule amount and any difference between the POS Fee schedule and the billed amount FFS US: 50% of the US FFS Plan allowance and any difference between our allowance and the billed amount.
Not covered: • *Infertility services after voluntary sterilization* • *Assisted reproductive technology (ART) procedures, such as:* - *artificial insemination* - *in vitro fertilization* - *embryo transfer and gamete intra-fallopian transfer (GIFT)* - *intravaginal insemination (IVI)* - *intracervical insemination (ICI)* - *intrauterine insemination (IUI)* • *Services and supplies related to ART procedures* • *Cost of donor sperm* • *Cost of donor egg*	*All charges*

Benefit Description	You Pay
Allergy care	
Allergy consultations	POS: $10 copayment for the consultation FFS Panama: 50% of the Panama POS Fee schedule amount and any difference between the POS Fee schedule and the billed amount FFS US: 50% of the US FFS Plan allowance and any difference between our allowance and the billed amount.
Testing and treatment, including materials (such as allergy serum) and allergy injections	POS: Nothing FFS Panama: 50% of the Panama POS Fee schedule amount and any difference between the POS Fee schedule and the billed amount FFS US: 50% of the US FFS Plan allowance and any difference between our allowance and the billed amount
Not covered: • *Provocative food testing* • *Sublingual allergy desensitization*	*All charges*
Treatment therapies	
• Chemotherapy and radiation therapy including medications used directly with the chemotherapy and radiation treatment Note: High dose chemotherapy in association with autologous bone marrow transplants is limited to those transplants listed on pages 35 and 36. • Medication to treat diabetes and its complications as specifically approved by the plan Note: This benefit is only available to POS members in the Republic of Panama and only covers those specific diabetes medications listed on the Plan's formulary. All other eligible medications are covered under the prescription drug benefit described on page 48. • Dialysis – Hemodialysis and peritoneal dialysis including medications used directly with the dialysis treatment. • Intravenous (IV)/Infusion Therapy – Home IV and antibiotic therapy • Growth hormone therapy (GHT) Note: Growth hormone is covered under the prescription drug benefit.	POS: Nothing FFS Panama: 50% of the Panama POS Fee schedule amount and any difference between the POS Fee schedule and the billed amount (No outpatient maximum) FFS US: 50% of the US FFS Plan allowance and any difference between our allowance and the billed amount (No outpatient maximum)

Treatment therapies - continued on next page

Benefit Description	You Pay
Treatment therapies (cont.)	
Note: – We only cover GHT when we preauthorize the treatment. Call 507-204-9200 in Panama, and 1-800-424-8196 or 312-935-3671 in the United States for pre-authorization. We will ask you to submit information that establishes that the GHT is medically necessary. Ask us to authorize GHT before you begin treatment; otherwise, we will only cover GHT services from the date you submit the information. If you do not ask or if we determine GHT is not medically necessary, we will not cover the GHT or related services and supplies. See *other services* under *How to get approval for…* in Section 3. • Respiratory and inhalation therapies	POS: Nothing FFS Panama: 50% of the Panama POS Fee schedule amount and any difference between the POS Fee schedule and the billed amount (No outpatient maximum) FFS US: 50% of the US FFS Plan allowance and any difference between our allowance and the billed amount (No outpatient maximum)
Physical and occupational therapies	
Short-term rehabilitative physical therapy (POS) or physical and occupational therapy (FFS) is provided on an inpatient or outpatient basis for up to $300 per year (POS) and $250 per year (FFS), if significant improvement can be expected within two months. Physical therapy is limited to services that assist the member to achieve and maintain self-care and improved functioning in other activities of daily living Note: The annual benefit limit for FFS option is $250.00 and the annual benefit limit for POS option is $300.00. Note: A physician must : 1) order the care; 2) identify the specific professional skills the patient requires and the medical necessity for skilled services; and 3) indicate the length of time the services are needed.	POS: $10 copayment for first visit in an authorized series and all charges over the $300 annual benefit maximum. FFS Panama: 50% of the Panama POS Fee schedule amount and any difference between the POS Fee schedule and the billed amount and all charges over the $250 annual benefit maximum FFS US: 50% of the US FFS Plan allowance and any difference between our allowance and the billed amount and all charges over the $250 annual benefit maximum.
Not covered: • *Long-term rehabilitative therapy* • *Exercise programs* • *Occupational Therapy (POS)*	*All charges*
Speech therapy	
• Speech therapy is covered up to $ 250 annually in all situations where it is medically necessary.	POS: $10 copayment for first visit in an authorized series and all charges over the $250 annual benefit maximum. FFS Panama: 50% of the Panama POS Fee schedule amount and any difference between the POS Fee schedule and the billed amount and all charges over the $250 annual benefit maximum FFS US: 50% of the US FFS Plan allowance and any difference between our allowance and the billed amount and all charges over the $250 annual benefit maximum.

Benefit Description	You Pay
Hearing services (testing, treatment, and supplies)	
• Hearing Exam-annual audiologic screening test • Routine Screening, testing, diagnostic evaluations and treatment for adults and children once every five years. • Hearing aid for children up to age 10 once every five years.	POS: $10 copayment FFS Panama: 50% of the Plan Allowance and any difference between our allowance and the billed amount FFS US: 50% of the Plan Allowance and any difference between our allowance and the billed amount
• $1000 lifetime maximum for hearing aids for adults	POS: $10 copayment and all charges over the $1000 lifetime benefit maximum FFS Panama: 50% of the Plan Allowance and any difference between our allowance and the billed amount and all charges over the $1000 lifetime benefit maximum FFS US: 50% of the Plan Allowance and any difference between our allowance and the billed amount and all charges over the $1000 lifetime benefit maximum
Not covered: • Hearing testing, except as mentioned above • Hearing aids, except as mentioned above	*All charges*
Vision services (testing, treatment, and supplies)	
• One pair of eyeglasses or contact lenses to correct an impairment directly caused by accidental ocular injury or intraocular surgery (such as for cataracts) Note: Eyeglasses or contact lenses are only covered within one year after intraocular surgery (such as cataracts) or after suffering an ocular injury, if the intraocular lens inserted during the surgery does not correct your vision.	POS: Nothing FFS Panama: 50% of the Panama POS Fee schedule amount and any difference between the POS Fee schedule and the billed amount FFS US: 50% of the US FFS Plan allowance and any difference between our allowance and the billed amount (No outpatient maximum)
Not covered: • *Eyeglasses or contact lenses and examinations for them, except as shown above* • *Eye exercises and orthoptics* • *Radial keratotomy and other refractive surgery*	*All charges*
Foot care	
Routine foot care when you are under active treatment for a metabolic or peripheral vascular disease, such as diabetes.	POS: $10 copayment FFS Panama: 50% of the Panama POS Fee schedule amount and any difference between the POS Fee schedule and the billed amount FFS US: 50% of the US FFS Plan allowance and any difference between our allowance and the billed amount
Not covered:	*All charges*

Foot care - continued on next page

Benefit Description	You Pay
Foot care (cont.)	
• *Cutting, trimming or removal of corns, calluses, or the free edge of toenails, and similar routine treatment of conditions of the foot, except as stated above* • *Treatment of weak, strained or flat feet or bunions or spurs; and of any instability, imbalance or subluxation of the foot (unless the treatment is by open cutting surgery)*	*All charges*
Orthopedic and prosthetic devices	
• Externally worn breast prostheses and surgical bras, including necessary replacements following a mastectomy. Note: Externally worn breast prostheses are limited to one per year • Internal prosthetic devices, such as artificial joints, pacemakers, cochlear implants, and surgically implanted breast implant following mastectomy. Note: See 5(b) for coverage of the surgery to insert the device. (No outpatient maximum)	POS: Nothing FFS Panama: 50% of the Panama POS Fee schedule amount and any difference between the POS Fee schedule and the billed amount FFS US: 50% of the US FFS Plan allowance and any difference between our allowance and the billed amount
Not covered: • *Artificial limbs and eyes; stump hose* • *Orthopedic and corrective shoes* • *Arch supports* • *Foot orthotics* • *Heel pads and heel cups* • *Lumbosacral supports* • *Corsets, trusses, elastic stockings, support hose, and other supportive devices*	*All charges*
Durable medical equipment (DME)	
Durable medical equipment (DME) is equipment and supplies that: • Are prescribed by your attending physician (i.e., the physician who is treating your illness or injury) • Are medically necessary; • Are primarily and customarily used only for a medical purpose; • Are generally useful only to a person with an illness or injury; • Are designed for prolonged use; and • Serve a specific therapeutic purpose in the treatment of an illness or injury	POS: All charges FFS Panama: All charges FFS US: All charges
Not covered: All DME such as • *Oxygen*	*All charges*

