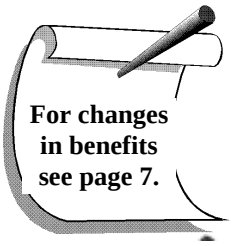
Panama Canal Area Benefit Plan

http://www.healthnetworkamerica.com

2001

A Managed Fee-for-Service plan with a Point of Service Option



Sponsored and administered by: *The Association of Retirees from the Panama Canal Area*

Who may enroll in this Plan: *A member of the Association (Panama Canal Area) who is eligible for coverage under the Federal Employees Health Benefits Program. Annuitants (retirees and/or survivors), residing in Panama may enroll in the Panama Canal Area Benefit Plan* ***provided they were previously enrolled in the Plan.***

Enrollment codes for this Plan:

431 Self Only
432 Self and Family

Authorized for distribution by the:

OPM
UNITED STATES
OFFICE OF PERSONNEL MANAGEMENT
RETIREMENT AND INSURANCE SERVICE
HTTP://WWW.OPM.GOV/INSURE

FEHB
Federal Employees
Health Benefits Program

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Introduction

Panama Canal Area Benefit Plan
Edificio Hatillo
Esquina Avenida Justo Arosemena y Calle 36
Panama, Republica de Panama

This brochure describes the benefits ***of the Panama Canal Area Benefit Plan*** **(PCABP)** under our contract (CS 1066) with the Office of Personnel Management (OPM), as authorized by the Federal Employees Health Benefits law. This brochure is the official statement of benefits. No oral statement can modify or otherwise affect the benefits, limitations, and exclusions of this brochure.

If you are enrolled in this Plan, you are entitled to the benefits described in this brochure. If you are enrolled for 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, 2001, unless those benefits are also shown in this brochure.

OPM negotiates benefits and rates with each plan annually. Benefit changes are effective January 1, 2001, and are summarized on page 7. Rates are shown at the end of this brochure.

Plain Language

The President and Vice President are making the Government's communication more responsive, accessible, and understandable to the public by requiring agencies to use plain language. In response, a team of health plan representatives and OPM staff worked cooperatively to make this brochure clearer. Except for necessary technical terms, we use common words. "You" means the enrollee or family member; "we" means *the Panama Canal Area Benefit Plan.*

The plain language team reorganized the brochure and the way we describe our benefits. When you compare this Plan with other FEHB plans, you will find that the brochures have the same format and similar information to make comparisons easier.

If you have comments or suggestions about how to improve this brochure, let us know. Visit OPM's "Rate Us" feedback area at www.opm.gov/insure or e-mail us at fehbwebcomments@opm.gov or write to OPM at Insurance Planning and Evaluation Division, P.O. Box 436, Washington, DC 20044-0436.

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

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

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

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

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

Contact us for the names of POS providers and to verify their continued participation. You can also go to our web page, which you can reach through the FEHB web site, www.opm.gov/insure. Do not call OPM or your agency (payroll office) for our provider directory.

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 to use a non-POS 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 "in-network" 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 only have to pay for your copayments described in this brochure and your prescription drug and dental claims.

If you live in Panama and select the Fee-for-Service (FFS) option, or if you live anywhere outside of Panama, you will usually have to pay for the medical services provided to you and then we will reimburse you according to the benefits described in this brochure.

In you permanently reside in the United States or any country outside of Panama you will usually have to pay the medical services provided to you and we will reimburse you based on the Health Insurance Association of America (HIAA) fee schedule at the 75th percentile and apply the benefits described in this brochure.

Patients' Bill of Rights

OPM requires that all FEHB Plans comply with the Patients' Bill of Rights, recommended by the Presidents Advisory Commission on Consumer Protection and Quality in the Health Care Industry. You may get information about us, our networks, providers, and facilities. OPM's FEHB website (www.opm.gov/insure) lists the specific types of information that we must make available to you. Some of the required information is listed below.

The Association of Retirees from 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 800-548-8969 in the United States (732-222-9696 if outside of the US or Panama) or 227-7555 within the Republic of Panama or write to:

Health Network America, Inc. (in the US or any country other than Panama)
Panama Canal Area
P.O. Box 398
W. Long Branch, NJ 07764

HNA Panama, S.A.
0832-1240 World Trade Center
Panama, Republica de Panama

You may also contact us by fax at 732-222-4584 (in the United States) or 227-8031 (in Panama) or visit our website at http://www.healthnetworkamerica.com.

Section 2. How we change for 2001

Program-wide changes

- The plain language team reorganized the brochure and the way we describe our benefits. We hope this will make it easier for you to compare plans.
- This year, the Federal Employees Health Benefits Program is implementing network mental health and substance abuse parity. This means that your coverage for mental health, substance abuse, medical, surgical, and hospital services from providers in our *Point-of-Service network* will be the same with regard to copays and day and visit limitations when you follow a treatment plan that we approve. Previously, we placed *shorter day or visit limitations* on mental health and substance abuse services than we did on services to treat physical illness, injury, or disease.
- Many healthcare organizations have turned their attention this past year to improving healthcare quality and patient safety. OPM asked all FEHB plans to join them in this effort. You can find specific information on our patient safety activities by calling one of our case management nurses in the United States at 800-548-8969 or in the Republic of Panama at 227-7555, **or** checking our website http://www.healthnetworkamerica.com. You can find out more about patient safety on the OPM website, www.opm.gov/insure. To improve your healthcare, take these five steps:
  - •• Speak up if you have questions or concerns.
  - •• Keep a list of all the medications you take.
  - •• Make sure you get the results of any test or procedure.
  - •• Talk with your doctor and health care team about your options if you need hospital care.
  - •• Make sure you understand what will happen if you need surgery.
- We clarified the language to show that anyone who needs a mastectomy may choose to have the procedure performed on an inpatient basis and remain in the hospital for up to 48 hours after the procedure. Previously, the language referenced only women.
- North Dakota is deleted from the list of states designated as medically underserved in 2001. See page 8 for information on medically underserved areas.

Changes to the Panama Canal Area Benefit Plan

- Your share of the non-Postal premium will increase by 52% for Self Only or 37% for Self and Family.
- Fee Schedules—In 2001 you will notice that you have three different fee schedules—Point-of-Service, Fee-for-Service Panama, and Fee-for-Service US. If you reside in Panama and elect the Point-of-Service option, you will be responsible for what is listed next to the POS benefit. If you reside in Panama and elect the Fee-for-Service option, your responsibility will be listed next to FFS Panama. If you live in the United States or a foreign country other than Panama, your responsibility will be based on what is written next to the FFS US benefit. Please refer to page 59 for a detailed description of how we calculate this Plan's allowance.
- Fee for Service—Under the FFS option your cost sharing responsibility has increased. Generally, you will be responsible for 50% of our allowance (POS fee schedule in the Republic of Panama and the US FFS fee schedule in the United States or any country other than Panama). Please refer to page 59 for an explanation of how we derive our allowable amount. Also, please review carefully the FFS benefits.
- Point-of-Service—This year you will be required to share the cost of the medical services provided to you in the form of copayments. Basically, for all outpatient professional visits, you will be responsible for a $10 copay and $75 for all admissions and ambulatory surgery facilities. Please see the POS section beginning on page 18 for a detailed explanation of your cost sharing responsibility.
- FFS Protection Against Catastrophic Costs—This year the catastrophic maximum for Inpatient services has been increased from $1,000 to $2,500. After your out-of-pocket expenses for the 50% coinsurance for Inpatient Hospital charges reach $2,500 in a calendar year, the Plan will then pay the remaining hospital inpatient charges at 100%.

