Panama Canal Area Benefit Plan

http://www.PanamaCanalAreaBenefitPlan.com.pa

Customer Service 507-366-1400 (Panama)/1-800-424-8196 (USA)

2013

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

IMPORTANT
- Rates: Back Cover
- Changes for 2013: Page 13
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Enrollment codes for this Plan:

431 – Self Only
432 – Self and Family

FEHB
Federal Employees
Health Benefits Program

Authorized for distribution by the:

United States
Office of Personnel Management

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

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 (October 15th through December 7th) 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 1-877-486-2048).

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Introduction

This brochure describes the benefits of The Panama Canal Area Benefit Plan (PCABP) under contract (CS 1066) between The Association of Retirees of the Panama Canal Area (AJAC) and the United States Office of Personnel Management (OPM), as authorized by the Federal Employees Health Benefits law. Customer Service may be reached at 507-366-1400 in Panama, and 1-800-424-8196 or 312-935-3671 in the United States, or through our website at www.PanamaCanalAreaBenefitPlan.com.pa. The address for the Panama Canal Area Benefit Plan administrator's offices is:

Panama Canal Area Benefit Plan at AXA Assistance, Vía España, Edificio P.H. Plaza Comercial San Fernando, Planta Baja, Locales No. 1 y 2, Corregimiento de Pueblo Nuevo. 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, 2013, unless those benefits are also shown in this brochure.

OPM negotiates benefits and rates with each plan annually. Benefit changes are effective January 1, 2013, and changes are summarized on page 13. Rates are shown at the end of this brochure.

Plain Language

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

- Except for necessary technical terms, we use common words. For instance, "you" means the enrollee 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.

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.
- Periodically review your claim history for accuracy to ensure we have not been billed for services that you did not receive.
- Do not ask your doctor to make false entries on certificates, bills or records in order to get us to pay for an item or service.
- If you suspect that a provider has charged you for services you did not receive, billed you twice for the same service, or misrepresented any information, do the following:
  - Call the provider and ask for an explanation. There may be an error.

- If the provider does not resolve the matter, call our Fraud and Abuse Compliance Hotline at 1-800-793-6745 in the United States and explain the situation.
- If we do not resolve the issue:

CALL - THE HEALTH CARE FRAUD HOTLINE

877-499-7295

OR go to www.opm.gov/oig

You can also write to:

United States Office of Personnel Management

Office of the Inspector General Fraud Hotline

1900 E Street NW Room 6400

Washington, DC 20415-1100

- Do not maintain as a family member on your policy:
  - Your former spouse after a divorce decree or annulment is final (even if a court order stipulates otherwise)
  - Your child age 26 or over (unless he/she was disabled and incapable of self-support prior to age 26).
- If you have any questions about the eligibility of a dependent, check with your personnel office if you are employed, with your retirement office (such as OPM) if you are retired, or with the National Finance Center if you are enrolled under Temporary Continuation of Coverage.
- Fraud or intentional misrepresentation of material fact is prohibited under the Plan. You can be prosecuted for fraud and your agency may take action against you. Examples of fraud include, falsifying a claim to obtain FEHB benefits, trying to or obtaining service or coverage for yourself or for someone else who is not eligible for coverage, or enrolling in the Plan when you are no longer eligible.
- If your enrollment continues after you are no longer eligible for coverage (i.e., you have separated from Federal service) and premiums are not paid, you will be responsible for all benefits paid during the period in which premiums were not paid. You may be billed by your provider for services received. You may be prosecuted for fraud for knowingly using health insurance benefits for which you have not paid premiums. It is your responsibility to know when you or a family member is no longer eligible to use your health insurance coverage.

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 and dosage that you take, including non-prescription (over-the-counter) medicines and nutritional supplements.

- Tell your doctor and pharmacist 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.

Patient Safety Links

- www.ahrq.gov/consumer/. The Agency for Healthcare Research and Quality makes available a wide-ranging list of topics not only to inform consumers about patient safety but 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.

Never Events

You will not be billed for inpatient services related to treatment of specific hospital acquired conditions or for inpatient services needed to correct never events, if you use our contracted hospitals in Panama City and Colon City in the Republic of Panama. This policy helps to protect you from preventable medical errors and improve the quality of care you receive.

When you enter the hospital for treatment of one medical problem, you don't expect to leave with additional injuries, infections or other serious conditions that occur during the course of your stay. Although some of these complications may not be avoidable, too often patients suffer from injuries or illnesses that could have been prevented if the hospital had taken proper precautions.

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

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
  - When the next open season for enrollment begins

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

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

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

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

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

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

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

- **Family Member Coverage**

Family members covered under your Self and Family enrollment are your spouse (including a valid common law marriage) and children as described in the chart below.

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

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

- **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 2013 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 2012 benefits until the effective date of your coverage with your new plan. Annuitants' coverage and premiums begin on January 1. If you joined at any other time during the year, your employing office will tell you the effective date of coverage.

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

- **When you retire**

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

When you lose benefits

- **When FEHB coverage ends**

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

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

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

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

- **Upon divorce**

If you are divorced from a Federal employee or annuitant, you may not continue to get benefits under your former spouse's enrollment. This is the case even when the court has ordered your former spouse to provide health coverage for you. However, you may be eligible for your own FEHB coverage under either the spouse equity law or Temporary Continuation of Coverage (TCC). If you are recently divorced or are anticipating a divorce, contact your ex-spouse's employing or retirement office to get RI 70-5, the *Guide to Federal Benefits for Temporary Continuation of Coverage and Former Spouse Enrollees,* or other information about your coverage choices. You 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 age 26, regardless of marital status, etc.

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

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

- **Converting to individual coverage**

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

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

- You are not eligible for coverage under TCC or the spouse equity law.

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

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

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

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

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

Section 1. How this plan works

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.

This plan is a "grandfathered health plan" under the Affordable Care Act. A grandfathered plan must preserve basic health coverage that was already in effect when the law passed. Specifically, this plan cannot eliminate all or substantially all benefits to diagnose or treat a particular condition; it cannot increase your coinsurance (the percentage of a bill you pay); and any increases in deductibles, out-of-pocket limits, and other copayments (the fixed-dollar amount you pay) must be minimal.

Questions regarding what protections apply may be directed to the Panama Canal Area Benefit Plan's customer service department at 507-366-1400 in Panama, and 1-800-424-8196 or 312-935-3671 in the United States. You can also read additional information from the U.S. Department of Health and Human Services at www.healthcare.gov.

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 *Republic of Panama* only.

Contact us for the names of POS providers and to verify their continued participation. You can also go to our Web page at www.PanamaCanalAreaBenefitPlan.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.

FFS: 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, Vía España, Edificio P.H. Plaza Comercial San Fernando, Planta Baja, Locales No. 1 y 2, Corregimiento de Pueblo Nuevo. 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 FAIR Health 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 507-366-1400 in Panama, and 1-800-424-8196 or 312-935-3671 in the United States.

You may visit our website at www.PanamaCanalAreaBenefitPlan.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.