Durable medical equipment (DME) - continued on next page

Benefit Description	You Pay
Durable medical equipment (DME) (cont.)	
• *Dialysis equipment* • *Hospital beds* • *Wheelchairs* • *Crutches* • *Walkers*	*All charges*
Home health services	
40 visits per calendar year when: • A registered nurse (R.N.), licensed practical nurse (L.P.N.), licensed vocational nurse (L.V.N.) or physiotherapist provides the services; • The attending physician orders the care; • The physician identifies the specific professional skills required by the patient and the medical necessity for skilled services; and • The physician indicates the length of time the services are needed. Note: Up to 4 hours of skilled services equal one visit	POS: Nothing FFS Panama: 50% of the Panama POS Fee schedule amount and any difference between the POS Fee schedule and the billed amount FFS US: 50% of the US FFS Plan allowance and any difference between our allowance and the billed amount (No outpatient maximum)
Not covered: • *Nursing care requested by, or for the convenience of, the patient or the patient's family;* • *Home care primarily for personal assistance that does not include a medical component and is not diagnostic, therapeutic, or rehabilitative*	*All charges*
Chiropractic	
Chiropractic Services – By a physician or licensed doctor of chiropractic medicine for pain management, asthma and arthritis up to the benefit maximum of $250 per calendar year • Manipulation of the spine and extremities • Adjunctive procedures such as ultrasound, electrical muscle stimulation, vibratory therapy, and cold pack application	POS: $10 copayment for first visit in an authorized series and all charges over the $250 annual benefit maximum. FFS Panama: 50% of the Panama POS Fee schedule amount and any difference between the POS Fee schedule and the billed amount and all charges over the $250 annual benefit maximum FFS US: 50% of the US FFS Plan allowance and any difference between our allowance and the billed amount and all charges over the $250 annual benefit maximum.
Alternative treatments	
Acupuncture – by a doctor of medicine or osteopathy for: anesthesia orpain relief, up to the benefit maximum of $250 per calendar year	POS: $10 copayment for first visit in an authorized series and all charges over the $250 annual benefit maximum. FFS Panama: 50% of the Panama POS Fee schedule amount and any difference between the POS Fee schedule and the billed amount and all charges over the $250 annual benefit maximum FFS US: 50% of the US FFS Plan allowance and any difference between our allowance and the billed amount and all charges over the $250 annual benefit maximum.
Not covered:	*All charges*

Alternative treatments - continued on next page

Benefit Description	You Pay
Alternative treatments (cont.)	
Naturopathic services *(Note: Benefits of certain alternative treatment providers may be covered in medically underserved areas; see page 8)*	*All charges*
Educational classes and programs	
Coverage is limited to: • Smoking Cessation – Up to $100 for one smoking cessation program per member per lifetime, including all related expenses such as drugs.	POS: Nothing up to $100. All charges greater than $100 FFS Panama: Nothing up to $100. All charges greater than $100 FFS US: Nothing up to $100. All charges greater than $100
Diabetes Management program	
• Diabetes Management-Limited to Panama POS* Eligibility Requirements for the Diabetes Management Program: • Diabetes diagnosis established through the diabetes diagnosis protocol • PCP notification to AXA of the patient's inclusion in the diabetes program Available Benefits through the Diabetes Management Program: • HbA1c at no cost to the patient; every 6 months for patients with results within accepted standards and every 3 months for patients with abnormal results • Annual determination of fasting lipid profile, including: total cholesterol, HDL, triglycerides and LDL • Annual microalbuminuria test • Medication to treat diabetes and its complications as specifically approved by the Plan** • Counseling and education sessions provided by a physician as approved by the Plan • Toe nail clipping included with routine medical check-up every 6 months by the PCP • Glucometer, lancets and strips as approved by the Plan * This benefit is only available to POS members in the Republic of Panama and only covers those specific diabetes medications listed on the Plan's formulary for diabetes. All other eligible medications are covered under the prescription drug benefit of the Plan.	POS: Nothing* FFS Panama: All charges FFS US: All charges

Benefit Description	You Pay
Osteoporosis Management program	
• Osteoporosis Management-Limited to Panama POS* Eligibility Requirements for the Osteoporosis Management Program: • Women (65 years old or older) diagnosed with osteoporosis through a bone density study • Women between 60 and 64 years old with predisposing factors • Patients with chronic back pain with a documented history of this problem and a reference by their PCP Available Benefits through the Osteoporosis Management Program: • Annual bone density study for women 65 and older • Annual bone density study beginning at age 60 for women who are at increased risk for osteoporosis • Counseling and education sessions provided by a physician as approved by the Plan *This benefit is only available to POS members in the Republic of Panama. Please refer to your plan for details on specific benefits covered under the osteoporosis management program.	POS: Nothing** FFS Panama: All charges FFS US: All charges **All eligible medications are covered under the prescription drug benefit of the Plan. See Section 5 (f).

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

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- This Plan has no calendar year deductible. However, in most cases, both POS and FFS members will be asked to share the costs of the procedures in the form of a copayment or coinsurance. In some cases, FFS benefits may be applied to a FFS outpatient maximum of $650 for self only and $1500 for self and family. When the benefits apply to the FFS outpatient maximum, we say (Outpatient maximum applies)
- The FFS benefits are the standard benefits of this Plan. POS benefits apply only when you use a POS provider. When no POS provider is available, FFS benefits apply.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works, with special sections for members who are age 65 or over. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- The amounts listed below are for the charges billed by a physician or other health care professional for your surgical care. Look in Section 5(c) for charges associated with the facility (i.e. hospital, surgical center, etc.).
- **YOU MUST GET PRECERTIFICATION FOR SOME SURGICAL PROCEDURES. Please refer to the precertification information shown in Section 3 to be sure which services require precertification.**

Benefit Description	You Pay
Surgical procedures	
A comprehensive range of services, such as: • Operative procedures • Treatment of fractures, including casting • Normal pre- and post-operative care by the surgeon • Correction of amblyopia and strabismus • Endoscopy procedures • Biopsy procedures • Electroconvulsive therapy	POS: Nothing FFS Panama: 50% of the Panama POS Fee schedule amount and any difference between the POS fee schedule and the billed amount FFS US: 50% of the US FFS Plan allowance and any difference between our allowance and the billed amount. Note: For plan allowances please see page 64.
• Removal of tumors and cysts (non-cosmetic) • Correction of congenital anomalies (see Reconstructive surgery) • Surgical treatment of morbid obesity (bariatric surgery) -- a condition in which an individual weighs 100 pounds or 100% over his or her normal weight according to current underwriting standards; eligible members must be age 18 or over Note: In order to become eligible for bariatric surgery, you must:	POS: Nothing FFS Panama: 50% of the Panama POS Fee schedule amount and any difference between the POS Fee schedule and the billed amount FFS US: 50% of the US FFS Plan allowance any difference between our allowance and the billed amount

Surgical procedures - continued on next page

Benefit Description	You Pay
Surgical procedures (cont.)	
-Have a pathological obesity with a body mass index (BMI) of at least 40 -Have had a psychiatric evaluation -Understand the risks and the postoperative care involved -Not have any serious concomitant illness -Receive approval by a peer review consultant. • Insertion of internal prosthetic devices. See 5(a) – Orthopedic and prosthetic devices for device coverage information • Voluntary sterilization (e.g., Tubal ligation, Vasectomy) • Surgically implanted contraceptives • Intrauterine devices (IUDs) • Eye surgery • Treatment of burns Note: You must precertify all surgical procedures. In additional, we may require you to obtain a second surgical opinion for certain procedures. If you are planning to have a surgery, please call our medical department at 507-204-9200 in Panama, and 1-800-424-8196 or 312-935-3671 in the United States to precertify and determine whether or not we require a second opinion for your specific procedure. If you do not precertify or obtain a required second opinion for your procedure, you will be responsible for 50%. You pay nothing for the second surgical opinion if we require you to obtain it. If you are a Panama POS member, you must obtain prior authorization for a second opinion or surgical procedure to be rendered outside of Panama prior to leaving Panama by contacting the medical department at 507-204-9200.	POS: Nothing FFS Panama: 50% of the Panama POS Fee schedule amount and any difference between the POS Fee schedule and the billed amount FFS US: 50% of the US FFS Plan allowance any difference between our allowance and the billed amount
When multiple or bilateral surgical procedures performed during the same operative session add time or complexity to patient care, our benefits are: • For the primary procedure: - POS: 100% of the POS fee schedule amount or - FFS: 50% of the plan allowance • For the secondary procedure(s): - POS: 100% of one-half of the POS fee schedule amount or - FFS: 50% of one-half of the plan allowance	POS: Nothing FFS Panama: 50% of the Panama POS Fee schedule amount for the primary procedure and 50% of one-half of the Plan allowance for the secondary procedure(s); and any difference between our payment and the billed amount FFS US: 50% of the US FFS Plan allowance for the primary procedure and 50% of one-half of the Plan allowance for the secondary procedure(s); and any difference between our payment and the billed amount