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. 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 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 800-548-8969 in the US or 227-7555 within the Republic of Panama.

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 point-of-service program, you will pay less.

- **Covered Providers**

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

For purposes of this Plan, covered providers include: a licensed doctor of medicine (M.D.) or a licensed doctor of osteopathy (D.O.); a licensed specialist in his/her specialty. Other covered providers include: a licensed doctor of podiatry (D.P.M.); a licensed dentist (D.D.S. or D.M.D.); licensed chiropractor (D.C.); licensed registered physical or occupational therapist (R.P.T., R.O.T.) practicing within the scope of their license. Other covered providers include a qualified clinical psychologist, clinical social worker, optometrist, nurse midwife, nurse practitioner/clinical specialist and nursing school administered clinic. For purposes of this FEHB brochure, the term "doctor" includes all of these providers when the services are performed within the scope of their license or certification.

••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: In medically underserved areas, we cover any licensed medical practitioner for any covered service performed within the scope of that license in states OPM determines are "medically underserved." For 2001, the states are: Alabama, Idaho, Kentucky, Louisiana, Mississippi, Missouri, New Mexico, South Carolina, South Dakota, Utah, and Wyoming.

- **Covered facilities**

Covered facilities include:

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

••Hospice—A public or private agency or organization which:

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

••Hospital

1. An institution which is accredited as a hospital under the Hospital Accreditation Program of the Joint Commission on Accreditation of Healthcare Organizations or
2. Any other institution which is operated persuant to law under the supervision of a staff of doctors and with 24-hour-a-day nursing service, and which is primarily engaged in providing:
   a) General patient care and treatment of sick or injured persons through medical, diagnostic and major surgical facilities, all of which must be provided on its premises or under its control; or
   b) Specialized inpatient medical care and treatment of sick or injured persons through medical and diagnostic facilities (including X-ray and laboratory) on its premises, under its control or through a written agreement with a Hospital (as defined above) or with a specialized provider of those facilities.

In no event shall the term Hospital include a convalescent nursing home, or an institution or part thereof which:

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

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

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

What you must do to get covered care

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

Transitional care:

Specialty care: If you have a chronic or disabling condition and lose access to your specialist because we:

- terminate our contract with your specialist for other than cause; or
- drop out of the Federal Employees Health Benefits (FEHB) Program and you enroll in another FEHB Plan,

you may be able to continue seeing your specialist 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 until the end of your postpartum care, even if it is beyond the 90 days.

Hospital care. 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 800-548-8969 in the US, 227-7555 in Panama or 732-222-9696 outside of the US and Panama

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

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

These provisions apply only to the benefits of the hospitalized person.

How to Get Approval for…

• Your hospital stay

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

In most cases, your physician or hospital will take care of precertification. Because you are still responsible for ensuring that we are asked to precertify your care, 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. In addition, if the stay is not medically necessary, we will only pay for any covered medical supplies and services that are otherwise payable on an outpatient basis**.**

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

- You, your representative, your doctor, or your hospital must call us at 800-548-8969 in the US, 227-7555 in Panama or 732-222-9696 if you reside outside of the US and Panama, at least 24 hours prior to admission.

- If you have an emergency admission due to a condition that you reasonably believe puts your life in danger or could cause serious damage to bodily function, you, your representative, the doctor, or the hospital must telephone us within two business days following the day of the emergency admission, even if you have been discharged from the hospital.

- Provide the following information:

  ●● Enrollee's name and Plan identification number;

  ●● Patient's name, birth date, and phone number;

  ●● Reason for hospitalization, proposed treatment, or surgery;

  ●● Name and phone number of admitting doctor;

  ●● Name of hospital or facility; and

  ●● Number of planned days of hospital stay.

- We will then tell the doctor and/or hospital the number of approved inpatient days and we will send written confirmation of our decision to you, your doctor, and the hospital.

Maternity care

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

If your hospital stay needs to be extended:

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

What happens when you do not follow the precertification rules

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

  ●● for the part of the admission that was medically necessary, we will pay inpatient benefits, but

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

- If no one contacted us, we will decide whether the hospital stay was

medically necessary.

- If we determine that the stay was medically necessary, we will pay the inpatient benefits. You will be responsible for a $500 penalty.

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

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

Exceptions:

You do not need precertification in these cases:

- You are admitted to a hospital outside the United States, Puerto Rico and Panama.

- You have another group health insurance policy that is the primary payer for the hospital stay.

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

• Other services

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

- For all elective (non-emergency) surgical procedures, we 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 require you to get a second surgical opinion. If you fail to comply with this requirement, we will limit our payment to 50% of our Plan allowance for these surgery charges if medical necessity can be determined.
- Growth hormone therapy (GHT)
- If designated outpatient surgical procedures (see page 31 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 a $500 penalty for inpatient charges.

Section 4. Your costs for covered services

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

•Copayments

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

Example: When you see a participating physician under the POS option, you pay a copayment of $10 per visit.

•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 do not count toward any deductible.

•• The calendar year deductible for prescription drugs is $400 per enrollee (see page 45). This Plan has no other calendar year deductibles.

Note: If you change plans during open season, 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.

•Coinsurance

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

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

Note: 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 US 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).

- **Fee-for-Service Outpatient Maximum**

Most Fee-for-Service outpatient benefits are subject to the outpatient benefit maximums of $650 for Self Only enrollment and $1,500 for Self and Family enrollment per calendar year, regardless of where the services are provided. If an enrollee has Self and Family enrollment, the $1,500 outpatient maximum can be reached by one or more family members.

•Differences between our allowance and the bill

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

Often, the provider's bill is more than the 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: You see a POS physician who charges $50, but our allowance is $30. You are only responsible for your copayment amount. That is, you pay just -- $10 of our $30 allowance. Because of the agreement, your POS physician should not bill you for the $20 difference between our allowance and his bill.

- **FFS providers**, on the other hand, have no agreement to limit what they will bill you. When you use the FFS option, 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 ($15.00). Plus, because there is no agreement between the FFS physician and us, he can bill you for the $20 difference between our allowance and his bill.

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

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

FFS 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 chargers at 100% of Plan allowance.

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

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

- Expenses in excess of our Plan allowances and maximum benefit limitations;
- Expenses for mental conditions, substance abuse, dental care or prescription drugs;
- Any amounts you pay because benefits have been reduced for non-compliance with this plan´s cost containment requirements (see pages 10 and 14); and
- The $125 copayment per person per admission for hospital room and board.

When government facilities bill us

Facilities of the Department of Veterans 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.

If we overpay

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

Under the FEHB law, we must limit our payments for those benefits you would be entitled to if you had Medicare. And, your physician and hospital must follow Medicare rules and cannot bill you for more than they could bill you if you had Medicare. 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 you owe 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; and
- The law prohibits a hospital from collecting more than the Medicare equivalent amount.

And, for your physician care, the law requires us to base our payment and your coinsurance 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 balance 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 only permitted to collect up to the Medicare approved amount.

Our explanation of benefits (EOB) form will tell you how much the physician or hospital may 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

We limit our payment to an amount that supplements the benefits that Medicare would pay under Part A (Hospital insurance) and 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.

If you are covered by Medicare Part B and it is primary, your out of pocket costs for services 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 our payment combined with Medicare's payment and the charge.

Note: The 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 them to reduce their charges. If they do not, report them to your Medicare carrier who sent you the MSN form. Call us if you need further assistance at 800-548-8969.

When you have a Medicare Private Contract

A physician may ask you to sign a private contract agreeing that you can be billed directly for service ordinarily covered by 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 Medicare's payment.