We protect the privacy of your protected health information as described in our current Panama Canal Area Benefit Plan Notice of Privacy Practices. You can obtain a copy of our Notice by calling us at 507-366-1400 in Panama, and 1-800-424-8196 or 312-935-3671 in the United States, or by visiting our website at www.PanamaCanalAreaBenefitPlan.com.pa.

Section 2. Changes for 2013

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

- Annual limits on essential health benefits as described in Section 1302 of the Affordable Care Act have been eliminated.
- FEHB Plans must provide coverage for routine patient costs for items and services furnished in connection with participation in an approved clinical trial.
- Additional coverage for preventive care and screenings for women provided in comprehensive guidelines adopted by the Health Resources and Services Administration (HRSA) has been added with no cost-sharing in network.
- Alaska and Kentucky were designated as a Medically Underserved Area in 2012, but will not be so designated for 2013. South Carolina is being added as a Medically Underserved Area for the 2013 calendar year.

Changes to this Plan

- Your share of the non-Postal premium will increase for Self only and for Self and Family. See page 78.
- We have updated the list of covered Organ/tissue transplants. Please refer to Section 5(b) for information.
- We have updated the list of vaccines and immunizations. See pages 27 and 28.
- We eliminated the Fee-For-Service outpatient benefit maximums per calendar year of $650 for Self Only enrollment and $1,500 for Self and Family enrollment.
- We eliminated the $300 POS and $250 FFS annual benefit maximums for rehabilitative services (Physical, Occupational, and Speech therapies). Rehabilitative services will be subject to a combined visit limitation per condition of up to 30 visits per calendar year. See page 31.
- We eliminated the $1,000 lifetime benefit maximum for adult hearing aids. External hearing aids will have an allowance of up to $1,000 ($500 per ear) every three years. See page 32.
- We eliminated the annual $250 benefit maximum for chiropractic care. Chiropractic services will be limited to 10 treatment sessions per calendar year. See page 34.
- Hospice benefits are no longer subject to a $5,000 lifetime maximum. See page 45.

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 507-366-1400 in Panama, and 1-800-424-8196 or 312-935-3671 in the United States. You may also request replacement cards through our website: www.PanamaCanalAreaBenefitPlan.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:

a licensed doctor of medicine (M.D.) or a licensed doctor of osteopathy (D.O.); a licensed specialist in his/her specialty; a licensed doctor of podiatry (D.P.M.); a licensed dentist (D.D.S. or D.M.D.); a licensed chiropractor (D.C.); a licensed registered physical, occupational, or speech therapist (R.P.T., R.O.T., or R.S.T.); a qualified clinical psychologist, clinical social worker, optometrist, nurse midwife, nurse practitioner/clinical specialist, nursing school administered clinic and nutritionists/licensed dieticians**.**

When we use the term doctor, we mean the following 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 2013, the states are: Alabama, Arizona, Idaho, Illinois, Louisiana, Mississippi, Missouri, Montana, New Mexico, North Dakota, Oklahoma, 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 administers and provides hospice care; and is:

- licensed or certified as such by the state in which it is located;
- certified (or is qualified and could be certified) to participate as such under Medicare;
- accredited as such by the Joint Commission on the Accreditation of Health Care Organizations; or
- meets the standards established by the National Hospice Organization.

Hospital - a facility that is:

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:
   - 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
   - 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
   - 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:

- Is used principally as a convalescent facility, rest facility, or facility for the aged;
- Furnishes primarily domiciliary or custodial care, including training in the routine of daily living; or
- 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 507-366-1400.

- **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. The specialist must request and receive authorization from AXA prior to additional consultations and/or treatment.

- **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 507-366-1400 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;
- The day your benefits from your former plan run out; or
- The 92nd day after you become a member of this Plan, whichever happens first.

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

You need prior Plan approval for certain services

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

- **Inpatient hospital admission**

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 only pay for any covered medical services and supplies that are otherwise payable on an outpatient basis.

Exceptions

You do not need precertification in these cases:

- You are admitted to a hospital outside the United States or Panama.
- You have another group health insurance policy that is the primary payor for the hospital stay.

- Medicare Part A is the primary payor for the hospital stay. Note: If you exhaust your Medicare hospital benefits and do not want to use your Medicare lifetime reserve days, then we will become the primary payor and you **do** need precertification.

- **Other Services**

You must obtain prior authorization as follows.

- All inpatient and/or outpatient surgeries (including organ/tissue transplants) 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) must be preauthorized.
- If designated outpatient surgical procedures (see page 39 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.
- All dental surgery, periodontics, endodontics require prior approval.

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

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.

First, you, your representative, your physician, or your hospital must call us at 507-366-1400 in Panama, and 1-800-424-8196 or 312-935-3671 in the United States before admission or services requiring prior authorization are rendered.

Next, provide the following information:

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

- **Non-urgent care claims**

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

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

If we need an extension because we have not received necessary information, our notice will describe the specific information required and we will allow you or your provider up to 45 days from the receipt of the notice to provide the information.

- **Urgent care claims**

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

If you fail to provide sufficient information, we will contact you within 24 hours after we receive the claim to provide notice of the specific information we need to complete our review of the claim. We will allow you up to 48 hours from the receipt of this notice to provide the necessary information. We will make our decision on the claim within 48 hours of (1) the time we received the additional information or (2) the end of the time frame, whichever is earlier.

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

You may request that your urgent care claim on appeal be reviewed simultaneously by us and OPM. Please let us know that you would like a simultaneous review of your urgent care claim by OPM either in writing at the time you appeal our initial decision, or by calling us at 507-366-1400 in Panama, and 1-800-424-8196 or 312-935-3671 in the United States. You may also call OPM's Health Insurance II at (202) 606-3818 between 8 a.m. and 5 p.m. eastern time to ask for the simultaneous review. We will cooperate with OPM so they can quickly review your claim on appeal. In addition, if you did not indicate that your claim was a claim for urgent care, then call us at 507-366-1400 in Panama, and 1-800-424-8196 or 312-935-3671 in the United States. If it is determined that your claim is an urgent care claim, we will hasten our review (if we have not yet responded to your claim).

- **Emergency inpatient admission**

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

- **Maternity care**

You do not need precertification of a maternity admission for a routine delivery. However, if your medical condition requires you to stay more than 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. If you remain in the hospital beyond the number of days we approved and did not get the additional days precertified, then

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

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

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

If you disagree with our pre-service claim decision

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

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

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

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

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

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

- **To reconsider an urgent care claim**

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

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

- **To file an appeal with OPM**

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

Section 4. Your costs for covered services

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

Cost-sharing	Cost-sharing is the general term used to refer to your out-of-pocket costs (e.g., deductible, coinsurance, and copayments) for the covered care you receive.
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 $5 per visit and when you go to a participating hospital, you pay $25 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 $100 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.
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 does not begin until you have met your calendar year 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 507-366-1400 in Panama, and 1-800-424-8196 or 312-935-3671 in the United States
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 -- $5 of our $30 allowance. Because of the agreement, your POS physician will not bill you for the $25 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:	25	50% of our allowance:	15
You owe: Coinsurance	$5 copayment:	5	50% of our allowance:	15
+Difference up to charge?	No:	0	Yes:	20
TOTAL YOU PAY		$ 5		$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 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 16-19); and
- The $100 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. You may be responsible to pay for certain services and charges. Contact the government facility directly for more information.