Surgical procedures - continued on next page

Benefit Description	You Pay
Surgical procedures (cont.)	
Note: Multiple or bilateral surgical procedures performed through the same incision are incidental to the primary surgery. That is, the procedure would not add time or complexity to patient care. We do not pay extra for incidental procedures.	POS: Nothing FFS Panama: 50% of the Panama POS Fee schedule amount for the primary procedure and 50% of one-half of the Plan allowance for the secondary procedure(s); and any difference between our payment and the billed amount FFS US: 50% of the US FFS Plan allowance for the primary procedure and 50% of one-half of the Plan allowance for the secondary procedure(s); and any difference between our payment and the billed amount
Not covered: • *Reversal of voluntary sterilization* • *Services of an assistant surgeon, except when required by law* • *Services of a standby surgeon, except during angioplasty or other high risk procedures when we determine standbys are medically necessary* • *Routine treatment of conditions of the foot; see Foot care*	*All charges*
Note: We have designated the following as outpatient surgical procedures. If you undergo one of the following procedures inpatient without explicit approval from us, we will apply a $500.00 penalty and limit our payment to 50% of our plan allowance: • Arthroscopy (internal exam of a joint) • Breast Biopsy • Bronchoscopy (internal exam of lung), adult, with or without biopsy • Cataract removal • Cystourethroscopy • 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 (incision of the membrane in ear) • Prostate biopsy • Reduction of nasal fracture, open or closed • Vasectomy (male sterilization). Note: All surgeries, both inpatient and outpatient, must be certified. See page 12.	

Benefit Description	You Pay
Reconstructive surgery	
• Surgery to correct a functional defect • Surgery to correct a condition caused by injury or illness if: - the condition produced a major effect on the member's appearance and - the condition can reasonably be expected to be corrected by such surgery • Surgery to correct a condition that existed at or from birth and is a significant deviation from the common form or norm. Examples of congenital anomalies are: protruding ear deformities; cleft lip; cleft palate; birth marks; and webbed fingers and toes. • All stages of breast reconstruction surgery following a mastectomy, such as: - Surgery to produce a symmetrical appearance of breasts; - treatment of any physical complications, such as lymphedemas; - breast prostheses; and surgical bras and replacements (see Prosthetic devices for coverage)	POS: Nothing FFS Panama: 50% of the Panama POS Fee schedule amount and any difference between the POS Fee schedule and the billed amount FFS US: 50% of the US FFS Plan allowance and any difference between our allowance and the billed amount
Note: We pay for internal breast prostheses as hospital benefits. Note: If you need a mastectomy, you may choose to have the procedure performed on an inpatient basis and remain in the hospital up to 48 hours after the procedure.	
Not covered: • *Cosmetic surgery – any surgical procedure (or any portion of a procedure) performed primarily to improve physical appearance through change in bodily form, except repair of accidental injury.* • *Surgeries related to sex transformation or sexual dysfunction*	*All charges*
Oral and maxillofacial surgery	
Oral surgical procedures, limited to: • Reduction of fractures of the jaws or facial bones • Surgical correction of cleft lip, cleft palate or severe functional malocclusion • Removal of stones from salivary ducts • Excision of leukoplakia or malignancies • Excision of cysts and incision of abscesses when done as independent procedures	POS: Nothing FFS Panama: 50% of the Panama POS Fee schedule amount and any difference between the POS fee schedule and the billed amount FFS US: 50% of the US FFS Plan allowance and any difference between our allowance and the billed amount.

Oral and maxillofacial surgery - continued on next page

Benefit Description	You Pay
Oral and maxillofacial surgery (cont.)	
• Other surgical procedures that do not involve the teeth or their supporting structures	POS: Nothing FFS Panama: 50% of the Panama POS Fee schedule amount and any difference between the POS fee schedule and the billed amount FFS US: 50% of the US FFS Plan allowance and any difference between our allowance and the billed amount.
Not covered: • *Oral implants and transplants* • *Procedures that involve the teeth or their supporting structures (such as the periodontal membrane, gingiva, and alveolar bone)*	*All charges*
Organ/tissue transplants	
Solid organ transplants limited to: • Cornea • Heart • Heart/lung • Single, double or lobar lung • Kidney • Liver • Pancreas • Intestinal transplants - Small intestine - Small intestine with the liver - Small intestine with multiple organs, such as the liver, stomach, and pancreas Blood or marrow stem cell transplants limited to the stages of the following diagnoses: (Medical necessity is considered satisfied if the patient meets the staging description) • Allogeneic transplants for - Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia - Chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL) - Advanced Hodgkin's lymphoma - Advanced non-Hodgkin's lymphoma - Chronic myelogenous leukemia - Hemoglobinopathy (i.e. Fanconi's, Thalessemia major) - Myelodysplasia/Myelodysplastic syndromes - Severe combined immunodeficiency	POS: Nothing FFS Panama: 50% of the Panama POS Fee schedule amount and any difference between the POS fee schedule and the billed amount FFS US: 50% of the US FFS Plan allowance and any difference between our allowance and the billed amount.

Organ/tissue transplants - continued on next page

Benefit Description	You Pay
Organ/tissue transplants (cont.)	
- Severe or very severe aplastic anemia - Amyloidosis • Autologous transplants for - Acute lymphocytic or nonlymphocytic (i.e., myelogenous) leukemia - Advanced Hodgkin's lymphoma - Advanced non-Hodgkin's lymphoma - Neuroblastoma - Amyloidosis • Autologous tandem transplants for - Recurrent germ cell tumors (including testicular cancer) - Multiple myeloma - De-novo myeloma Blood or marrow stem cell transplants for • Allogeneic transplants for - Phagocytic/Hemophagocytic deficiency diseases (e.g., Wiskott-Aldrich syndrome) • Autologous transplants for - Multiple myeloma - Testicular, mediastinal, retroperitoneal, and ovarian germ cell tumors - Breast cancer - Epithelial ovarian cancer - Waldenstrom's macroglobulinemia	POS: Nothing FFS Panama: 50% of the Panama POS Fee schedule amount and any difference between the POS fee schedule and the billed amount FFS US: 50% of the US FFS Plan allowance and any difference between our allowance and the billed amount.
Mini-transplants (non-myeloblative, reduced intensity conditioning) for covered transplants: Subject to medical necessity	
Tandem transplants for covered transplants: Subject to medical necessity	
Note: We cover related medical and hospital expenses of the donor when we cover the recipient. If you are a Panama POS member, you must obtain prior authorization for a second opinion or surgical procedure to be rendered outside of Panama prior to leaving Panama by contacting the medical department at 507-204-9200.	
Not covered: • *Donorscreening tests and donor search expenses, except those performed for the actual donor*	*All charges*

Organ/tissue transplants - continued on next page

Benefit Description	You Pay
Organ/tissue transplants (cont.)	
• *Implants of artificial organs* • *Transplants not listed as covered*	*All charges*
Anesthesia	
Professional services provided in – • Hospital (inpatient)	POS: Nothing FFS Panama: 50% of the Panama POS Fee schedule amount and any difference between the POS fee schedule and the billed amount FFS US: 50% of the US FFS Plan allowance and any difference between our allowance and the billed amount.
Professional services provided in – • Hospital outpatient department • Skilled nursing facility • Ambulatory surgical center • Office	POS: Nothing FFS Panama: 50% of the Panama POS Fee schedule amount and any difference between the POS Fee schedule and the billed amount FFS US: 50% of the US FFS Plan allowance and any difference between our allowance and the billed amount Note: If your POS provider uses a nonparticipating anesthesiologist, we will pay FFS benefits for those anesthesia charges

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

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- In this section a $50 per admission copayment for POS members and a $125 per admission copayment for FFS members applies to only a few benefits
- The FFS benefits are the standard benefits of this Plan. POS benefits apply only when you use a POS provider. When no POS provider is available, FFS benefits apply. FFS Outpatient maximum does not apply for any of these services.
- Be sure to read Section 4, *your costs for covered services* for valuable information about how cost sharing works, with special sections for members who are age 65 or over. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- The amounts listed below are for the charges billed by the facility (i.e. hospital or surgical center) or ambulance service for your surgery or care. Any costs associated with the professional charge (i.e. physicians, etc.) are in Sections 5(a) or (b).
- **YOU MUST GET PRECERTIFICATION FOR HOSPITAL STAYS; FAILURE TO DO SO WILL RESULT IN A MINIMUM $500 PENALTY.** Please refer to the precertification information shown in Section 3 to be sure which services require precertification.