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

Section 5. Benefits – OVERVIEW

(See page 7 for how our benefits changed this year and pages 65-66 for a benefits summary.)

NOTE: This benefits section is broken into subsections. Please read the important things you should keep in mind at the beginning of each subsection. Also read the general exclusions in section 6; they apply to the benefits in the following subsections. To obtain claims forms, claims filing advice, or more information about our benefits, contact us at 800-548-8969 in the United States or 227-7555 in the Republic of Panama or at our website http://www.healthnetworkamerica.com.

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

IMPORTANT

Here are some 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.
- Except for the prescription drug benefit there is no calendar year deductible. However, if you are a FFS member, almost all outpatient benefits are applied to an outpatient maximum of $650 under the self only option and $1500 under the self and family option. We added "No outpatient maximum" to show when the calendar year outpatient maximum does not apply.
- Be sure to read Section 4, *Your costs for covered services* for valuable information about how cost sharing works, with special sections for members who are age 65 or over. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

IMPORTANT

Benefit Description	You pay
NOTE: The outpatient maximum applies to almost all FFS benefits. We say "No Outpatient maximum" when it does not apply.	
Diagnostic and treatment services	
Professional services of physicians • In physician's office • Office medical consultations • Physician home visits • In a skilled nursing facility	POS: $10 copayment FFS Panama: 50% of the Panama POS Fee schedule amount and any difference between the POS Fee schedule and the billed amount. FFS US: 50% of the US FFS Plan allowance (see page 59 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	POS: Nothing FFS Panama: 50% of the Panama POS Fee schedule amount and any difference between the POS Fee schedule and the billed amount. FFS US: 50% of the US FFS Plan allowance and any difference between our allowance and the billed amount

Inpatient Physician Hospital Visit Note: Under the FFS option this benefit is limited to $35 per day per doctor.	POS: Nothing FFS Panama: Nothing up to $35 per doctor per day and all charges thereafter. FFS US: Nothing up to $35 per doctor per day and all charges thereafter.

Lab, X-ray and other diagnostic tests	**You pay**
Laboratory tests, such as: • Blood tests • Urinalysis • Non-routine pap tests • Pathology • X-rays • Non-routine Mammograms • CAT Scans/MRI • Ultrasound • Electrocardiogram and EEG	POS: Nothing FFS Panama: 50% of the Panama POS Fee schedule amount and any difference between the POS fee schedule and the billed amount FFS US: 50% of the US FFS Plan allowance and any difference between our allowance and the billed amount Note: If your POS provider uses a FFS lab or radiologist, we will pay FFS benefits for any lab and X-ray charges.
Preventive care, adult	**You pay**
Routine Medical Check-up every 6 months	POS: Nothing FFS Panama: All Charges FFS US: All Charges
Routine screenings, limited to: • Blood lead level – One annually • Total Blood Cholesterol – once every three years, ages 19 through 64 • Colorectal Cancer Screening, including •• Fecal occult blood test •• Sigmoidoscopy, screening – every five years starting at age 50	POS: Nothing FFS Panama: 50% of the Panama POS Fee schedule amount and any difference between the POS fee schedule and the billed amount (No outpatient maximum). FFS US: 50% of the US FFS Plan allowance and any difference between our allowance and the billed amount (No outpatient maximum).

Preventive care, adult--*continued*	**You pay**
Prostate Specific Antigen (PSA test) – one annually for men age 40 and older	POS: Nothing FFS Panama: 50% of the Panama POS Fee schedule amount and any difference between the POS fee schedule and the billed amount (No outpatient maximum). FFS US: 50% of the US FFS Plan allowance and any difference between our allowance and the billed amount (No outpatient maximum).
Routine pap test .	POS: Nothing FFS Panama: 50% of the Panama POS Fee schedule amount and any difference between the POS fee schedule and the billed amount (No outpatient maximum). FFS US: 50% of the US FFS Plan allowance and any difference between our allowance and the billed amount (No outpatient maximum).
Routine 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 (No outpatient maximum). FFS US: 50% of the US FFS Plan allowance and any difference between our allowance and the billed amount (No outpatient maximum).

Preventive care, adult	**You pay**
Routine Immunizations, limited to: • Tetanus-diphtheria (Td) booster – once every 10 years, ages19 and over (except as provided for under Childhood immunizations) • Influenza, annually, age 60 and over • Pneumococcal vaccines, every 5 years age 60 and over	POS: Nothing FFS Panama: Not a covered benefit. You pay all billed charges FFS US: Not a covered benefit. You pay all billed charges.

Preventive care, children	You pay
• Childhood immunizations for dependent children under the age of 22 as follows: DPT (diphtheria, tetanus, pertussis vaccine); OPV (oral polio vaccine); Hepatitis B Vaccine; Haemophilis influenza type b vaccine (flu shot); MMR (measles, mumps, rubella vaccine); and Td (tetanus diphtheria toxoid booster).	POS: Nothing FFS Panama: 50% of the Panama POS Fee schedule amount and any difference between the POS fee schedule and the billed amount (No outpatient maximum). FFS US: 50% of the US FFS Plan allowance and any difference between our allowance and the billed amount (No outpatient maximum).
• For well-child care charges for routine examinations, the following schedule applies: 6 annual visits up to age 1; 2 annual visits between the ages of 1 and 2; 1 annual visit ages 3 to 13.	POS: Nothing FFS Panama: 50% of the Panama POS Fee schedule amount and any difference between the POS fee schedule and the billed amount (No outpatient maximum). FFS US: 50% of the US FFS Plan allowance and any difference between our allowance and the billed amount (No outpatient maximum).
• Examinations, limited to: •• Examinations for amblyopia and strabismus – limited to one screening examination (ages 2 through 6) •• Examinations done on the day of immunizations (ages 3 through 22) See above schedule.	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	You pay
Complete maternity (obstetrical) care, such as: • Prenatal care • Delivery • Postnatal care Note: Here are some things to keep in mind: • You do not need to precertify your normal delivery; however, you must obtain precertification for other circumstances, such as extended stays for you or your baby. • You may remain in the hospital up to 48 hours after a regular delivery and 96 hours after a cesarean delivery. We will cover an extended stay, if medically necessary, but you must precertify.	POS: $10 copayment for all office visits. FFS Panama: 50% of the Panama POS Fee schedule amount and any difference between the POS fee schedule and the billed amount FFS US: 50% of the US FFS Plan allowance and any difference between our allowance and the billed amount.
• 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. • We pay hospitalization and surgeon services (delivery) the same as for illness and injury. See Hospital benefits (Section 5c) and Surgery benefits (Section 5b).	*(see above)*
Not covered: Routine sonograms to determine fetal age, size or sex	*All charges*
Family planning	
• Voluntary sterilization • Surgically implanted contraceptives • Injectable contraceptive drugs • Intrauterine devices (IUDs) Note: We cover contraceptive drugs in 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	You pay
Diagnosis and treatment of infertility, except as excluded.	POS: $10 copayment per consultation FFS Panama: 50% of the Panama POS Fee schedule amount and any difference between the POS fee schedule and the billed amount FFS US: 50% of the US FFS Plan allowance and any difference between our allowance and the billed amount.
Not covered: • *Assisted reproductive technology (ART) procedures, such as:* •• *artificial insemination* •• *in vitro fertilization* •• *embryo transfer and GIFT* •• *intravaginal insemination (IVI)* •• *intracervical insemination (ICI)* •• *intrauterine insemination (IUI)* • *Services and supplies related to ART procedures.*	*All charges.*