Section 5. Benefits

(See page 13 for how our benefits changed this year and page 76 for a benefits summary.)

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

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- The 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. Under the FFS benefits, you owe all charges that exceed our allowable charges.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost-sharing works. Also read Section 9 for information about how we pay if you have other coverage, or if you are age 65 or older.
- If you are enrolled in the POS Option in Panama, you must obtain a referral from your primary care physician before seeing a specialist. When you are referred to a specialist, the specialist must request and receive authorization from AXA prior to additional consultations and/or treatment.

Benefit Description	You Pay
Diagnostic and treatment services	
Professional services of physicians • In physician's office • Office medical consultations • Physician home visits	POS: $5 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 page 71 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 • In a skilled nursing facility	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	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
Lab, X-ray and other diagnostic tests	
Tests, such as: • Blood tests • Urinalysis • Non-routine pap tests • Pathology • X-rays	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

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

Benefit Description	You Pay
Lab, X-ray and other diagnostic tests (cont.)	
• Non-routine Mammograms • CAT Scans/MRI • Ultrasound • Electrocardiogram and EEG Note: CAT Scans/MRIs require preauthorization. See How to request precertification for an admission or get prior authorization for Other services on page 17.	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 such as: • 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 members 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 FFS US: 50% of the US FFS Plan allowance and any difference between our allowance and the billed amount
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 FFS US: 50% of the US FFS Plan allowance and any difference between our allowance and the billed amount

Preventive care, adult - continued on next page

Benefit Description	You Pay
Preventive care, adult (cont.)	
Well woman - one annually, including, but not limited to: • Routine pap test • Human papillomavirus testing for women age 30 and up once every three years • Counseling for sexually transmitted infections on an annual basis • Counseling and screening for human immune-deficiency virus on an annual basis • Contraceptive methods and counseling • Screening and counseling for interpersonal and domestic violence	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
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	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
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 23 to 64. • Tdap vaccine 65 years or older • Td Vaccine and Pregnancy • Tetanus-diphtheria (Td) booster – once every 10 years, ages 65 and over • 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 23 to 49 • VariZIG for Postexposure Prophylaxis of Varicella • Hepatitis B Vaccine in Adults with Diabetes • Human Papillomavirus (HPV2 and HPV4) vaccine • HPV4 in Males • Herpes Zoster (Shingles) adults 60 years or older • Meningococcal Conjugate vaccine from 23 through 54 years old with reduced immune response • Yellow Fever vaccine • Influenza (H1N1) vaccine • Anthrax vaccine • Rabies vaccine • Japanese Encephalitis vaccines • Hepatitis B vaccine	POS: Nothing FFS Panama: Not a covered benefit. You pay all billed charges. FFS US: Not a covered benefit. You pay all billed charges.

Benefit Description	You Pay
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. • Meningococcal Conjugate vaccine at 2 through 22 years old with reduced immune response • Pneumococcal (PCV13 and PPSV23) vaccine (infants & children) • Rotavirus vaccine children and infants • Quadrivalent Meningococcal Conjugate Vaccine Children 9 through 23	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
• 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) - 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 FFS US: 50% of the US FFS Plan allowance and any difference between our allowance and the billed amount
Maternity care	
Complete maternity (obstetrical) care, such as: • Prenatal care • Screening for gestational diabetes for pregnant women between 24-28 weeks gestation or first prenatal visit for women at a high risk. • Breasfeeding support, supplies and counseling for each birth	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
• 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.	POS: $5 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.

Maternity care - continued on next page

Benefit Description	You Pay
Maternity care (cont.)	
• 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 for non-maternity care the same as for illness and injury.	POS: $5 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.
Family Planning	
A range of voluntary family planning services, limited to: • Contraceptive counseling • Voluntary sterilization (See Surgical procedures Section 5 (b) • Surgically implanted contraceptives • Injectable contraceptive drugs (such as Depo provera) • Intrauterine devices (IUDs) • 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: $5 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: $5 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 40 through 42. • Dialysis – Hemodialysis and peritoneal dialysis including medications used directly with the dialysis treatment. • Intravenous (IV)/Infusion Therapy – Home IV and antibiotic therapy • Inhaler based medications to treat asthma and chronic obstructive pulmonary disease (COPD) • Growth hormone therapy (GHT) Note: Growth hormone is covered under the prescription drug benefit. Note: We only cover GHT when we preauthorize the treatment. Call 507-366-1400 in Panama, and 1-800-424-8196 or 312-935-3671 in the United States for preauthorization. We will ask you to submit information that establishes that the GHT is medically necessary. We will only cover GHT services and related services and supplies that we determine are medically necessary. Ask us for preauthorization before you begin treatment because we will only cover GHT services that are rendered after the date we authorize treatment.	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
• Respiratory and inhalation therapies including oxygen; supplies and the rental of equipment to administer the oxygen.	POS: Nothing FFS Panama: Nothing FFS US: Nothing

Benefit Description	You Pay
Physical and occupational therapies	
Short-term rehabilitative physical therapy (POS) or physical and occupational therapy (FFS) is provided on an inpatient or outpatient basis, 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: Physical, Occupational and Speech therapies are subject to a combined visit limitation per condition of up to 30 visits per calendar year as authorized by the Plan's Medical Director. 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 combined visit limitation of 30 visits 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 combined visit limitation of 30 visits FFS US: 50% of the US FFS Plan allowance and any difference between our allowance and the billed amount and all charges over the combined visit limitation of 30 visits
Not covered: • *Long-term rehabilitative therapy* • *Exercise programs* • *Occupational Therapy (POS)*	*All charges*
Speech therapy	
• Speech therapy when it is medically necessary. Note: Physical, Occupational and Speech therapies are subject to a combined visit limitation per condition of up to 30 visits per calendar year as authorized by the Plan's Medical Director.	POS: $10 copayment for first visit in an authorized series and all charges over the combined visit limitation of 30 days 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 combined visit limitation of 30 days FFS US: 50% of the US FFS Plan allowance and any difference between our allowance and the billed amount and all charges over the combined visit limitation of 30 days
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.	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

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

Benefit Description	You Pay
Hearing services (testing, treatment, and supplies) (cont.)	
• External hearing aid for children up to age 10 once every five years • External hearing aids for adults up to $1000 ($500 per ear) every three 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
Not covered: • *Hearing services that are not shown as covered*	*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
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: $5 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: • *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*

Benefit Description	You Pay
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. • External hearing aids for adults up to $1000 ($500 per ear) every three years • External hearing aid for children up to age 10 once every five years.	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)	
Oxygen; supplies and the rental of equipment to administer the oxygen.	POS: Nothing FFS Panama: Nothing FFS US: Nothing
Not covered: All other DME such as • *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

Home health services - continued on next page

Benefit Description	You Pay
Home health services (cont.)	
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 10 treatment sessions 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 in excess of 10 treatment sessions 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 in excess of 10 treatment sessions FFS US: 50% of the US FFS Plan allowance and any difference between our allowance and the billed amount and all charges in excess of 10 treatment sessions
Alternative treatments	
Acupuncture – by a doctor of medicine or osteopathy for anesthesia or pain 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: • *Naturopathic services* *Note: Benefits of certain alternative treatment providers may be covered in medically underserved areas; see page 14.*	*All charges*
Tobacco Cessation Program	
• Up to 2 tobacco cessations program per year • Up to 4 tobacco cessations counseling sessions per program (includes proactive telephone counseling, group counseling and individual counseling) • Physician prescribed over-the-counter (OTC) and prescription drugs approved by the FDA to treat tobacco dependence are covered at 100%.	POS, FFS Panama, and FFS US: Nothing for counseling for up to two quit attempts per year and nothing for OTC and prescription drugs approved by the FDA to treat tobacco dependence.