Benefit Description	You Pay
Inpatient hospital	
Room and board, such as • Ward, semiprivate, or intensive care accommodations; • General nursing care; and • Meals and special diets. Note: We only cover a private room when you must be isolated to prevent contagion. Otherwise, we will pay the hospital's average charge for semiprivate accommodations. If the hospital only has private rooms, we base our payment on the average semiprivate rate of the most comparable hospital in the area. Note: When the FFS hospital bills a flat rate, we prorate the charges to determine how to pay them, as follows: 30% room and board and 70% other charges.	POS: Nothing after the $50 per admission copayment FFS Panama: $125 per admission, then 50% of the Panama POS fee schedule amount and any difference between the POS Fee schedule and the billed amount FFS US: $125 per admission and 50% of the covered charges Note: When you select the POS option and are readmitted to a participating hospital with the same diagnosis within 30 days of being discharged, we will waive the $50 copayment for the readmission
Other hospital services and supplies, such as: • Operating, recovery, maternity, and other treatment rooms • Prescribed drugs and medicines • Diagnostic laboratory tests and X-rays • Blood or blood plasma, if not donated or replaced • Dressings, splints, casts, and sterile tray services • Medical supplies and equipment, including oxygen	POS: Nothing after the $50 per admission copayment FFS Panama: $125 per admission, then 50% of the Panama POS fee schedule amount and any difference between the POS Fee schedule and the billed amount FFS US: $125 per admission and 50% of the covered charges

Inpatient hospital - continued on next page

Benefit Description	You Pay
Inpatient hospital (cont.)	
• Anesthetics, including nurse anesthetist services • Take-home items • Medical supplies, appliances, medical equipment, and any covered items billed by a hospital for use at home. Note: We base payment on whether the facility or health care professional bills for the services or supplies. For example, when the hospital bills for its nurse anesthetists' services, we pay Hospital benefits and when the anesthesiologist bills, we pay Surgery benefits.	POS: Nothing after the $50 per admission copayment FFS Panama: $125 per admission, then 50% of the Panama POS fee schedule amount and any difference between the POS Fee schedule and the billed amount FFS US: $125 per admission and 50% of the covered charges Note: When you select the POS option and are readmitted to a participating hospital with the same diagnosis within 30 days of being discharged, we will waive the $50 copayment for the readmission
Notcovered: • *Any part of a hospital admission that is not medically necessary (see definition), such as when you do not need acute hospital inpatient (overnight) care, but could receive care in some other setting without adversely affecting your condition or the quality of your medical care. Note: In this event, we pay benefits for services and supplies other than room and board and in-hospital physician care at the level they would have been covered if provided in an alternative setting* • *Custodial care; see definition.* • *Non-covered facilities, such as nursing homes, schools.* • *Personal comfort items, such as telephone, television, barber services, guest meals and beds* • *Private nursing care*	*All charges*
Outpatient hospital or ambulatory surgical center	
• Operating, recovery, and other treatment rooms • Prescribed drugs and medicines • Diagnostic laboratory tests, X-rays, and pathology services • Administration of blood, blood plasma, and other biologicals • Blood and blood plasma, if not donated or replaced • Pre-surgical testing • Dressings, casts, and sterile tray services • Medical supplies, including oxygen • Anesthetics and anesthesia service	POS: $50 copayment to facility for surgeries in operating room and nothing for other services FFS Panama: 50% of the Panama POS Fee schedule amount and any difference between the POS Fee schedule and the billed amount FFS US: 50% of the US FFS Plan allowance and any difference between our allowance and the billed amount

Outpatient hospital or ambulatory surgical center - continued on next page

Benefit Description	You Pay
Outpatient hospital or ambulatory surgical center (cont.)	
Note: – We cover hospital services and supplies related to dental procedures when necessitated by a non-dental physical impairment. We do not cover the dental procedures.	POS: $50 copayment to facility for surgeries in operating room and nothing for other services FFS Panama: 50% of the Panama POS Fee schedule amount and any difference between the POS Fee schedule and the billed amount FFS US: 50% of the US FFS Plan allowance and any difference between our allowance and the billed amount
Extended care benefits/Skilled nursing care facility benefits	
Skilled nursing facility (SNF): We cover semiprivate room, board, services and supplies in a SNF for up to 60 days per confinement when: 1) You are admitted directly from a pre-certified hospital stay of at least 3 consecutive days; and 2) You are admitted for the same condition as the hospital stay; and 3) Your skilled nursing care is supervised by a physician and provided by an R.N., L.P.N., or L.V.N.; and 4) SNF care is medically appropriate.	POS: Nothing FFS Panama: 50% of the Panama POS Fee schedule amount and any difference between the POS fee schedule and the billed amount FFS US: 50% of the US FFS Plan allowance and any difference between our allowance and the billed amount.
Extended care benefit: Sub-Acute Care: We cover room, board (i.e., meals) and general nursing services, in a hospital or sub-acute care facility, when we determine that you are eligible for this less acute hospital care.	POS: Nothing FFS: Not an eligible benefit outside of the POS network
Not Covered: Custodial care	*All charges*
Hospice care	
Hospice is a coordinated program of maintenance and supportive care for the terminally ill provided by a medically supervised team under the direction of a Plan-approved independent hospice administration. • We pay $5000 per lifetime	POS: Nothing up to lifetime maximum of $5000. All charges after the $5000 maximum FFS Panama: 50% of the Panama POS Fee schedule amount and any difference between the POS Fee schedule and the billed amount. You pay all charges after the $5000 lifetime benefit maximum FFS US: 50% of the US FFS Plan allowance and any difference between our allowance and the billed amount. You pay all charges after the $5000 lifetime benefit maximum
Not covered: Independent nursing, homemakerservices	*All charges*

Benefit Description	You Pay
Ambulance	
• Professional ambulance service when medically appropriate • Under the POS option, we pay a maximum of $100 per incident for intra-province ambulance service that results in transfer between medical facilities or medical facility and patient's home. • Under the POS option, we pay a maximum of $200 per incident for inter-province ambulance service that results in transfer between medical facilities or medical facility and patient's home. • Under the FFS option, we pay a maximum of $100 per incident that results in transfer between medical facilities or medical facility and patient's home. • We require you to pre-authorize the use of an ambulance if it is not an emergency situation. NOTE: Under FFS benefits, we make no distinction between intra and inter-province ambulance use. The FFS benefit maximum is $100.	POS: Nothing. All charges after $100 maximum for intra-province ambulance use and $200 for inter-province ambulance use. FFS Panama: 50% of the Panama POS Fee schedule amount and any difference between the POS fee schedule and the billed amount. All charges after the $100 maximum FFS US: 50% of the US FFS Plan allowance and any difference between our allowance and the billed amount. All charges after the $100 maximum

Section 5(d). Emergency services/accidents

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Please remember, we require both FFS and POS Plan members to precertify all admissions to evaluate th*e medical necessity of your proposed admissions and the number of hospital days you will need.*
- Emergency and accident services listed below are not subject to FFS outpatient maximum.
- The FFS benefits are the standard benefits of this Plan. POS benefits apply only when you use a POS provider. When no POS provider is available, FFS benefits apply.
- If you have an emergency admission due to a condition that you reasonably believe puts your life in danger or could cause serious damage to bodily function, you, your representative, the doctor, or the hospital must telephone us within two business days following the day of the emergency admission, even if you have been discharged from the hospital.
- Be sure to read Section 4, *Your costs for covered services,* for valuable information about how cost sharing works, with special sections for members who are age 65 or over. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

What is an accidental injury?

An accidental injury is a bodily injury sustained solely through violent, external, and accidental means, such as broken bones, animal bites, and poisonings. We cover dental care for accidental injury up to a maximum of $ 250.

Benefit Description	You pay
Accidental injury	
If you receive care for your accidental injury within 72 hours, we cover: • Physician services and supplies • Related outpatient hospital services Note: We pay Hospital benefits if you are admitted.	POS: Nothing FFS Panama: 50% of the Panama POS Fee schedule amount and any difference between the POS Fee schedule and the billed amount FFS US: 50% of the US FFS Plan allowance and any difference between our allowance and the billed amount
If you receive care for your accidental injury after 72 hours, we cover: • Physician services and supplies • Surgical care Note: We pay Hospital benefits if you are admitted.	POS: $10 copayment for office visit or emergency room visit FFS Panama: 50% of the Panama POS Fee schedule amount and any difference between the POS Fee schedule and the billed amount FFS US: 50% of the US FFS Plan allowance and any difference between our allowance and the billed amount
Medical emergency	
Outpatient medical or surgical services and supplies	POS: $10 facility copayment for emergency room visit or office visit. FFS Panama: 50% of the Panama POS Fee schedule amount and any difference between the POS fee schedule and the billed amount FFS US: 50% of the US FFS Plan allowance and any difference between our allowance and the billed amount.