Allergy care	You pay
Testing and treatment, including materials (such as allergy serum) and allergy injections.	POS: $10 copayment for the consultation; nothing for the authorized injections. 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 and sublingual allergy desensitization	*All charges*

Treatment therapies	You pay
• Chemotherapy and radiation therapy Note: High dose chemotherapy in association with autologous bone marrow transplants is limited to those transplants listed on page 33. • Dialysis – Hemodialysis and peritoneal dialysis • Intravenous (IV)/Infusion Therapy – Home IV and antibiotic therapy • Growth hormone therapy (GHT) Note: – We only cover GHT when we preauthorize the treatment. Call 800-548-8969 in the US or 227-7555 in Panama for preauthorization. We will ask you to submit information that establishes that the GHT is medically necessary. Ask us to authorize GHT before you begin treatment; otherwise, we will only cover GHT services from the date you submit the information. If you do not ask or if we determine GHT is not medically necessary, we will not cover the GHT or related services and supplies. See *Services requiring our prior approval* in Section 3. • Respiratory and inhalation therapies	POS: Nothing FFS Panama: 50% of the Panama POS Fee schedule amount and any difference between the POS fee schedule and the billed amount. "No outpatient maximum". FFS US: 50% of the US FFS Plan allowance and any difference between our allowance and the billed amount. "No outpatient Maximum".

Rehabilitative therapies	You pay
Short-term rehabilitative physical therapy (POS) or physical and occupational therapy (FFS) is provided on an inpatient or outpatient basis for up to two months per condition 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.	POS: $10 copayment for first visit in an authorized series (for example, if we authorize 10 visits to a physical therapist, you are responsible for a $10 copayment for the first visit and nothing thereafter). 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: 50% of the US FFS Plan allowance and any difference between our allowance and the billed amount up to an internal limit of $250 per calendar year.

Rehabilitative therapies-*continued*	You pay
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.	*Same as above*
Not covered: • *long-term rehabilitative therapy* • *exercise programs* • *Speech therapy* • *Occupational therapy (POS)*	*All charges.*
Hearing services (testing, treatment, and supplies)	
Hearing Exam—annual audiologist visit.	POS: $10 copayment FFS Panama: Not covered. You must pay all billed charges. FFS US: Not covered. You must pay all billed charges.
Not covered: • *hearing testing, except as mentioned above* • *hearing aids*	*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)	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* • *Eye exercises and orthoptics* • *Radial keratotomy and other refractive surgery*	*All charges.*

Foot care	You pay
Specific foot care when you are under active treatment for a metabolic or peripheral vascular disease, such as diabetes. Note: See orthopedic and prosthetic devices for information on podiatric shoe inserts	POS: $10 copayment FFS Panama: 50% of the Panama POS Fee schedule amount and any difference between the POS fee schedule and the billed amount FFS US: 50% of the US FFS Plan allowance and any difference between our allowance and the billed amount.
Not covered: • *Cutting, trimming or removal of corns, calluses, or the free edge of toenails, and similar routine treatment of conditions of the foot, except as stated above* • *Treatment of weak, strained or flat feet or bunions or spurs; and of any instability, imbalance or subluxation of the foot (unless the treatment is by open cutting surgery)*	*All charges*

Orthopedic and prosthetic devices	
• Externally worn breast prostheses and surgical bras, including necessary replacements following a mastectomy • 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.	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: Prosthetic appliances such as: • *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)	You pay
Durable medical equipment (DME) is equipment and supplies that: 1. Are prescribed by your attending physician (i.e., the physician who is treating your illness or injury); 2. Are medically necessary; 3. Are primarily and customarily used only for a medical purpose; 4. Are generally useful only to a person with an illness or injury; 5. Are designed for prolonged use; and 6. Serve a specific therapeutic purpose in the treatment of an illness or injury.	POS: All charges FFS Panama: All charges FFS US: All charges
Not covered: All DME such as: • Hospital beds; • Wheelchairs • Crutches • Walkers.	*All charges*

Home health services	
40 days per calendar year up to the Plan allowable amount: • A registered nurse (R.N.), licensed practical nurse (L.P.N.) or licensed vocational nurse (L.V.N.) 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.
Not covered: • *Nursing care requested by, or for the convenience of, the patient or the patient's family;* • *nursing care primarily for hygiene, feeding, exercising, moving the patient, homemaking, companionship or giving oral medication.*	*All charges.*

Alternative treatments	You pay
Acupuncture – by a doctor of medicine or osteopathy for: anesthesia or pain relief up benefit maximum of $250 per calendar year. Chiropractic Services—By a physician or licensed doctor of chiropractic medicine for pain management, asthma and arthritis up to benefit maximum of $250 per calendar year.	POS: $10 Copayment per treatment 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 8)	. *All charges*

Educational classes and programs	
Coverage is limited to: • Smoking Cessation – Up to $100 for one smoking cessation program per member per lifetime, including all related expenses such as drugs.	POS: Nothing up to $100. All charges greater than $100. FFS Panama: Nothing up to $100. All charges greater than $100 FFS US: Nothing up to $100. All Charges greater than $100.

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

IMPORTANT

Here are some 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 Non-POS members will be asked to share the costs of the procedures in the form of a copayment or coinsurance.
- Be sure to read Section 4, *Your costs for covered services* for valuable information about how cost sharing works, with special sections for members who are age 65 or over. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- The amounts listed below are for the charges billed by a physician or other health care professional for your surgical care. Any costs associated with the facility charge (i.e. hospital, surgical center, etc.) are in Section 5 (c).
- **YOU MUST GET PRECERTIFICATION OF ALL SURGICAL PROCEDURES.** Please refer to the precertification information shown in Section 3 to be sure which services require precertification.

IMPORTANT

Surgical procedures	You Pay
• Operative procedures • Treatment of fractures, including casting • Normal pre- and post-operative care by the surgeon • Correction of amblyopia and strabismus • Endoscopy procedure • Biopsy procedure • Electroconvulsive therapy	POS: Nothing. FFS Panama: 50% of the Panama POS Fee schedule amount and any difference between the POS fee schedule and the billed amount FFS US: 50% of the US FFS Plan allowance and any difference between our allowance and the billed amount.

Surgical procedures-*continued*	You pay
• Removal of tumors and cysts (non-cosmetic) • Correction of congenital anomalies (see Reconstructive surgery) • Surgical treatment of morbid obesity -- 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 • Insertion of internal prostethic devices • Voluntary sterilization, Norplant (a surgically implanted contraceptive), and intrauterine devices (IUDs) • Eye Surgery • Treatment of burns Note: You must precertify all surgical procedures. In additional, we may require you to obtain a second surgical opinion for certain procedures. If you are planning to have a surgery, please call our nursing department at 800-548-8969 in the US or 227-7555 in Panama 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.	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
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 procedures performed through the same incision may be "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

Surgical procedures-*continued*	**You pay**
Not covered: • *Reversal of voluntary sterilization* • *Services of an assistant surgeon except when required by law.* • *Services of a standby surgeon, except during angioplasty or other high risk procedures when we determine standbys are medically necessary* • *Routine treatment of conditions of the foot; see Foot care*	*All charges.*
Note: We have designated the following as outpatient surgical procedures. If you undergo one of the following procedures inpatient without explicit approval from us, we will apply a $500 penalty: • 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 (puncture of the membrane in ear) • Prostate biopsy • Reduction of nasal fracture, open or closed • Vasectomy (male sterilization).	