Benefit Description	You Pay
Diabetes Management program	
The Diabetes Management Program is available for POS members in the Republic of Panama only. 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 (See note below) • 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 Note: Only those medications **listed on the Plan's formulary for diabetes** are covered under this program. All other eligible medications are covered under the normal prescription drug benefits of the Plan. See Section 5(f). Note: Although the Diabetes Management Program is only for POS members, the Plan will cover diabetes medications listed on the Plan's formulary at 100% of the allowable charge for FFS members in the U. S. and FFS members in the Republic of Panama.	POS: Nothing FFS Panama: Nothing for medication to treat diabetes listed on the Plan's formulary for diabetes. 100% of all other charges. FFS US: Nothing for medication to treat diabetes listed on the Plan's formulary for diabetes. 100% of all other charges.
Osteoporosis Management program	
The Osteoporosis Management Program is available for POS members in the Republic of Panama only. 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 referral 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 members who are at increased risk for osteoporosis • Counseling and education sessions provided by a physician as approved by the Plan	POS: Nothing FFS Panama: All charges FFS US: All charges

Osteoporosis Management program - continued on next page

Benefit Description	You Pay
Osteoporosis Management program (cont.)	
Note: The Osteoporosis Management Program is not available to FFS members in the U.S. or FFS members in the Republic of Panama. Note: Eligible medications are covered under the prescription drug benefits and subject to coinsurance. See Section 5(f). 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
Wellness program	
The Wellness Program is benefit for all members of the Plan that reside in the Republic of Panama only. The Wellness program includes: • Education on preventive care, • Participation in the Prevention of Caregiver's Burnout Program. • Indoor and outdoor physical activities for a health lifestyle. • Health Risk Assessment (HRA) For more information about the wellness program, visit our wellness web page online at http://axa-wellness.com.pa/. Note: All members that participate in activities of the wellness program should consult their Primary Care Physician for recommendations on type and intensity of physical activities you can perform.	POS: Nothing FFS Panama: Nothing FFS US: Service is not available outside of Panama except for access to the web page which costs nothing

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.
- 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. Under the FFS benefits, you owe all charges that exceed our our allowable charges.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost-sharing works. Also read Section 9 for information about how we pay if you have other coverage or if you are age 65 or older.
- 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 SURGICAL PROCEDURES. Please refer to the precertification information shown in Section 3 to be sure which services require precertification.**
- **Certain surgical procedures have been designated as outpatient procedures.** Please refer to page 39 for a list of the procedures.

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	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 70.
• Removal of tumors and cysts (non-cosmetic) • Correction of congenital anomalies (see Reconstructive surgery) • 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 • 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 and satisfy the following criteria:	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; and - Receive approval by a peer review consultant. Note: You must precertify all surgical procedures. In addition, 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 507-366-1400 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 507-366-1400.	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 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*

Surgical procedures - continued on next page

Benefit Description	You Pay
Surgical procedures (cont.)	
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 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 17.	
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) 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 for up to 48 hours after the procedure.	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

Reconstructive surgery - continued on next page

Benefit Description	You Pay
Reconstructive surgery (cont.)	
Not covered: • *Cosmetic surgery - any surgical procedure (or any portionof 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 • 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 are limited to: • Cornea • Heart • Heart/lung • Intestinal transplants - Small intestine - Small intestine with the liver - Small intestine with multiple organs, such as the liver, stomach, and pancreas • Kidney • Liver • Lung single/bilateral/lobar • Pancreas	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.
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 • Advanced Hodgkin's lymphoma with reoccurrence (relapsed)	POS: Nothing FFS Panama: 50% of the Panama POS Fee schedule amount and any difference between the POS fee schedule and the billed amount

Organ/tissue transplants - continued on next page

Benefit Description	You Pay
Organ/tissue transplants (cont.)	
• Advanced non-Hodgkin's lymphoma with reoccurrence (relapsed) • Acute myeloid leukemia • Advanced Myeloproliferative Disorders (MPDs) • Amyloidosis • Chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL) • Hemoglobinapathy • Marrow failure and related disorders (i.e. Fanconi's, PNH, Pure Red Cell Aplasia) • Myelodysplasia/Myelodysplastic syndromes • Paroxysmal Nocturnal Hemoglobinuria • Severe combined immunodeficiency • Severe or very severe aplastic anemia Autologous transplants for • Acute lymphocytic or nonlymphocytic (i.e., myelogenous) leukemia • Advanced Hodgkin's lymphoma with reoccurrence (relapsed) • Advanced non-Hodgkin's lymphoma with reoccurrence (relapsed) • Amyloidosis • Neuroblastoma • Childhood rhabdomyosarcoma • Advanced Ewing sarcoma • Advanced Childhood kidney cancers • Mantle Cell (Non-Hodgkin lymphoma) Autologous Tandem transplants for - AL Amyloidosis - Multiple Myeloma (de novo and treated) - Recurrent germ cell tumors (including testicular cancer)	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.
Blood or Marrow Stem Cell Transplants Allogeneic transplants for • Phagocytic/Hemophagocytic deficiency diseases (e.g., Wiskott-Aldrich syndrome) Autologous transplants for • Multiple myeloma • Testicular, Mediastinal, Retroperinoneal, and Ovarian germ cell tumors • Breast cancer • Epithelial ovarian cancer	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.)	
Mini-transplants (non-myeloblative, reduced intensity conditioning) for covered transplants: subject to medical necessity	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.
Tandem transplants for covered transplants: Subject to medical necessity	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 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 507-366-1400.	
Not covered: • *Donor screening tests and donor search expenses, except as shown above* • *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 $25 per admission copayment for POS members and a $100 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. Under the FFS benefits, you owe all charges that exceed our allowable charges.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost-sharing works. Also read Section 9 for information about how we pay if you have other coverage, or if you are age 65 or older.
- 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 • 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 $25 per admission copayment FFS Panama: $100 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: $100 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 $25 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 • 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.	POS: Nothing after the $25 per admission copayment FFS Panama: $100 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: $100 per admission and 50% of the covered charges

Inpatient hospital - continued on next page

Benefit Description	You Pay
Inpatient hospital (cont.)	
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. 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 $25 copayment for the readmission.	POS: Nothing after the $25 per admission copayment FFS Panama: $100 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: $100 per admission and 50% of the covered charges
Not covered: • *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 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: $25 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

Benefit Description	You Pay
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 as approved by the Plan's Medical Director.	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: Independent nursing, homemaker services	*All charges*
Ambulance (non-emergency)	
• Professional ambulance service when medically appropriate • Under the POS option, we pay an allowance 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 an allowance 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 an allowance 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 allowance is $100.	POS: Nothing. All charges after $100 allowance 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 allowance FFS US: 50% of the US FFS Plan allowance and any difference between our allowance and the billed amount. All charges after the $100 allowance

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 the *medical necessity of your proposed admissions and the number of hospital days you will need.*
- 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. Under the FFS benefits, you owe all charges that exceed our allowable charges.
- 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. Also read Section 9 for information about how we pay if you have other coverage, or if you are age 65 or older.