Medical emergency - continued on next page

Benefit Description	You pay
Medical emergency (cont.)	
Note: We define medical emergency as the sudden and unexpected onset of a condition requiring immediate medical care, in the judgment of a lay person with average knowledge of medical science. The severity of the condition as revealed by the doctor's diagnosis must be such as would normally require emergency care. Examples of medical emergencies include heart attacks, cardiovascular accidents, poisoning, and loss of consciousness or respiration, convulsions, etc. Examples of non emergent care are refilling of medications, rash, common cold, sore throat, cough, physical exam, hemorrhoids, diarrhea and runny nose. It is the member's responsibility to notify the Panama Canal Area Benefit Plan within 48 hours of onset of the emergency room visit at 507-204-9200 in Panama, and 1-800-424-8196 or 312-935-3671 in the United States. If you are under the Point of Service option, traveling outside of Panama, and require medical emergency care, you will be covered at the POS benefit level. Medical services received while traveling outside of Panama for conditions not serious enough to be classified as emergencies, will be reimbursed under the FFS benefit provisions. You will usually have to pay directly for care for medical services provided to you outside of Panama and then we will reimburse you according to the benefits described in this brochure. However, if the provider agrees to file the claim directly to the plan, he/she should send a completed Claim Form and the itemized bills to the Panama Canal Area Benefit Plan at AXA assistance, PO Box 31-0940, Miami Florida 33231-0940. Medical services received while traveling outside of the service area for conditions not serious enough to be classified as emergencies, will be reimbursed under the FFS benefit provisions.	POS: $10 facility copayment for emergency room visit or office visit. FFS Panama: 50% of the Panama POS Fee schedule amount and any difference between the POS fee schedule and the billed amount FFS US: 50% of the US FFS Plan allowance and any difference between our allowance and the billed amount.
Ambulance	
We pay reasonable and customary charges up to $100 per incident for intra-province ambulance use and $200 for inter-province ambulance use that results in admission to a hospital or transfer between medical facilities, when Preauthorization is obtained and services are provided by a Plan participating ambulance service provider.	POS: Nothing. All charges after $100 maximum for intra-province ambulance use and $200 for inter-province ambulance use FFS Panama: 50% of the Panama POS Fee schedule amount and any difference between the POS fee schedule and the billed amount. All charges after $100 maximum FFS US: 50% of the US FFS Plan allowance and any difference between our allowance and the billed amount. All charges after $100 maximum

Ambulance - continued on next page

Benefit Description	You pay
Ambulance (cont.)	
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 reasonable and customary charges. NOTE: Under FFS benefits, we make no distinction between intra and inter-province ambulance use. The FFS benefit maximum is $100. Note: See 5 (c) for non-emergent service	POS: Nothing. All charges after $100 maximum for intra-province ambulance use and $200 for inter-province ambulance use FFS Panama: 50% of the Panama POS Fee schedule amount and any difference between the POS fee schedule and the billed amount. All charges after $100 maximum FFS US: 50% of the US FFS Plan allowance and any difference between our allowance and the billed amount. All charges after $100 maximum
Air Ambulance In certain extreme emergency situations we may pay for air ambulance services to transfer a Panama member either from outlying areas in the Republic of Panama to Panama City, or from Panama to the United States if you require care that we determine cannot be adequately provided in the Republic of Panama.	POS: Nothing FFS Panama: 50% of the Panama POS Fee schedule amount and any difference between the POS fee schedule and the billed amount FFS US: Not an eligible benefit

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

You may choose to get care as Point-of-Service or Fee-for-Service. When you receive POS care, you must get our approval for services and follow a treatment plan we approve. If you do, cost-sharing and limitations for POS mental health and substance abuse benefits will be no greater than for similar benefits for other illnesses and conditions.

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- The outpatient and inpatient copayments apply to almost all benefits in this Section. We added (No copayment) to show when a copayment does not apply.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- **YOU MUST GET PREAUTHORIZATION FOR THESE SERVICES.** See the instructions after the benefits descriptions below.
- POS mental health and substance abuse benefits are below, then Fee-for-Service benefits begin on page 46.

Point-of-Service benefit

Description	You pay
All diagnostic and treatment services contained in a treatment plan that we approve. The treatment plan may include services, drugs, and supplies described elsewhere in this brochure. Note: POS benefits are payable only when we determine the care is clinically appropriate to treat your condition and only when you receive the care as part of a treatment plan that we approve.	Your cost sharing responsibilities are no greater than for other illnesses or conditions.
• Professional services, including individual or group therapy by providers such as psychiatrists, psychologists, or clinical social workers • Medication management	$10 copayment per visit
• Diagnostic tests	(Nothing)
• Services provided by a hospital or other facility • Services in approved alternative care settings such as partial hospitalization, half-way house, residential treatment, full-day hospitalization, facility based intensive outpatient treatment	$ 50 per admission copayment or $ 10 copayment per office visit
Not covered: Services we have not approved. *Note:OPM will base its review of disputes about treatment plans on the treatment plan's clinical appropriateness. OPM will generally not order us to pay or provide one clinically appropriate treatment plan in favor of another.*	*All charges*

Preauthorization

To be eligible to receive these enhanced mental health and substance abuse benefits you must obtain a treatment plan and follow all of the following network authorization processes. These include:

- After your initial visit to your PCP (with a mental health illness) or a POS mental health provider, you or your provider must contact our medical department at 507-204-9200 in Panama, and 1-800-424-8196 or 312-935-3671 in the United States. Our case management nurses and medical director will work with you and your mental health provider to develop a treatment plan for you.
- If you are initially diagnosed with a mental health illness while in the hospital or emergency room, you, your representative, your doctor or the hospital must contact us within 48 hours so that we may coordinate a treatment Plan with you and your mental health provider.

If you fail to follow these obligations or do not follow your prescribed treatment Plan, we will reimburse you at the Panama FFS benefit level.

Network limitation

If you do not obtain an approved treatment plan, we will provide only Fee-for-Service benefits.

Fee-For-Service Benefit
Mental Health and Substance Abuse Benefit

Description	You Pay
Outpatient Care *Mental Health:* We pay for a maximum of 30 visits per calendar year. This benefit is subject to the outpatient maximum limits of $650 (self only) and $1500 (self and family).	FFS Panama: 50% of the Panama POS Fee schedule amount and any difference between the POS fee schedule and the billed amount FFS US: 50% of the US FFS Plan allowance and any difference between our allowance and the billed amount
Substance Abuse: We pay a maximum of $30 per session with a licensed Psychologist or clinical social worker. This benefit has a $600 calendar year maximum and is subject to the outpatient maximum.	FFS Panama: 50% of the Panama POS Fee schedule amount and any difference between the POS fee schedule and the billed amount FFS US: 50% of the US FFS Plan allowance and any difference between our allowance and the billed amount.
Inpatient hospital *Mental Health*: We pay for up to 90 days per calendar year *Substance Abuse*: We pay for up to 30 days per calendar year up to a Plan limit of $700.	FFS Panama: 50% of Panama POS Fee schedule amount and any difference between the POS fee schedule and the billed amount. $125 per admission deductible applies. FFS US: 50% of US FFS Plan allowance and any difference between our allowance and the billed amount. $125 per admission deductible applies.
Inpatient professional charges: We pay our allowance for a maximum of one visit per day per doctor.	FFS Panama: You pay all charges in excess of $35 per doctor per day. FFS US: You pay all charges in excess of $35 per doctor per day.

Description	You Pay
Not covered FFS: • *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)*	*All charges*

Precertification The medical necessity of your admission to a hospital or other covered facility must be pre-certified for you to receive these Fee-for-Service benefits. Emergency admissions must be reported within two business days following the day of admission even if you have been discharged. Otherwise, benefits will be reduced by $500. See Section 3 for details.

- See Sections 7, *Filing a claim for covered services*, for information about submitting FFS claims.

Section 5(f). Prescription drug benefits

Important things you should keep in mind about these benefits:

- We cover FDA approved prescribed drugs and medications (and their equivalents), as described in the chart below.
- Please remember that all benefits are subject to the definitions, limitations and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Be sure to read Section 4, *your costs for covered services,* for valuable information about how cost sharing works, with special sections for members who are age 65 or over. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

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

- **Who can write your prescription?** A licensed physician or licensed dentist must write the prescription
- **Where you can obtain them.** You may fill the prescription at any pharmacy.
- **How to submit your claims for prescription drugs:** Claims for prescription drugs and medicines must include receipts that include the patient's name, prescription number, name of drug, prescribing doctor's name, date and charge.

Benefits Description	You Pay
Covered medications and supplies	
You may purchase the following medications and supplies prescribed by a physician from a pharmacy: • Drugs and medicines (including those administered during a non-covered admission or in a non-covered facility) that by Federal law of the United States require a physician's prescription for their purchase, except those listed as *Not covered.* • Insulin • Needles and syringes for the administration of covered medications • FDA approved prescription drugs and devices for birth control NOTE: We cover approved medications for treatment of diabetes, cancers, aplastic anemia, sickle -cell anemia, and myelodysplasia syndrome at 100%. Preauthorization is required. NOTE: Coinsurance for prescription drugs goes towards a $5000 annual prescription out-of-pocket limit (for Self Only or Self and Family enrollments)	POS: 40% of charges plus any non-covered expenses FFS Panama: 40% of charges plus any non-covered expenses FFS US: 40% of charges plus any non-covered expenses
Not covered: • *Drugs and supplies for cosmetic purposes* • *Vitamins, nutrients and food supplements even if a physician prescribes or administers them* • *Nonprescription medicines* • *Medical supplies such as dressings and antiseptics* • *Medication not FDA approved or not FDA equivalent*	*All Charges*

Note: **Why use generic drugs?** Generic drugs offer a safe and economic way to meet your prescription drug needs. The generic name of a drug is its chemical name; the name brand is the name under which the manufacturer advertises and sells a drug. Under federal law, generic and name brand drugs must meet the same standards for safety, purity, strength, and effectiveness. A generic prescription costs you – and us – less than a name brand prescription.