Reconstructive surgery	You pay
• 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 deformaties; 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 on the other breast; •• 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 this procedure performed on an inpatient basis and remain in the hospital 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.
Not covered: • *Cosmetic surgery – any surgical procedure (or any portion of a procedure) performed primarily to improve physical appearance through change in bodily form, except repair of accidental injury.* • *Surgeries related to sex transformation or sexual dysfunction*	All charges

Oral and maxillofacial surgery	You pay
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	
Limited to: • Cornea • Heart • Heart/lung • Kidney • Kidney/Pancreas • Liver • Lung: Single – only for the following end-stage pulmonary diseases: primary fibrosis, primary pulmonary hypertension, or emphysema; Double – only for patients with cystic fibrosis • Pancreas • Allogeneic bone marrow transplants – only for patients with acute lymphocytic or non-lymphocytc leukemia: advanced Hodgkins lymphoma; advanced non-Hodgkins lymphoma; advanced neuroblastoma; and testicular, mediastinal, retroperitoneal and ovarian germ cell tumors. • Autologous bone marrow transplants (autologous stem cell support) and autologous peripheral stem cell support for acute lymphocytic or non-lymphocytic leukemia; advanced Hodgkin´s lymphoma; advanced non-Hodgkin´s lymphoma; advanced neuroblastoma; breast cancer; multiple myloma and epithelial ovarian cancer; and testicular, mediastinal, retroperitoneal and ovarian germ cell tumors. Note: We cover related medical and hospital expenses of the donor when we cover the recipient.	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: • *Donor screening tests and donor search expenses, except those performed for the actual donor* • *Implants of artificial organs* • *Transplants not listed as covered*	*All charges*

Anesthesia	You pay
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 non-participating anesthesiologist, we will pay FFS benefits for any anesthesia charges.

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

IMPORTANT

Here are some 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 $75 per admission copayment for POS members and a $125 per admission copayment for Non-POS members applies to only a few benefits.
- Be sure to read Section 4, *Your costs for covered services* for valuable information about how cost sharing works, with special sections for members who are age 65 or over. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- The amounts listed below are for the charges billed by the facility (i.e. hospital or surgical center) or ambulance service for your surgery or care. Any costs associated with the professional charge (i.e. physicians, etc.) are in Section 5(a) or (b).
- **YOU MUST GET PRECERTIFICATION OF 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.

IMPORTANT

Benefit Description	You pay
Inpatient hospital	
Room and board, such as • ward, semiprivate, or intensive care accommodations; • general nursing care; and • meals and special diets. NOTE: We only cover a private room when you must be isolated to prevent contagion. Otherwise, we will pay the hospital's average charge for semiprivate accommodations. If the hospital only has private rooms, we base our payment on the average semiprivate rate of the most comparable hospital in the area. NOTE: When the non-POS 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 $75 per admission copayment FFS Panama: $125 per admission, then 50% of the Panama POS Fee schedule amount and any difference between the POS fee schedule and the billed amount FFS US: $125 per admission and 50% of the covered charges (per admission deductible applies).

Inpatient hospital - Continued on next page.

Inpatient hospital - *Continued*	**You pay**
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—Except medicines • Medical supplies, appliances, medical equipment, and any covered items billed by a hospital for use at home. NOTE: We base payment on whether the facility or a 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.	(see above)
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 or 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 • Injectable 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: $75 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.

Extended care benefits/Skilled nursing care facility benefits	You pay
We pay a comprehensive range of extended care benefits for up to 60 days per calendar year when full-time skilled nursing care is necessary and confinement in a skilled nursing facility is medically appropriate as determined by a Plan doctor and approved by the Plan. All necessary services are covered.	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 and general nursing services, in a hospital or sub-acute care facility, when we determine that you are eligible for this less acute hospital care.	POS: Nothing FFS: Not an eligible benefit outside of the POS network.
Not covered: Custodial care	*All charges.*
Hospice care	
Hospice is a coordinated program of maintenance and supportive care for the terminally ill provided by a medically supervised team under the direction of a Plan-approved independent hospice administration. • We pay $5000 per lifetime.	POS: Nothing until benefits stop at $5000. FFS Panama: 50% of the Panama POS Fee schedule amount and any difference between the POS fee schedule and the billed amount. You pay all charges after the $5000 lifetime benefit maximum. FFS US: 50% of the US FFS Plan allowance and any difference between our allowance and the billed amount You pay all charges after the $5000 lifetime benefit maximum.
Not covered: Independent nursing, homemaker	*All charges.*

Ambulance (non-emergency)	You pay
• Local professional ambulance service when medically appropriate. • We pay a maximum of $100 per incident that results in transfer between medical facilities or medical facility and patient's home. • We require you to pre-authorize the use of an ambulance if it is not an emergency situation.	POS: Nothing. All charges after $100 maximum FFS Panama: 50% of the Panama POS Fee schedule amount and any difference between the POS fee schedule and the billed amount. All charges after $100 maximum FFS US: 50% of the US FFS Plan allowance and any difference between our allowance and the billed amount. All charges after $100 maximum

Section 5 (d). Emergency services/accidents

IMPORTANT

Here are some important things to keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure.
- If you are a FFS member, almost all outpatient benefits are applied to an outpatient maximum of $650 under the self only option and $1500 under the self and family option.
- Be sure to read Section 4, *Your costs for covered services* for valuable information about how cost sharing works, with special sections for members who are age 65 or over. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

IMPORTANT

What is an accidental injury?

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

Benefit Description	You pay
Accidental injury	
If you receive care for your accidental injury within 72 hours, we cover: • Physician services and supplies • Related outpatient hospital services Note: We pay Hospital benefits if you are admitted.	POS: Nothing FFS Panama: 50% of the Panama POS Fee schedule amount and any difference between the POS fee schedule and the billed amount FFS US: 50% of the US FFS Plan allowance and any difference between our allowance and the billed amount.

Accidental injury -- Continued on next page

Accidental injury-*continued*	You pay
If you receive care for your accidental injury after 72 hours, we cover: • Physician services and supplies • Surgical care Note: We pay Hospital benefits if you are admitted.	POS: $10 copayment for office visit or emergency room visit. FFS Panama: 50% of the Panama POS Fee schedule amount and any difference between the POS fee schedule and the billed amount FFS US: 50% of the US FFS Plan allowance and any difference between our allowance and the billed amount.

Medical emergency	
Outpatient medical or surgical services and supplies Note: We define medical emergency as the sudden and unexpected onset of a condition requiring immediate medical care, that the covered person secures within 72 hours after the onset. The severity of the condition as revealed by the doctor´s diagnosis, must be such as would normally require emergency care. Medical emergencies include heart attacks, cardiovascular accidents, poisonings, loss of consciousness or respiration, convulsions, and such other acute conditions as may be determined by the Plan to be medical emergencies	POS: $10 facility copayment for emergency room visit or office visit. FFS Panama: 50% of the Panama POS Fee schedule amount and any difference between the POS fee schedule and the billed amount FFS US: 50% of the US FFS Plan allowance and any difference between our allowance and the billed amount.
Ambulance	
We pay 100% of reasonable and customary charges up to $100 per incident that results in admission to a hospital or transfer between medical facilities, when pre-authorization 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 100% of reasonable and customary charges. Note: See5 (c) for non-emergent service	POS: Nothing if you use a network ambulance service FFS Panama: 50% of the Panama POS Fee schedule amount and any difference between the POS fee schedule and the billed amount.All charges after $100 maximum FFS US: 50% of the US FFS Plan allowance and any difference between our allowance and the billed amount. All charges after $100 maximum
Air Ambulance In certain extreme emergency situations we may pay for air ambulance services to transfer a Panama member either from outlying areas in the Republic of Panama to Panama City, or from Panama to the United States if you require care that we determine cannot be adequately provided in the Republic of Panama.	POS: Nothing FFS Panama: 50% of the Panama POS Fee schedule amount and any difference between the POS fee schedule and the billed amount FFS US: Not an eligible benefit

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

IMPORTANT

Parity

Beginning in 2001, all FEHB plans' mental health and substance abuse benefits will achieve "parity" with other benefits. This means that we will provide mental health and substance abuse benefits differently than in the past.