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 at 80% of Plan allowance.

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: $5 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

Benefit Description	You pay
Medical emergency	
Outpatient medical or surgical services and supplies 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 507-366-1400 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, FL. 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: $5 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. 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 allowance is $100. Note: See 5 (c) for non-emergent service	POS: Nothing. All charges after $100 allowance 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 allowance FFS US: 50% of the US FFS Plan allowance and any difference between our allowance and the billed amount. All charges after $100 allowance
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 need to get Plan approval (preauthorization) for services and follow a treatment plan we approve in order to get benefits. When you receive services as part of an approved treatment plan, cost-sharing and limitations for Plan mental health and substance abuse benefits are no greater than for similar benefits for other illnesses and conditions

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- The outpatient and inpatient copayments apply to almost all benefits in this Section.
- 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. Under the FFS benefits, you owe all charges that exceed our allowable charges.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost-sharing works. Also read Section 9 for information about how we pay if you have other coverage or if you are age 65 or over.
- **YOU MUST GET PREAUTHORIZATION FOR THESE SERVICES.** See the instructions after the benefits descriptions below.

Benefit Description	You pay
Professional Services	
We cover professional services by licensed professional mental health and substance abuse practitioners when acting within the scope of their license, such as psychiatrists, psychologists, clinical social workers. Diagnosis and treatment of psychiatric conditions, mental illness, or mental disorders. Services include: • Diagnostic evaluation • Crisis Intervention and stabilization for acute episodes • Medication evaluation and management (pharmacotherapy) • Psychological and neuropsychological testing necessary to determine the appropriate psychiatric treatment • Treatment and counseling (including individual or group therapy visits) • Diagnosis and treatment of alcoholism and drug abuse, including detoxification, treatment and counseling • Professional charges for intensive outpatient treatment in a provider's office or other professional setting • Electroconvulsive therapy	Your cost-sharing responsibilities are no greater than for other illnesses or conditions. POS: $5 copayment per 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 (see page 71 describing how we derive our US FFS allowance) and any difference between our allowance and the billed amount
• Inpatient physician hospital visit	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

Benefit Description	You pay
Diagnostics	
• Outpatient diagnostic tests provided and billed by a licensed mental health and substance abuse practitioner • Outpatient diagnostic tests provided and billed by a laboratory, hospital or other covered facility • Inpatient diagnostic tests provided and billed by a hospital or other covered facility	Your cost-sharing responsbilities are no greater than for other illness or conditions. 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 (see page 71 describing how we derive our US FFS allowance) and any difference between our allowance and the billed amount
Inpatient Hospital or other covered facility	
Inpatient services provided and billed by a hospital or other covered facility • Room and board, such as semiprivate or intensive accommodations, general nursing care, meals and special diets, and other hospital services	Your cost-sharing responsibilities are no greater than for other illness or conditions. POS: $25 per hospitalization 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 page 71 describing how we derive our US FFS allowance) and any difference between our allowance and the billed amount
Outpatient hospital or other covered facility	
Outpatient services provided and billed by a hospital or other covered facility • Services such as partial hospitalization, half-way house, residential treatment, full-day hospitalization, or facility-based intensive outpatient treatment	Your cost-sharing responsibilities are no greater than for other illnesses or conditions. POS: $25 per hospitalization 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 page 71 describing how we derive our US FFS allowance) and any difference between our allowance and the billed amount
Not covered	
Services that are not medically necessary or clinically appropriate	*All Charges*

Preauthorization	To be eligible to receive these mental health and substance abuse benefits you should obtain a treatment plan and follow all of the following authorization processes. These include: • After your initial visit to your PCP (with a mental health illness), a POS mental health provider, or a FFS mental health practitioner, you or your provider must contact our medical department at 507-366-1400 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.
Percertification	The medical necessity of your admission to a hospital or other covered facility must be pre-certified. 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.
Filing a Claim	See Section 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. Also read Section 9 for information about how we pay if you have other coverage or if you are age 65 or older.

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 Note: We cover diabetes medications that are part of the Diabetes Disease Management Program formulary at 100%. For other Diabetes medications regular benefits apply.	POS: 20% of charges plus any non-covered expenses FFS Panama: 20% of charges plus any non-covered expenses FFS US: 20% of charges plus any non-covered expenses NOTE: Coinsurance for prescription drugs accumulates to the $5000 annual prescription out-of-pocket limit (for Self Only or Self and Family enrollments).
Women's FDA approved contraceptive drugs and devices for birth control with a physician prescription	Nothing
FDA and Plan approved medications for treatment of cancers, aplastic anemia, sickle -cell anemia, inhaler based medications for asthma and chronic obstructive pulmonary disease (COPD), and myelodysplasia syndrome. NOTE: Preauthorization is required for medications that treat cancer, aplastic anemia, sickle -cell anemia, and myelodysplasia syndrome at 100%.	Nothing

Covered medications and supplies - continued on next page

Benefits Description	You Pay
Covered medications and supplies (cont.)	
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* *Note: Physician prescribed over-the-counter or prescription drugs approved by the FDA to treat tobacco dependence are covered under the Tobacco cessation benefit. (See page 34).*	*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 payor 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. Also read Section 9 for information about how we pay if you have other coverage, or if you are age 65 or older.
- 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
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 for covered dental work required as a result of accidental injury that you incur within 52 weeks after the accident.

Dental Benefits	Service	
Office visits	**We pay**	**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 our fee schedule payment.
Dental Surgery	**We pay**	**You pay**
Extraction of impacted teeth, including x-rays	$100	All charges in excess of our fee schedule payment
Apicoectomy	$85	All charges in excess of our fee schedule payment
Lancing of erupting tooth	$70	All charges in excess of our fee schedule payment
Periodontics	**We pay**	**You pay**
Periodontal scaling and root planing Note: Prior to treatment, you must submit a competed 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.	$60 per quadrant	All charges in excess of our fee schedule payment
Endodontics	**We pay**	**You pay**
Root canal treatment, including • intra-oral drainage of abscess • devitalization • removal of pulp • root canal filing (limited to 4 canals)	$120 for one canal $150 for two canals $180 for three canals $210 for four canals	All charges in excess of our fee schedule payment