Section 5(g). Dental benefits

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- If you are enrolled in a Federal Employees Dental/Vision Insurance Program (FEDVIP) Dental Plan, your FEHB Plan will be First/Primary payer of any Benefit payments and your FEDVIP Plan is secondary to your FEHB Plan. See Section 9 Coordinating benefits with other coverage.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works, with special sections for members who are age 65 or over. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- Note: We cover hospitalization for dental procedures only when a non-dental physical impairment exists which makes hospitalization necessary to safeguard the health of the patient. We do not cover the dental procedure. See Section 5(c) for inpatient hospital benefits.

Accidental injury benefit	You Pay
Accidental injury benefit	
We cover restorative services and supplies necessary to promptly repair (but not replace) sound natural teeth. The need for these services must result from an accidental injury.	We pay 80% of our Plan allowance up to a maximum of $250 (per incident) for covered dental work required as a result of accidental injury that you incur within 52 weeks after the accident. You pay all charges over $250.

Dental Benefits		
Service	**We pay (scheduled allowance)**	**You pay**
Office visits for preventive care. Oral prophylaxis or periodontal maintenance limited to two visits per calendar year.	$20 per visit	All charges in excess of the scheduled amounts listed to the left
Dental Surgery		
Extraction of impacted teeth, including X-rays	$100	
Apicoectomy	$85	
Lancing of erupting tooth	$70	
Periodontics*		
Periodontal scaling and root planing	$60 per quadrant	
Endodontics*		
Root Canal treatment, including:	$120 for one canal	
• intra-oral drainage of abscess	$150 for two canals	
• devitalization	$180 for three canals	
• removal of pulp	$210 for four canals	
• root canal filling (limited to 4 canals)		
• X-rays		

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
- Tooth extractions not specified as covered above
- X-Ray not specified as covered above
- Dental surgery other than those specifically described above
- Dental surgery, appliances, and adjustments of occlusion for temporomandibular joint syndrome (TMJ)

*Note: Prior to treatment, you must submit a completed dental Pre-Treatment Estimate form to obtain approval of benefits for the work to be performed. If approval is not obtained, we will limit benefits to 50% of the fee schedule.

Section 5(h). Special features

Special feature	Description
Health support programs	The Panama Canal Area Benefit Plan offers patient education and health support programs for post-hospitalization and health maintenance in Panama. Examples of these services may include hospital discharge planning, coordination with community support, local social work services and coordination of home care services. Call the Customer Service team in Panama at (507) 204-9200 to find out what programs are available.
Flexible benefits option	Under the flexible benefits option, we determine the most effective way to provide services. • We may identify medically appropriate alternatives to traditional care and coordinate other benefits as a less costly alternative benefit. If we identify a less costly alternative, we will ask you to sign an alternative benefits agreement that will include all of the following terms. Until you sign and return the agreement, regular contract benefits will continue. • Alternative benefits will be made available for a limited time period and are subject to our ongoing review. You must cooperate with the review process. • By approving an alternative benefit, we cannot guarantee you will get it in the future. • The decision to offer an alternative benefit is solely ours, and except as expressly provided in the agreement, we may withdraw it at any time and resume regular contract benefits. • If you sign the agreement, we will provide the agreed-upon alternative benefits for the stated time period (unless circumstances change). You may request an extension of the time period, but regular benefits will resume if we do not approve your request. • Our decision to offer or withdraw alternative benefits is not subject to OPM review under the disputed claims process.
Centers of excellence	In the United States we have designated certain specialty hospitals. We strongly encourage Plan members to use them for highly specialized procedures. If you are planning to undergo a highly specialized surgical procedure such as open heart surgery, or would like additional information on these facilities, please call our case management department in Panama at 507-204-9200, and 1-800-424-8196 or 312-935-3671 in the United States.

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

The exclusions in this section apply to all benefits. There may be other exclusions and limitations listed in Section 5 of this brochure. **Although we may list a specific service as a benefit, we will not cover it unless we determine it is medically necessary to prevent, diagnose, or treat your illness, disease, injury, or condition.**

We do not cover the following:

- Services, drugs, or supplies you receive while you are not enrolled in this Plan;
- Services, drugs, or supplies not medically necessary.
- Services, drugs, or supplies not required according to accepted standards of medical, dental, or psychiatric practice;
- Experimental or investigational procedures, treatments, drugs or devices (see specifics regarding transplants);
- Services, drugs, or supplies related to abortions, except when the life of the mother would be endangered if the fetus were carried to term, or when the pregnancy is the result of an act of rape or incest
- Services, drugs, or supplies related to sex transformations;
- Services, drugs, or supplies you receive from a provider or facility barred from the FEHB Program; or
- Services, drugs, or supplies you receive without charge while in active military service.
- 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 Plan will calculate the actual provider fee or charge by reducing the fee or charge of the waived amount.
- 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 15), doctor's charges exceeding the amount specified by the Department of Health and Human Services when benefits are payable under Medicare (limiting charge) (see page 16), or State premium taxes however applied;
- Private duty nursing care services, in or out of hospital;
- Expenses to the extent they exceed the Plan allowance for the service or supply;
- 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 physical, speech or occupational therapist; or
- Eye refractions, eyeglasses and contact lenses.

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 by immediate relatives or household members, such as spouse, parent, child, brother or sister by blood, marriage or adoption;
- Furnished or billed by a non-covered 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: or
- Not provided in accordance with accepted professional medical standards in the United States and/or Panama.

Section 7. Filing a claim for covered services

How to claim benefits

To obtain claim forms, claims filing advice or answers about our benefits, contact us at 507-204-9200 in Panama, and 1-800-424-8196 or 312-935-3671 in the United States or at our Web site at http://www.axa-assistance.com.pa.

In most cases, providers and facilities file claims for you. Your physician must file on the form HCFA-1500, Health Insurance Claim Form. Your facility will file on the UB-92 form.

When you must file a claim – such as for services you received overseas or when another group health plan is primary – submit it on the HCFA-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 or supplies were furnished;
- Diagnosis;
- Type of each service or supply; and
- The charge for each service or supply.

Note: Canceled checks, cash register receipts, or balance due statements are not acceptable substitutes for itemized bills.

In addition:

- You must send a copy of the explanation of benefits (EOB) statement you received from any primary payer (such as the Medicare Summary Notice (MSN)) with your claim.
- Bills for home nursing care must show that the nurse is a registered or licensed practical nurse.
- Claims for speech, physical and occupational therapy require a written statement from the physician specifying the medical necessity for the service or supply and the length of time needed.
- Claims for prescription drugs and supplies must include receipts that show the patient's name, prescription number, name of drug or supply, prescribing physician's name, date, and charge.
- You must provide translation and currency conversion services for claims for overseas (foreign) services.

Records

Keep a separate record of the medical expenses of each covered family member as maximum allowances apply separately to each person. Save copies of all medical bills. In most instances they will serve as evidence of your claim. We will not provide duplicate or year-end statements.

Deadline for filing your claim

Send us all the documents for your claim as soon as possible. You must file all claims you have paid by December 31st of the year after the year you received the service. We are not required to honor a claim submitted after this period unless you were prevented from filing promptly due to administrative operations of Government or legal incapacity, provided you submitted the claim as soon as reasonably possible. Once we pay benefits, there is a three-year limitation on the re-issuance of uncashed checks.

If your POS contracted healthcare provider files the claim on your behalf, they must submit the claim within 90 days after the expenses for which the claim is made were incurred. We are not required to honor a claim submitted by your POS contracted healthcare provider after the 90 day period.

Overseas claims

For covered services you receive in hospitals outside the United States, Panama and Puerto Rico and performed by physicians outside the United States, send a completed Claim Form and the itemized bills to the Panama Canal Area Benefit Plan at AXA Assistance, PO Box 31-0940, Miami, FL. 33231- 0940. You may also obtain Claim Forms from the same address. Send any written inquiries concerning the processing of overseas claims to this address.