You may now choose to get care as Fee-for-Service (same as before) or Point-of-Service (new in 2001). When you receive Point-of-Service (POS) care, you must get our approval for services and follow a treatment plan we approve. If you do, cost-sharing and limitations for POS mental health and substance abuse benefits will be no greater than for similar benefits for other illnesses and conditions.

Here are some important things to keep in mind about these benefits:

- All benefits are subject to the definitions, limitations, and exclusions in this brochure.
- The outpatient and inpatient copayments apply to almost all benefits in this section. We added "(No copayment)" to show when a copayment does not apply.
- Be sure to read Section 4, *Your costs for covered services* for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- **YOU MUST GET PREAUTHORIZATION FOR THESE SERVICES**. See the instructions after the benefits descriptions below.
- POS mental health and substance abuse benefits are below, then Fee-for-Service (FFS) benefits begin on page 43.

IMPORTANT

Point-of-Service Benefit	
Description	**You Pay**
All diagnostic and treatment services contained in a treatment plan that we approve. The treatment plan may include services, drugs, and supplies described elsewhere in this brochure. Note: POS benefits are payable only when we determine the care is clinically appropriate to treat your condition and only when you receive the care as part of a treatment plan that we approve.	Your cost sharing responsibilities are no greater than for other illnesses or conditions.
• Professional services, including individual or group therapy by providers such as psychiatrists, psychologists, or clinical social workers • Medication management	$10 copayment per visit
• Diagnostic tests	Nothing
• Services provided by a hospital or other facility	$75 per admission copayment or $10 copayment per office visit
Not covered: Services we have not approved *Note: OPM will base its review of disputes about treatment plans on the treatment plan's clinical appropriateness. OPM will generally not order us to pay or provide one clinically appropriate treatment plan in favor of another*	*All charges*

Network mental health and substance abuse benefits -- Continued on next page.

Point-of-Service Benefit – *CONTINUED*

Preauthorization

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

- After your initial visit to your PCP (with a mental health illness) or a POS mental health provider, you or your provider must contact our nursing department. 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 must contact us within 24 hours so that we may coordinate a treatment Plan with you and your mental health provider.
- If you fail to follow these obligations or do not follow your prescribed treatment Plan we will reimburse you at the Panama FFS benefit level.

Special transitional benefit

If a mental health or substance abuse professional provider is treating you under our plan as of January 1, 2001, you will be eligible for continued coverage with your provider for up to 90 days under the following conditions:

- If your mental health or substance abuse professional provider with whom you are currently in treatment leaves the plan at our request for other than cause, or
- If changes to this plan's benefit structure for 2001 cause your out-of-pocket costs for your FFS provider to be greater than they were in contract year 2000.

If these conditions apply to you, we will allow you reasonable time to transfer your care to a POS mental health or substance abuse professional provider. During the transitional period, you may continue to see your treating provider and will not pay any more out-of-pocket than you did in the year 2000 for services. This transitional period will begin with our notice to you of the change in coverage and will end 90 days after you receive our notice. The transitional period will last for up to 90 days from the date you receive notice of the change. If we write to you before October 1, 2000, the 90 day period ends before January 1 and this transitional benefit does not apply.

POS limitation

If you do not obtain and follow an approved treatment plan, we will provide only FFS benefits.

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

FFS Benefit-*continued*	You pay
Not covered FFS: • *Marital, family, or other counseling or training services.* • *Specialized treatment for mental retardation and/or learning disabilities.* • *All charges for chemical aversion therapy, condition reflex treatments, narcotherapy or any similar aversion treatments and all related charges (including room and board).*	*All charges.*

Precertification

The medical necessity of your admission to a hospital or other covered facility must be precertified for you to receive these FFS benefits. **E**mergency admissions must be reported within two business days following the day of admission even if you have been discharged. Otherwise, the benefits payable will be reduced by $500. See section 3 for details.

See these sections of the brochure for more valuable information about these benefits:

- Section 7, *Filing a claim for covered services*, for information about submitting FFS claims

Section 5 (f). Prescription drug benefits

IMPORTANT

Here are some important things to keep in mind about these benefits:

- We cover prescribed drugs and medications, as described in the chart below.
- 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´s prescription drug deductible is $400 per member per calendar year.
- Be sure to read Section 4, *Your costs for covered services* for valuable information about how cost sharing works, with special sections for members who are age 65 or over. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

IMPORTANT

- **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 or, in the US, by mail.
- **How to submit your claims for prescription drugs:** Claims for prescription drugs and medicines must include receipts that include the prescription number, name of drug, prescribing doctor's name, date and charge.

Benefit Description	You Pay After the calendar year deductible…
NOTE: The prescription drug deductible applies to all benefits in this Section.	
Covered medications and supplies	**You Pay**
After a $400 deductible per member per calendar year has been met, we Pay 50% of covered expenses. You may purchase the following medications and supplies prescribed by a physician from either a pharmacy or by mail: • 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 as excluded below • Insulin • Needles and syringes for the administration of covered medications • FDA approved prescription drugs and devices for birth control.	POS: 50% of charges plus any non-covered expenses. FFS Panama: 50% of charges plus any non-covered expenses FFS US: 50% of charges plus any non-covered expenses.
Not covered: • *Drugs and supplies for cosmetic purposes* • *Vitamins, nutrients and food supplements even if a physician prescribes or administers them* • *Nonprescription medicines* • *Medical supplies such as dressings and antiseptics*	*All Charges*

Section 5 (g). Special features

Special features	Description
Flexible benefits option	Under the flexible benefits option, we determine the most effective way to provide services. • We may identify medically appropriate alternatives to traditional care and coordinate other benefits as a less costly alternative benefit. • Alternative benefits are subject to our ongoing review. • By approving an alternative benefit, we cannot guarantee you will get it in the future. • The decision to offer an alternative benefit is solely ours, and we may withdraw it at any time and resume regular contract benefits. • Our decision to offer or withdraw alternative benefits is not subject to OPM review under the disputed claims process.
Centers of excellence for transplants/heart surgery/etc	In the United States we have designated certain specialty hospitals we strongly encourage Plan members to use 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 the United States at 1-800-548-8969.

Section 5 (h). Dental benefits

IMPORTANT	**Here are some important things to 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. • Be sure to read Section 4, *Your costs for covered services* for valuable information about how cost sharing works, with special sections for members who are age 65 or over. Also read Section 9 about coordinating benefits with other coverage, including with Medicare. • Note: We cover hospitalization for dental procedures only when a non-dental physical impairment exists which makes hospitalization necessary to safeguard the health of the patient. We do not cover the dental procedure.	IMPORTANT

Accidental injury benefit

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

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

*Note: Prior to treatment, you must submit a completed dentist Pre-Treatment Estimate form to obtain approval of benefits for the work to be performed. If approval is not obtained, we will limit benefits to50% of the fee schedule.