Endodontics - continued on next page

Dental Benefits	Service	
Endodontics (cont.)	**We pay**	**You pay**
Note: Prior to treatment, you must submit a competed dental Pre-Treatment EstimSate 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. Note: The Endodontics fee schedule allowance includes x-rays and there is no additional allowance for x-rays.	$120 for one canal $150 for two canals $180 for three canals $210 for four canals	All charges in excess of our fee schedule payment
What is not covered	**We pay**	**You pay**
• *Realignment of teeth (orthodontia) or treatment for cosmetic purposes* • *Repair of cavities* • *Repair or replacement of teeth except as shown above* • *Masticating (chewing) incidents* • *Tooth extractions not specified as covered above* • *X-rays (fee schedule includes the x-ray)* • *Dental surgery other than those specifically described above* • *Dental surgery, appliances, and adjustments of occlusion for temporomandibular joint syndrome (TMJ)*	*Nothing*	*All charges*

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 507-366-1400 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 regular contract benefits as a less costly alternative. If we identify a less costly, we will ask you to sign an alternative benefits agreement that will include all of the following terms in addition to other terms as necessary. Until you sign and return the agreement, regular contract benefits will continue. • Alternative benefits will be made available for a limited time period and are subject to our ongoing review. You must cooperate with the review process. • By approving an alternative benefit, we do not guarantee you will get it in the future. • The decision to offer an alternative benefit is solely ours, and except as expressly provided in the agreement, we may withdraw it at any time and resume regular contract benefits. • If you sign the agreement, we will provide the agreed-upon alternative benefits for the stated time period (unless circumstances change). You may request an extension of the time period, but regular contract benefits will resume if we do not approve your request. • Our decision to offer or withdraw alternative benefits is not subject to OPM review under the disputed claims process. However, if at the time we make a decision regarding alternative benefits, we also decide that regular contract benefits are not payable, then you may dispute our regular contract benefits decision under the OPM disputed claim process (see Section 8).
Centers of excellence	In the United States we have designated certain specialty hospitals as centers of excellence. 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 507-366-1400, and 1-800-424-8196 or 312-935-3671 in the United States.

Section 6. General exclusions – services, drugs and supplies we do not cover

The exclusions in this section apply to all benefits. There may be other exclusions and limitations listed in Section 5 of this brochure. Although we may list a specific service as a benefit, we will not cover it unless we determine it is medically necessary to prevent, diagnose, or treat your illness, disease, injury, or condition. For information on obtaining prior approval for specific services, such as transplants, (see Section 3 *When you need prior Plan approval for certain services*).

We do not cover and will not pay for 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, sexual dysfunctions or sexual inadequacy.
- Services, drugs, or supplies you receive from a provider or facility barred from the FEHB Program.
- Services, drugs, or supplies you receive without charge while in active military service.
- Services or supplies for which no charge would be made if the covered individual had no health insurance coverage.
- Services or supplies furnished by immediate relatives or household members, such as spouse, parents, children, brothers or sisters by blood, marriage or adoption.
- Services or supplies furnished or billed by a non-covered facility, except that medically necessary prescription drugs and physical, speech and occupational therapy rendered by a qualified professional therapist on an outpatient basis are covered subject to plan limits.
- Charges which 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 67), doctor's charges exceeding the amount specified by the Department of Health & Human Services when benefits are payable under Medicare (limiting charge, see page 68, or State premium taxes however applied).
- 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.
- 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.
- Eye refractions, eyeglasses and contact lenses unless its to correct an impairment directly caused by accidental ocular injury or intraocular surgery.
- Research costs related to conducting the clinical trial such as research physician and nurse time, analysis of results, and clinical tests performed only for research purposes.
- Extra care costs related to taking part in a clinical trial such as additional tests that a patient may need as part of the trial, but not as part of the patient's routine care.

Section 7. Filing a claim for covered services

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

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

How to claim benefits

To obtain claim forms, claims filing advice or answers about our benefits, contact us at 507-366-1400 in Panama, and 1-800-424-8196 or 312-935-3671 in the United States or at our website at www.PanamaCanalAreaBenefitPlan.com.pa.

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

When you must file a claim – such as for services you received overseas or when another group health plan is primary – submit it on the CMS-1500 or a claim form that includes the information shown below. Bills and receipts should be itemized and show:

- Patient's name, date of birth, address, phone number and relationship to enrollee
- Patient's Plan identification number
- Name and address of person or company providing the service or supply
- Dates that services or supplies were furnished
- Diagnosis
- Type of each service or supply
- Charge for each service or supply

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

In addition:

- If another health plan is your primary payor, you must send a copy of the explanation of benefits (EOB) form you received from your primary payor (such as the Medicare Summary Notice (MSN)) with your claim.
- Bills for home nursing care must show that the nurse is a registered or licensed practical nurse.
- If your claim is for the rental or purchase of durable medical equipment; private duty nursing; and physical therapy, occupational therapy, or speech therapy, you must provide 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 prescription number, name of drug or supply, prescribing physician's name, date, and charge.
- We will provide translation and currency conversion services for claims for overseas (foreign) services.

Post-service claims procedures

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

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

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

Records	Keep a separate record of the medical expenses of each covered family member as deductibles and maximum allowances apply separately to each person. Save copies of all medical bills, including those you accumulate to satisfy a deductible. In most instances they will serve as evidence of your claim. We will 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 submit the claim by December 31 of the year after the year you received the service. If you could not file on time because of Government administrative operations or legal incapacity, you must submit your claim as soon as reasonably possible. 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 and Panama, 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. If you have questions about the processing of overseas claims, contact us at 1-800-424-8196 or 312-935-3671 in the United States.
When we need more information	Please reply promptly when we ask for additional information. We may delay processing or deny benefits for your claim if you do not respond. Our deadline for responding to your claim is stayed while we await all of the additional information needed to process your claim.
Authorized Representative	You may designate an authorized representative to act on your behalf for filing a claim or to appeal claims decisions to us. For urgent care claims, a health care professional with knowledge of your medical condition will be permitted to act as your authorized representative without your express consent. For the purposes of this section, we are also referring to your authorized representative when we refer to you.
Notice Requirements	The Secretary of Health and Human Services has identified counties where at least 10 percent of the population is literate only in certain non-English languages. The non-English languages meeting this threshold in certain counties are Spanish, Chinese, Navajo and Tagalog. If you live in one of these counties, we will provide language assistance in the applicable non-English language. You can request a copy of your Explanation of Benefits (EOB) statement, related correspondence, oral language services (such as telephone customer assistance), and help with filing claims and appeals (including external reviews) in the applicable non-English language. The English versions of your EOBs and related correspondence will include information in the non-English language about how to access language services in that non-English language. Any notice of an adverse benefit determination or correspondence from us confirming an adverse benefit determination will include information sufficient to identify the claim involved (including the date of service, the health care provider, and the claim amount, if applicable), and a statement describing the availability, upon request, of the diagnosis and procedure codes and its corresponding meaning, and the treatment code and its corresponding meaning).

Section 8. The disputed claims process

You may be able to appeal directly to the Office of Personnel Management (OPM) if we do not follow required claims processes. For more information about situations in which you are entitled to immediately appeal to OPM, including additional requirements not listed in Sections 3, 7 and 8 of this brochure, please visit www.PanamaCanalAreaBenefitPlan.com.pa.