When we need more information

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

Section 8. The disputed claims process

Follow this Federal Employees Health Benefits Program disputed claims process if you disagree with our decision on your claim or request for services, drugs, or supplies – including a request for preauthorization/prior approval required by Section 3:

Step	Description
1	Ask us in writing to reconsider our initial decision. You must: (a) Write to us within 6 months from the date of our decision; and (b) Send your request to us to the Panama Canal Area Benefit Plan at AXA Assistance, PO Box 31-0940, Miami, FL. 33231- 0940. If you reside in the Republic of Panama, please submit your disputed claim to the Panama Canal Area Benefit Plan at AXA Assistance, Via España, Edificio Via España 120, Planta Baja, Panama City, Republic of Panama and (c) Include a statement about why you believe our initial decision was wrong, based on specific benefit provisions in this brochure; and (d) Include copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms.
2	We have 30 days from the date we receive your request to: a) Pay the claim (or, if applicable, arrange for the health care provider to give you the care); or b) Write to you and maintain our denial - go to step 4; or c) Ask you or your provider for more information. If we ask your provider, we will send you a copy of our request—go to step 3.
3	You or your provider must send the information so that we receive it within 60 days of our request. We will then decide within 30 more days. If we do not receive the information within 60 days, we will decide within 30 days of the date the information was due. We will base our decision on the information we already have. We will write to you with our decision.
4	If you do not agree with our decision, you may ask OPM to review it. You must write to OPM within: • 90 days after the date of our letter upholding our initial decision; or • 120 days after you first wrote to us -- if we did not answer that request in some way within 30 days; or • 120 days after we asked for additional information. Write to OPM at: United States Office of Personnel Management, Insurance Services Programs, Health Insurance Group II, 1900 E Street, NW, Washington, DC 20415-3620. Send OPM the following information: • A statement about why you believe our decision was wrong, based on specific benefit provisions in this brochure; • Copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms; • Copies of all letters you sent to us about the claim; • Copies of all letters we sent to you about the claim; and • Your daytime phone number and the best time to call.

Note: If you want OPM to review more than one claim, you must clearly identify which documents apply to which claim.

Note: You are the only person who has a right to file a disputed claim with OPM. Parties acting as your representative, such as medical providers, must include a copy of your specific written consent with the review request.

Note: The above deadlines may be extended if you show that you were unable to meet the deadline because of reasons beyond your control.

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

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

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

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

Note: **If you have a serious or life threatening condition** (one that may cause permanent loss of bodily functions or death if not treated as soon as possible), and

(a) We haven't responded yet to your initial request for care or preauthorization/prior approval, then call us at 507-204-9200 in Panama, and 1-800-424-8196 or 312-935-3671 in the United States and we will expedite our review; or

(b) We denied your initial request for care or preauthorization/prior approval, then:

- If we expedite our review and maintain our denial, we will inform OPM so that they can give your claim expedited treatment too, or
- You may call OPM's Health Insurance Group II at 202-606-3818 between 8 a.m. and 5 p.m. eastern time.

Section 9. Coordinating benefits with other coverage

When you have other health coverage

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

When you have double coverage, one plan normally pays its benefits in full as the primary payer and the other plan pays a reduced benefit as the secondary payer. We, like other insurers, determine which coverage is primary according to the National Association of Insurance Commissioners' guidelines.

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

When we are the secondary payer, we will determine our allowance. After the primary plan pays, we will pay what is left of our allowance, up to our regular benefit. We will not pay more than our allowance.

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

What is Medicare?

Medicare is a health insurance program for:

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

Medicare has four parts:

- Part A (Hospital Insurance). Most people do not have to pay for Part A. If you or your spouse worked for at least 10 years in Medicare-covered employment, you should be able to qualify for premium-free Part A insurance. (If you were a Federal employee at any time both before and during January 1983, you will receive credit for your Federal employment before January 1983.) Otherwise, if you are age 65 or older, you may be able to buy it. Contact 1-800-MEDICARE for more information.
- Part B (Medical Insurance). Most people pay monthly for Part B. Generally, Part B premiums are withheld from your monthly Social Security check or your retirement check.
- Part C (Medicare Advantage). You can enroll in a Medicare Advantage plan to get your Medicare benefits. We do not offer a Medicare Advantage plan. Please review the information on coordinating benefits with Medicare Advantage plans on the next page.
- Part D (Medicare prescription drug coverage). There is a monthly premium for Part D coverage. If you have limited savings and a low income, you may be eligible for Medicare's Low-Income Benefits. For people with limited income and resources, extra help in paying for a Medicare prescription drug plan is available. Information regarding this program is available through the Social Security Administration (SSA). For more information about this extra help, visit SSA online at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778). Before enrolling in Medicare Part D, please review the important disclosure notice from us about the FEHB prescription drug coverage and Medicare. The notice is on the first inside page of this brochure. The notice will give you guidance on enrolling in Medicare Part D.

- **Should I enroll in Medicare?**

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

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

Everyone is charged a premium for Medicare Part B coverage. The Social Security Administration can provide you with premium and benefit information. Review the information and decide if it makes sense for you to buy the Medicare Part B coverage.

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

(Please refer to page 15 for information about how we provide benefits when you are age 65 or older and do not have medicare.)

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

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

When you enroll in Original Medicare along with this Plan, you still need to follow the rules in this brochure for us to cover your care.

Claims process when you have the Original Medicare Plan – You will probably not need to file a claim form when you have both our Plan and the Original Medicare Plan.

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

When Original Medicare is the primary payer, Medicare processes your claim first. In most cases, your claim will be coordinated automatically and we will then provide secondary benefits for covered charges. To find out if you need to do something to file your claim, call us at 507-204-9200 in Panama, and 1-800-424-8196 or 312-935-3671 in the United States or visit our Web site at http://www.axa-assistance.com.pa.

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

- Medical services and supplies provided by physicians and other health care professionals. If you are enrolled in Medicare Part B we will waive your copayments and coinsurance amounts.
- Hospital room and board and other charges. If you are enrolled in Medicare Part A, we waive your copayment and coinsurance amounts.

- **Private contract with your physician**

A physician may ask you to sign a private contract agreeing that you can be billed directly for services ordinarily covered by Original Medicare. Should you sign an agreement, Medicare will not pay any portion of the charges, and we will not increase our payment. We will still limit our payment to the amount we would have paid after Original Medicare's payment. You may be responsible for paying the difference between the billed amount and the amount we paid.

- **Medicare Advantage (Part C)**

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

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

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

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

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

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

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

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

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

TRICARE and CHAMPVA

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

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

Workers' Compensation

We do not cover services that:

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

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

Medicaid

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

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

When other Government agencies are responsible for your care

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

When others are responsible for injuries

When you receive money to compensate you for medical or hospital care for injuries or illness caused by another person, you must reimburse us for any expenses we paid. However, we will cover the cost of treatment that exceeds the amount you received in the settlement.

If you do not seek damages you must agree to let us try. This is called subrogation. Additionally, you must avoid doing anything that would prejudice the Plan's right of subrogation, and execute any documents required to enforce the Plan's right. If you need more information, contact us for our subrogation procedures.

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

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

Section 10. Definitions of terms we use in this brochure

Calendar year

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

Coinsurance

Coinsurance is the percentage of our allowance that you must pay for your care. You may also be responsible for additional amounts. See page 13.

Copayment

A copayment is a fixed amount of money you pay when you receive covered services. See page 13.

Cost-sharing

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

Covered services

Services we provide benefits for, as described in this brochure.

Custodial care

Treatment or services, regardless of who recommends them or where they are provided, that 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 a 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 tubes.

Deductible

A deductible is a fixed amount of covered expenses you must incur for certain covered services and supplies before we start paying benefits for those services. See page 13.

Emergency

See page 43 for definition of emergency.

Experimental or investigational services

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

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

Reliable evidence 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. If you desire additional information concerning the experimental/ investigational determination process, please contact the Plan.

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**.**

Medical necessity

Services, drugs, supplies or equipment provided by a hospital or covered provider that we determine:

1. Are appropriate to diagnose or treat your medical condition, illness or injury;

2. Are consistent with standards of good medical practice in the United States;

3. Are not primarily for your personal comfort or convenience

4. Are not part of or associated with your scholastic education or vocational training; and

5. In the case of inpatient care, cannot be provided on an outpatient basis.

Plan allowance

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

Panama Point-of-Service (In -network)

In the Republic of Panama, we determine our Fee schedule amount by applying the health care charges made by local providers for health care services or supplies in the absence of insurance. From this determination we have negotiated rates with all point-of - service providers. These negotiated rates are what we refer to in the benefit section as the Panama POS fee schedule.

Panama Fee-for-Service

If you reside in the Republic of Panama and select the Fee-for-Service option, or reside outside of Panama (including the US) but receive medical services within the Republic of Panama, we base all claims reimbursement payments on the Panama POS fee schedule (or POS) amounts described above. However, your cost sharing responsibility is much greater. Please refer to the section 5 “Benefits” for additional detail regarding your responsibility.

US Fee-for-Service

We use INGENIX (HIAA) data for claims incurred in the United States, updated twice a year, at the 75th percentile to determine our Plan allowance. Some inpatient doctor services are paid on a fee schedule.

Us/We

Us and we refer to Panama Canal Area Benefit Plan

You

You refers to the enrollee and each covered family member.

Section 11. FEHB Facts

Coverage information

- **No pre-existing condition limitation**

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

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

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

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

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

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

We don't determine who is eligible for coverage and, in most cases, cannot change your enrollment status without information from your employing or retirement office.