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

The exclusions in this section apply to all benefits. **Although we may list a specific service as a benefit, we will not cover it unless we determine it is medically necessary to prevent, diagnose, or treat your illness, disease, injury or condition.**

We do not cover the following:

- Services, drugs, or supplies you receive while you are not enrolled in this Plan;
- Services, drugs, or supplies that are not medically necessary;
- Services, drugs, or supplies not required according to accepted standards of medical, dental, or psychiatric practice;
- Experimental or investigational procedures, treatments, drugs or devices;
- Services, drugs, or supplies related to abortions, except when the life of the mother would be endangered if the fetus were carried to term, or when the pregnancy is the result of an act of rape or incest.
- Services, drugs, or supplies related to sex transformations;
- Services, drugs, or supplies you receive from a provider or facility barred from the FEHB Program;
- Any portion of a provider's fee or charge that is ordinarily due from the enrollee but has been waived. If a provider routinely waives (does not require the enrollee to pay) a deductible or coinsurance, the Plan will calculate the actual provider fee or charge by reducing the fee or charge of the waived amount.
- Charges the enrollee or Plan has no legal obligation to pay, such as: excess charges for an annuitant age 65 or older who is not covered by Medicare parts A and/or B (see page 55), doctor's charges exceeding the amount specified by the Department of Health and Human Services when benefits are payable under Medicare (limiting charge) (see page 15), or State premium taxes however applied;
- Private duty nursing care services, in or out of hospital;
- Expenses to the extent they exceed the Plan allowance for the service or supply;
- Weight control or any treatment of obesity, except surgery for morbid obesity;
- Any facility not included in the definition of hospital or clinic;
- Services of any practitioner not included in the definition of covered provider, with the exception of a physical or occupational therapist; or
- Eye refractions, eyeglasses and contact lenses.

Benefits will not be paid for services and supplies when:

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

Section 7. Filing a claim for covered services

How to claim benefits

To obtain claim forms or other claims filing advice or answers about our benefits, contact us at 800-548-8969 in the US, 227-7555 in Panama or 732-222-9696 if you reside elsewhere, or at our website at http://www.healthnetworkamerica.com.

In most cases, providers and facilities file claims for you. Your physician must file on the form HCFA-1500, Health Insurance Claim Form. Your facility will file on the UB-92 form. For claims questions and assistance, call us at 800-548-8969 in the US, 227-7555 in Panama or 732-222-9696 if you reside elsewhere.

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

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

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

In addition:

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

Records

Keep a separate record of the medical expenses of each covered family member as 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 documents for your claim as soon as possible.You must file all claims within 90 days after the expense for which you are making the claim was incurred. We are not required to honor a claim submitted after the 90-day period unless you were prevented from filing promptly due to administrative operations of Government or legal incapacity, provided you submitted the claim as soon as reasonably possible. Once we pay benefits, there is a three year limitation on the issuance of uncashed checks.

Overseas claims

For covered services you receive in hospitals outside the United States, Panama and Puerto Rico and performed by physicians outside the United States, send a completed Overseas Claim Form and the itemized bills to: Health Network America, Inc. Panama Canal Area. P.O. Box 398. West Long Branch, NJ 07764. You may also obtain Overseas Claim Forms from the same address. Send any written inquiries concerning the processing of overseas claims to this address.

When we need more information

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

Section 8. The disputed claims process

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

Step	Description
1	Ask us in writing to reconsider our initial decision. You must: (a) Write to us within 6 months from the date of our decision; and (b) Send your request to us at: Health Network America, Inc. Panama Canal Area. P.O. Box 398. West Long Branch, NJ 07764 (US and outside of Panama). If you reside in the Republic of Panama, please submit your disputed claim to HNA Panama, S.A. Edificio Hatillo Local A. Esquina Avenida Justo Arosemena y Calle 36 in Panama City; and (c) Include a statement about why you believe our initial decision was wrong, based on specific benefit provisions in this brochure; and (d) Include copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms.
2	We have 30 days from the date we receive your request to: (a) Pay the claim (or, if applicable, arrange for the health care provider to give you the care); or (b) Write to you and maintain our denial -- go to step 4; or (c) Ask you or your provider for more information. If we ask your provider, we will send you a copy of our request—go to step 3.
3	You or your provider must send the information so that we receive it within 60 days of our request. We will then decide within 30 more days. If we do not receive the information within 60 days, we will decide within 30 days of the date the information was due. We will base our decision on the information we already have. We will write to you with our decision.
4	If you do not agree with our decision, you may ask OPM to review it. You must write to OPM within: • 90 days after the date of our letter upholding our initial decision; or • 120 days after you first wrote to us -- if we did not answer that request in some way within 30 days; or • 120 days after we asked for additional information. Write to OPM at: Office of Personnel Management, Office of Insurance Programs, Contracts Division II, P.O. Box 436, Washington, D.C. 20044-0436.

The disputed claims process-*continued*

Send OPM the following information:

- A statement about why you believe our decision was wrong, based on specific benefit provisions in this brochure;
- Copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms;
- Copies of all letters you sent to us about the claim;
- Copies of all letters we sent to you about the claim; and
- Your daytime phone number and the best time to call.

Note: If you want OPM to review different claims, 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 provide a copy of your specific written consent with the review request.

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

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

6 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. This is the only deadline that may not be extended.

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

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

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

(a) We haven't responded yet to your initial request for care or preauthorization/prior approval, then call us at 800-548-8969 (in the US), 227-7555 (within the Republic of Panama) or 732-222-9696 (outside of the US and Panama) and we will expedite our review; or

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

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

Section 9. Coordinating benefits with other coverage

When you have other health coverage

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

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

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

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

- **What is Medicare?**

Medicare is a Health Insurance Program for:

- People 65 years of age and 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 two parts:

- Part A (Hospital Insurance). Most people do not have to pay for Part A
- Part B (Medical Insurance). Most people pay monthly for Part B.

If you are eligible for Medicare, you may have choices in how you get your health care. Medicare+Choice is the term used to describe the various health plan choices available to Medicare beneficiaries. The information in the next few pages shows how we coordinate benefits with Medicare, depending on the type of Medicare+Choice plan you have.

- **The Original Medicare Plan**

The Original Medicare Plan is available everywhere in the United States. It is the way most people get their Medicare Part A and Part B benefits. You may go to any doctor, specialist, or hospital that accepts Medicare. Medicare pays its share and you pay your share. Some things are not covered under Original Medicare, like prescription drugs.

When you are enrolled in this Plan and Original Medicare, you still need to follow the rules in this brochure for us to cover your care. You are still required to fulfill all precertification requirements listed on page 10-12.

Claims process -- You probably will never have to file a claim form when you have both our Plan and Medicare.

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

- When Original Medicare is the primary payer, Medicare processes your claim first. In most cases, your claims will be coordinated automatically and we will pay the balance of covered charges. You will not need to do anything. To find out if you need to do something about filing your claims, call us at 800-548-8969 in the US or 227-7555 in Panama or visit our website at http://www.healthnetworkamerica.com.

We waive some costs when you have Medicare -- When Medicare is the primary payer, we will waive some out-of-pocket costs, as follows:

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

The following chart illustrates whether Original Medicare or this Plan should be the primary payer for you according to your employment status and other factors determined by Medicare. It is critical that you tell us if you or a covered family member has Medicare coverage so we can administer these requirements correctly.