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

To help you prepare your appeal, you may arrange with us to review and copy, free of charge, all relevant materials and Plan documents under our control relating to your claim, including those that involve any expert review(s) of your claim. To make your request, please contact our Customer Service Department by writing to AXA Assistance, PO Box 31-0940, Miami Florida 33231-0940 (if services were provided anywhere outside of Panama) or to AXA Assistance, Vía España, Edificio P.H. Plaza Comercial San Fernando, Planta Baja, Locales No. 1 y 2, Corregimiento de Pueblo Nuevo. Panama City, Republic of Panama (if services were provided in Panama), or by calling 507-366-1400 in Panama, and 1-800-424-8196 or 312-935-3671 in the United States.

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

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

Our reconsideration decision will not afford deference to the initial decision and will be conducted by a plan representative who is neither the individual who made the initial decision that is the subject of the reconsideration, nor the subordinate of that individual.

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

Step	Description
1	Ask us in writing to reconsider our initial decision. You must: (a) Write to us within 6 months from the date of our decision; and (b) Send your request to us 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, Vía España, Edificio P.H. Plaza Comercial San Fernando, Planta Baja, Locales No. 1 y 2, Corregimiento de Pueblo Nuevo. Panama City, Republic of Panama. (c) Include a statement about why you believe our initial decision was wrong, based on specific benefit provisions in this brochure; and (d) Include copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms. (e) Include your email address (optional for member), if you would like to receive our decision via email. Please note that by giving us your email, we may be able to provide our decision more quickly. We will provide you, free of charge and in a timely manner, with any new or additional evidence considered, relied upon, or generated by us or at our direction in connection with your claim and any new rationale for our claim decision. We will provide you with this information sufficiently in advance of the date that we are required to provide you with our reconsideration decision to allow you a reasonable opportunity to respond to us before that date. However, our failure to provide you with new evidence or rationale in sufficient time to allow you to timely respond shall not invalidate our decision on reconsideration. You may respond to that new evidence or rationale at the OPM review stage described in step 4.

Step	Description
2	In the case of a post-service claim, we have 30 days from the date we receive your request to: a) Pay the claim b) Write to you and maintain our denial or c) Ask you or your provider for more information You or your provider must send the information so that we receive it within 60 days of our request. We will then decide within 30 more days. If we do not receive the information within 60 days we will decide within 30 days of the date the information was due. We will base our decision on the information we already have. We will write to you with our decision.
3	If you do not agree with our decision, you may ask OPM to review it. You must write to OPM within: • 90 days after the date of our letter upholding our initial decision; or • 120 days after you first wrote to us -- if we did not answer that request in some way within 30 days; or • 120 days after we asked for additional information. Write to OPM at: United States Office of Personnel Management, Healthcare and Insurance, Federal Employee Insurance Operations, Health Insurance 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. • Your email address, if you would like to receive OPM's decision via email. Please note that by providing your email address, you may receive OPM's decision more quickly. Note: If you want OPM to review more than one claim, you must clearly identify which documents apply to which claim. Note: You are the only person who has a right to file a disputed claim with OPM. Parties acting as your representative, such as medical providers, must include a copy of your specific written consent with the review request. However, for urgent care claims, a health care professional with knowledge of your medical condition may act as your authorized representative without your express consent. Note: The above deadlines may be extended if you show that you were unable to meet the deadline because of reasons beyond your control.
4	OPM will review your disputed claim request and will use the information it collects from you and us to decide whether our decision is correct. OPM will send you a final decision within 60 days. There are no other administrative appeals. If you do not agree with OPM's decision, your only recourse is to sue. If you decide to sue, you must file the suit against OPM in Federal court by December 31 of the third year after the year in which you received the disputed services, drugs, or supplies or from the year in which you were denied precertification or prior approval. This is the only deadline that may not be extended.

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

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

Note: **If you have a serious or life threatening condition** (one that may cause permanent loss of bodily functions or death if not treated as soon as possible), and you did not indicate that your claim was a claim for urgent care, then call us at 507-366-1400 in Panama, and 1-800-424-8196 or 312-935-3671 in the United States. We will hasten our review (if we have not yet responded to your claim); or we will inform OPM so they can quickly review your claim on appeal. You may call OPM's Health Insurance II at (202) 606-3818 between 8 a.m. and 5 p.m. eastern time.

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

Section 9. Coordinating benefits with Medicare and other coverage

When you have other health coverage

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

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

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

When we are the secondary payor, we will determine our allowance. 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.

- **TRICARE and CHAMPVA**

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

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

- **Workers' Compensation**

We do not cover services that:

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

Once OWCP or 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. 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.

Clinical Trials

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

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

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

When you have Medicare

- **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
- People with End-Stage Renal Disease (permanent kidney failure requiring dialysis or a transplant)

Medicare has four parts:

- Part A (Hospital Insurance). Most people do not have to pay for Part A. If you or your spouse worked for at least 10 years in Medicare-covered employment, you should be able to qualify for premium-free Part A insurance. (If you were a Federal employee at any time both before and during January 1983, you will receive credit for your Federal employment before January 1983.) Otherwise, if you are age 65 or older, you may be able to buy it. Contact 1-800-MEDICARE (1-800-633-4227), (TTY 1-877-486-2048) for more information.
- Part B (Medical Insurance). Most people pay monthly for Part B. Generally, Part B premiums are withheld from your monthly Social Security check or your retirement check.
- Part C (Medicare Advantage). You can enroll in a Medicare Advantage plan to get your Medicare benefits. 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, (TTY 1-800-325-0778) to set up an appointment to apply. If you do not apply for one or more Parts of Medicare, you can still be covered under the FEHB Program.

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

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

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

(Please refer to page 67 for information about how we provide benefits when you are age 65 or older and do not have medicare.)

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

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

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

When you 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 payor, we process the claim first.

When Original Medicare is the primary payor, 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 507-366-1400in Panama, and 1-800-424-8196 or 312-935-3671 in the United States or visit our website at www.PanamaCanalAreaBenefitPlan.com.pa.

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

- Medical services and supplies provided by physicians and other health care professionals. 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.

- **Tell us about your Medicare coverage**

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

- **Private contract with your physician**

A physician may ask you to sign a private contract agreeing that you can be billed directly for services ordinarily covered by Original Medicare. 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), (TTY 1-877-486-2048) or at www.medicare.gov.

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

This Plan and another plan's Medicare Advantage plan: You may enroll in another plan's Medicare Advantage plan and also remain enrolled in our FEHB plan. We will still provide benefits when your Medicare Advantage plan is primary, even out of the Medicare Advantage plan's network and/or service area (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 payor, we process the claim first. If you enroll in Medicare Part D and we are the secondary payor, we will review claims for your prescription drug costs that are not covered by Medicare Part D and consider them for payment under the FEHB plan.

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

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

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

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

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

If you:

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

Then, for your inpatient hospital care:

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

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

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

If your physician:	**Then you are responsible for:**
Participates with Medicare,	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.