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

Self Only coverage is for you alone. Self and Family coverage is for you, your spouse, and your unmarried dependent children under age 22, including any foster children or stepchildren your employing or retirement office authorizes coverage for. Under certain circumstances, you may also continue coverage for a disabled child 22 years of age or older who is incapable of self-support.

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

Your employing or retirement office will **not** notify you when a family member is no longer eligible to receive benefits, nor will we. Please tell us immediately when family members are added or lose coverage for any reason, including your marriage, divorce, annulment, or when your child under age 22 turns age 22 or has a change in marital status.

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

- **Children's Equity Act**

OPM has implemented the Federal Employees Health Benefits Children's Equity Act of 2000. This law mandates that you be enrolled for Self and Family coverage in the FEHB Program, if you are an employee subject to a court or administrative order requiring you to provide health benefits for your child (ren).

If this law applies to you, you must enroll for Self and Family coverage in a health plan that provides full benefits in the area where your children live or provide documentation to your employing office that you have obtained other health benefits coverage for your children. If you do not do so, your employing office will enroll you involuntarily as follows:

- If you have no FEHB coverage, your employing office will enroll you for Self and Family coverage in the Blue Cross and Blue Shield Service Benefit Plan's Basic Option;
- If you have a Self Only enrollment in a fee-for-service plan or in an HMO that serves the area where your children live, your employing office will change your enrollment to Self and Family in the same option of the same plan; or
- If you are enrolled in an HMO that does not serve the area where the children live, your employing office will change your enrollment to Self and Family in the Blue Cross and Blue Shield Service Benefit Plan's Basic Option.

As long as the court/administrative order is in effect, and you have at least one child identified in the order who is still eligible under the FEHB Program, you cannot cancel your enrollment, change to Self Only, or change to a plan that doesn't serve the area in which your children live, unless you provide documentation that you have other coverage for the children. If the court/administrative order is still in effect when you retire, and you have at least one child still eligible for FEHB coverage, you must continue your FEHB coverage into retirement (if eligible) and cannot cancel your coverage, change to Self Only, or change to a plan that doesn't serve the area in which your children live as long as the court/administrative order is in effect. Contact your employing office for further information.

- **When benefits and premiums start**

The benefits in this brochure are effective January 1. If you joined this Plan during Open Season, your coverage begins on the first day of your first pay period that starts on or after January 1. **If you changed plans or plan options during Open Season and you receive care between January 1 and the effective date of coverage under your new plan or option, your claims will be paid according to the 2009 benefits of your old plan or option.** However, if your old plan left the FEHB Program at the end of the year, you are covered under that plan's 2008 benefits until the effective date of your coverage with your new plan. Annuitants' coverage and premiums begin on January 1. If you joined at any other time during the year, your employing office will tell you the effective date of coverage.

- **When you retire**

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

When you lose benefits

- **When FEHB coverage ends**

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

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

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

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

- **Upon divorce**

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

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

If you leave Federal service, or if you lose coverage because you no longer qualify as a family member, you may be eligible for Temporary Continuation of Coverage (TCC). For example, you can receive TCC if you are not able to continue your FEHB enrollment after you retire, if you lose your Federal job, if you are a covered dependent child and you turn 22 or marry, etc.

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

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

- **Converting to individual coverage**

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

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

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

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

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

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

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

Section 12. Three Federal Programs complement FEHB benefits

Important information

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

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

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

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

The Federal Flexible Spending Account Program – *FSAFEDS*

What is an FSA?

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

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

- **Health Care FSA (HCFSA)** – Reimburses you for eligible health care expenses (such as copayments, deductibles, over-the-counter medications and products, vision and dental expenses, and much more) for you and your dependents which are not covered or reimbursed by FEHBP or FEDVIP coverage or any other insurance.
- **Limited Expense Health Care FSA (LEX HCFSA**) – Designed for employees enrolled in or covered by a High Deductible Health Plan with a Health Savings Account. Eligible expenses are limited to dental and vision care expenses for you and your dependents which are not covered or reimbursed by FEHBP or FEDVIP coverage or any other insurance.
- **Dependent Care FSA (DCFSA)** – Reimburses you for eligible non-medical day care expenses for your child(ren) under age 13 and/or for any person you claim as a dependent on your Federal Income Tax return who is mentally or physically incapable of self-care. You (and your spouse if married) must be working, looking for work (income must be earned during the year), or attending school full-time to be eligible for a DCFSA.

Where can I get more information about FSAFEDS?

Visit www.FSAFEDS.com or call an FSAFEDS Benefits Counselor toll-free at 1-877-FSAFEDS (1-877-372-3337), Monday through Friday, 9 a.m. until 9 p.m., Eastern time. TTY: 1-800-952-0450.

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

Important Information

The Federal Employees Dental and Vision Insurance Program (FEDVIP) is a program, separate and different from the FEHB Program, established by the Federal Employee Dental and Vision Benefits Enhancement Act of 2004. This Program provides comprehensive dental and vision insurance at competitive group rates with no pre-existing condition limitations.

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

Dental Insurance

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

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

Vision Insurance

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

Additional Information

You can find a comparison of the plans available and their premiums on the OPM website at www.opm.gov/insure/dentalvision. This site also provides links to each plan's website, where you can view detailed information about benefits and preferred providers.

How do I enroll?

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

The Federal Long Term Care Insurance Program – *FLTCIP*

It's important protection

The Federal Long Term Care Insurance Program (FLTCIP) can help you pay for the potentially high cost of long term care services, which are not covered by FEHB plans. Long term care is help you receive to perform activities of daily living – such as bathing or dressing yourself - or supervision you receive because of a severe cognitive impairment. To qualify for coverage under the FLTCIP, you must apply and pass a medical screening (called underwriting). Certain medical conditions, or combinations of conditions, will prevent some people from being approved for coverage. You must apply to know if you will be approved for enrollment. To request an Information Kit and application, call 1-800-LTC-FEDS (1-800-582-3337) (TTY 1-800-843-3557) or visit www.ltcfeds.com.

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Workers' Compensation.....61, 62
X-rays.....50, 69

Summary of benefits for the Panama Canal Area Benefit Plan - 2009

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

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

Under FFS Option after we pay, you generally pay any difference between our allowance and the billed amount.

If you are a POS member and receive your medical care through your primary care physician and other POS providers you can limit your out-of-pocket expenses. Please refer to Section 5 (benefits) for a complete list of POS benefits and your payment obligations under this option.

Benefits	You pay	Page
Medical services provided by physicians:		
• Diagnostic and treatment services provided in the office	POS: $10 copayment FFS Panama: 50% of the Panama POS Fee schedule amount and any difference between the POS Fee schedule and the billed amount FFS US: 50% of the US FFS Plan allowance and any difference between our allowance and the billed amount	19
Services provided by a hospital:		
• Inpatient	POS: Nothing after the $50 per admission copayment FFS Panama: $125 per admission, then 50% of the Panama POS fee schedule amount and any difference between the POS Fee schedule and the billed amount FFS US: $125 per admission and 50% of the covered charges	38
• Outpatient	POS: $50 copayment to facility for surgeries and nothing for other services FFS Panama: 50% of the Panama POS Fee schedule amount and any difference between the POS Fee schedule and the billed amount FFS US: 50% of the US FFS Plan allowance and any difference between our allowance and the billed amount	39
Emergency benefits:		
• Accidental injury (after 72 hours)	POS: $10 copayment FFS Panama: 50% of the Panama POS Fee schedule amount and any difference between the POS Fee schedule and the billed amount FFS US: 50% of the US FFS Plan allowance and any difference between our allowance and the billed amount	42
• Medical emergency		42

Benefits	You pay	Page
Mental health and substance abuse treatment	POS: Regular cost sharing FFS: Benefits are limited	45
Prescription drugs	40% of eligible charges	48
Coinsurance for prescription drugs goes towards a $5000 annual prescription out-of-pocket limit		
Dental care	Scheduled allowances	50
Special Features:		52
Health Support Programs		
Flexible Benefits Option		
Centers of Excellence		
Protection against catastrophic costs (your catastrophic protection out-of-pocket maximum) *Note: Applies only to FFS benefits*	After the 50% for hospital inpatient room and board and other expenses reaches $2500 per member per year, we will pay the remaining hospital room and board and other charges at 100% Some costs do not count toward this protection	14

2009 Rate Information for the Panama Canal Area Benefit Plan

Non-Postal rates apply to most non-Postal employees. If you are in a special enrollment category, refer to the *Guide to Federal Benefits* for that category or contact the agency that maintains your health benefits enrollment.

Type of Enrollment	Enrollment Code	Non-Postal Premium				Postal Premium	
		Biweekly		Monthly		Biweekly	
		Gov't Share	Your Share	Gov't Share	Your Share	USPS Share	Your Share
High Option Self Only	431	137.54	45.84	297.99	99.33	0	0
High Option Self and Family	432	287.08	95.69	622.01	207.33	0	0