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.
Clinical Trials Cost Categories	• Routine care costs – costs for routine services such as doctor visits, lab tests, x-rays and scans, and hospitalizations related to treating the patient's condition whether the patient is in a clinical trial or is receiving standard therapy • Extra care costs – costs related to taking part in a clinical trial such as additional tests that a patient may need as part of the trial, but not as part of the patient's routine care • Research costs – costs related to conducting the clinical trial such as research physician and nurse time, analysis of results, and clinical tests performed only for research purposes
Coinsurance	Coinsurance is the percentage of our allowance that you must pay for your care. You may also be responsible for additional amounts. See page 20.
Copayment	A copayment is a fixed amount of money you pay when you receive covered services. See page 20.
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 20.
Emergency	See page 47 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**.**

Health care professional

A physician or other health care professional licensed, accredited, or certified to perform specified health services consistent with state law.

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 and/or Panama;

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 FAIR Health 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.

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

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

Us/We Us and we refer to Panama Canal Area Benefit Plan

You You refers to the enrollee and each covered family member.

Urgent care claims A claim for medical care or treatment is an urgent care claim if waiting for the regular time limit for non-urgent care claims could have one of the following impacts:

- Waiting could seriously jeopardize your life or health;
- Waiting could seriously jeopardize your ability to regain maximum function; or
- In the opinion of a physician with knowledge of your medical condition, waiting would subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

Urgent care claims usually involve Pre-service claims and not Post-Service Claims. We will judge whether a claim is an urgent care claim by applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine.

If you believe your claim qualifies as an urgent care claim, please contact our Customer Service Department at us at 507-366-1400 in Panama, and 1-800-424-8196 or 312-935-3671 in the United States. You may also prove that your claim is an urgent care claim by providing evidence that a physician with knowledge of your medical condition has determined that your claim involves urgent care.

Section 11. Other Federal Programs

Please note, the following programs are not part of your FEHB benefits. They are separate Federal programs that complement your FEHB benefits and can potentially reduce your annual out-of-pocket expenses. These programs are offered independent of the FEHB Program and require you to enroll separately with no government contribution.

Important information about 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. The maximum annual election for a health care flexible spending account (HCFSA) or a limited expense health care spending account (LEX HCFSA) is $2,500.

- **Health Care FSA (HCFSA) –** Reimburses you for eligible health care expenses (such as copayments, deductibles, insulin, products, **physician prescribed** over-the-counter drugs and medications, vision and dental expenses, and much more) for you and your tax dependents, including adult children (through the end of the calendar year in which they turn 26) which are not covered or reimbursed by FEHBP or FEDVIP coverage or any other insurance. FSAFEDS offers paperless reimbursement for your HCFSA through a number of FEHB and FEDVIP plans. This means that when you or your provider file claims with your FEHB or FEDVIP plan, FSAFEDS will automatically reimburse your eligible out-of-pocket expenses based on the claim information it receives from your plan.
- **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 tax dependents including adult children (through the end of the calendar year in which they turn 26) which are not covered or reimbursed by FEHBP or FEDVIP coverage or any other insurance.
- **Dependent Care FSA (DCFSA)** – Reimburses you for eligible **non-medical** day care expenses for your child(ren) under age 13 and/or for any person you claim as a dependent on your Federal Income Tax return who is mentally or physically incapable of self-care. You (and your spouse if married) must be working, looking for work (income must be earned during the year), or attending school full-time to be eligible for a DCFSA.
- If you are a new or newly eligible employee you have 60 days from your hire date to enroll in an HCFSA or LEX HCFSA and/or DCFSA, but you must enroll before October 1. If you are hired or become eligible on or after October 1, you must wait and enroll during the Federal Benefits Open Season held each fall.

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

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

Important Information	The Federal Employees Dental and Vision Insurance Program (FEDVIP) is separate and different from the FEHB Program and was established by the Federal Employee Dental and Vision Benefits Enhancement Act of 2004. **This Program provides comprehensive dental and vision insurance at competitive group rates with no pre-existing condition limitations for enrollment.** 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	All dental plans provide a comprehensive range of services, including: • 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 for dependent children up to age 19.
Vision Insurance	All 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/vision and www.opm.gov/insure/dental. These sites also provide 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 pay for the potentially high cost of long term care services, which are not covered by FEHB plans. Long term care is help you receive to perform activities of daily living - such as bathing or dressing yourself - or supervision you receive because of a severe cognitive impairment such as Alzheimer's disease. For example, long term care can be received in your home from a home health aide, in a nursing home, in an assisted living facility or in adult day care. To qualify for coverage under the FLTCIP, you must apply and pass a medical screening (called underwriting). Federal and U.S. Postal Service employees and annuitants, active and retired members of the uniformed services, and qualified relatives, are eligible to apply. Certain medical conditions, or combinations of conditions, will prevent some people from being approved for coverage. You must apply to know if you will be approved for enrollment. For more information, call 1-800-LTC-FEDS (1-800-582-3337) (TTY 1-800-843-3557) or visit www.ltcfeds.com.

Pre-existing Condition Insurance Program (PCIP)

Do you know someone who needs health insurance but can't get it? The Pre-Existing Condition Insurance Plan (PCIP) may help.

An individual is eligible to buy coverage in PCIP if:

- He or she has a pre-existing medical condition or has been denied coverage because of the health condition;
- He or she has been without health coverage for at least the last six months. (If the individual currently has insurance coverage that does not cover the pre-existing condition or is enrolled in a state high risk pool then that person is not eligible for PCIP.);
- He or she is a citizen or national of the United States or resides in the U.S. legally.

The Federal government administers PCIP in the following states: Alabama, Arizona, District of Columbia, Delaware, Florida, Georgia, Hawaii, Idaho, Indiana, Kentucky, Louisiana, Massachusetts, Minnesota, Mississippi, North Dakota, Nebraska, Nevada, South Carolina, Tennessee, Texas, Vermont, Virginia, West Virginia, and Wyoming. To find out about eligibility, visit www.pcip.gov and/or www.healthcare.gov or call 1-866-717-5826 (TTY): 1-866-561-1604.

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Summary of benefits for the Panama Canal Area Benefit Plan - 2013

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: $5 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	25
Services provided by a hospital:		
• Inpatient	POS: Nothing after the $25 per admission copayment FFS Panama: $100 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: $100 per admission and 50% of the covered charges	43
• Outpatient	POS: $25 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	44
Emergency Benefits		
• Accidental injury (after 72 hours) • Medical Emergency	POS: $5 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	46 47
Mental health and substance abuse treatment	POS: Regular cost-sharing FFS: Regular cost-sharing	48

Benefits	You Pay	Page
Prescription drugs		
• FDA and Plan approved medication Note: Coinsurance for prescription drugs goes towards a $5000 annual prescription out-of-pocket limit.	20% of eligible charges	51
Dental care	All charges in excess of the fee schedule	53
Special Features: Health Support Programs Flexible Benefits Option Centers of Excellence		55
Protection against catastrophic costs After the 50% for hospital inpatient room and board and other eligible expenses reach $2500 per member per year, we will pay the remaining hospital room and board and other charges at 100% Note: This maximum applies only to FFS benefits. Some costs do not count toward this out-of-pocket protection maximum.	All charges that exceed our allowance.	21

2013 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			
		Biweekly		Monthly	
		Gov't Share	Your Share	Gov't Share	Your Share
Self Only	431	$154.67	$51.55	$335.11	$111.70
Self and Family	432	$322.84	$107.61	$699.48	$233.16