Primary Payer Chart		
A. When either you -- or your covered spouse -- are age 65 or over and …	**Then the primary payer is…**	
	Original Medicare	**This Plan**
1) Are an active employee with the Federal government (including when you or a family member are eligible for Medicare solely because of a disability),		✓
2) Are an annuitant,	✓	
3) Are a reemployed annuitant with the Federal government when…		
a) The position is excluded from FEHB……	✓	
b) The position is not excluded from FEHB…….	……..	……..✓
Ask your employing office which of these applies to you.		
4) 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),	✓	
5) Are enrolled in Part B only, regardless of your employment status,	✓ (for Part B services)	✓ (for other services)
6) Are a former Federal employee receiving Workers' Compensation and the Office of Workers' Compensation Programs has determined that you are unable to return to duty,	✓ (except for claims related to Workers' Compensation.)	
B. When you -- or a covered family member -- have Medicare based on end stage renal disease (ESRD) and…		
1) Are within the first 30 months of eligibility to receive Part A benefits solely because of ESRD,		✓
2) Have completed the 30-month ESRD coordination period and are still eligible for Medicare due to ESRD,	✓	
3) Become eligible for Medicare due to ESRD after Medicare became primary for you under another provision,	✓	
C. When you or a covered family member have FEHB and…		
1) Are eligible for Medicare based on disability, and		
a) Are an annuitant, or……..	……✓	
b) Are an active employee……	……..	……..✓

•Medicare Managed Care Plan

If you are eligible for Medicare, you may choose to enroll in and get your Medicare benefits from a Medicare managed care plan. These are health care choices (like HMOs) in some areas of the country. In most Medicare managed care plans, you can only go to doctors, specialists, or hospitals that are part of the plan. Medicare managed care plans cover all Medicare Part A and B benefits. Some cover extras, like prescription drugs. To learn more about enrolling in a Medicare managed care plan, contact Medicare at 1-800-MEDICARE (1-800-633-4227) or at www.medicare.gov. If you enroll in a Medicare managed care plan, the following options are available to you:

This Plan and another Plan's Medicare managed care plan: You may enroll in another plan's Medicare managed care plan and also remain enrolled in our FEHB plan. We will still provide benefits when your Medicare managed care plan is primary, even out of the managed care plan's network and/or service area, but we will not waive any of our copayments, coinsurance, or deductibles

Suspended FEHB coverage and a Medicare managed care plan: If you are an annuitant or former spouse, you can suspend your FEHB coverage to enroll in a Medicare managed care plan, eliminating your FEHB premium. (OPM does not contribute to your Medicare managed care 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 managed care plan's service area.

- Private Contract

A physician may ask you to sign a private contract agreeing that you can be billed directly for service 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.

- **Enrollment in Medicare Part B**

Note: We cannot require you to enroll in Medicare. If you choose not to enroll in Medicare Part B, you can still be covered under the FEHB Program.

TRICARE

TRICARE is the health care program for eligible dependents of military persons, and retirees of the military. TRICARE includes the CHAMPUS program. If both TRICARE and this Plan cover you, we pay first. See your TRICARE Health Benefits Advisor if you have questions about TRICARE coverage.

Workers' Compensation

We do not cover services that:

- you need because of a workplace-related disease 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 benefits.

Medicaid

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

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. If you need more information, contact us for our subrogation procedures.

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.

Copayment

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

Coinsurance

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

Covered services

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

Custodial care

Treatment or services, regardless of who recommends them or where they are provided, that could be rendered safely and reasonably by a person not medically skilled, or that are designed mainly to help the patient with daily living activities. These activities include but are not limited to:

1. Personal care such as help in: walking; getting in and out of bed; bathing; eating by spoon, tube or gastrostomy; exercising; dressing;
2. Homemaking, such as preparing meals or special diets;
3. Moving the patient;
4. Acting as a companion or sitter;
5. Supervising medication that can usually be self administered; or
6. Treatment or services that any person may be able to perform with minimal instruction, including but not limited to recording temperature, pulse, and respirations, or administration and monitoring of feeding tubes.

Deductible

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

Emergency

See page 40 for definition of medical emergency

Experimental or investigational services

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

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

Reliable evidence shall mean only published reports and articles in the authoritative medical and scientific literature; the written protocol or protocols used by the treating facility or the protocol(s) of another facility studying substantially the same drug, device or medical treatment or procedure; or the written informed consent used by the treating facility or by another facility studying substantially the same drug, device or medical treatment or procedure. If you desire additional information concerning the experimental/investigational determination process, please contact the Plan.

Group health coverage

Health care coverage that a member is eligible for because of employment, membership in, or connection with, a particular organization or group that provides payment for hospital, medical, or other health care services or supplies, or that pays a specific amount for each day or period of hospitalization if the specified amount exceeds $200 per day, including extension of any of these benefits through COBRA**.**

Medical necessity

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

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

Plan allowance

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

Panama Point-of-Service (In-network)

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

Panama Fee-for-Service

If you reside in the Republic of Panama and select the Fee-for-Service option, or reside outside of Panama (including the US) but receive medical services within the Republic of Panama, we base all claims reimbursement payments on the Panama POS fee schedule (or in-network) amounts described above. However, your cost sharing responsibility is much greater. Please refer to the section 2 “How we change for 2001” and section 5 “Benefits” for additional detail regarding your responsibility.

US Fee-for-Service

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

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

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

Section 11. FEHB facts

No pre-existing condition limitation

We will not refuse to cover the treatment of a condition that 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. Also, your employing or retirement office can answer your questions, and give you *a Guide to Federal Employees Health Benefits Plans*, brochures for other plans, and other materials you need to make an informed decision about:

- 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;
- When your enrollment ends; and
- When the next open season for enrollment begins.

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

Types of coverage available for you and your family

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

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

Your employing or retirement office will **not** notify you when a family member is no longer eligible to receive health benefits, nor will we. Please tell us immediately when you add or remove family members from your coverage for any reason, including divorce, or when your child under age 22 marries or turns 22.

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.

When benefits and premiums start

The benefits in this brochure are effective on January 1. If you are new to this Plan, your coverage and premiums begin on the first day of your first pay period that starts on or after January 1. Annuitants' premiums begin on January 1.

Your medical and claims records are confidential

We will keep your medical and claims information confidential. Only the following will have access to it:

- OPM, this Plan, and subcontractors when they administer this contract;
- This Plan, and appropriate third parties, such as other insurance plans and the Office of Workers' Compensation Programs (OWCP), when coordinating benefit payments and subrogating claims;
- Law enforcement officials when investigating and/or prosecuting alleged civil or criminal actions;
- OPM and the General Accounting Office when conducting audits;
- Individuals involved in bona fide medical research or education that does not disclose your identity; or
- OPM, when reviewing a disputed claim or defending litigation about a claim.

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.

You may be eligible for spouse equity coverage or Temporary Continuation of Coverage.

• Spouse equity coverage

If you are divorced from a Federal employee or annuitant, you may not continue to get benefits under your former spouse's enrollment. But, you may be eligible for your own FEHB coverage under the spouse equity law. 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 Employees Health Benefits Plans for Temporary Continuation of Coverage and Former Spouse Enrollees*, or other information about your coverage choices.

•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.

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

Get the RI 79-27, which describes TCC, and the RI 70-5, the *Guide to Federal Employees Health Benefits Plans for Temporary Continuation of Coverage and Former Spouse Enrollees*, from your employing or retirement office or from www.opm.gov/insure.

•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

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.

Inspector General Advisory

Stop health care fraud! Fraud increases the cost of health care for everyone. If you suspect that a physician, pharmacy, or hospital has charged you for services you did not receive, billed you twice for the same service, or misrepresented any information, do the following:

- Call the provider and ask for an explanation. There may be an error.
- If the provider does not resolve the matter, call us at 800-548-8969 or 227-7555 (within Panama) and explain the situation.
- If we do not resolve the issue, call **THE HEALTH CARE FRAUD HOTLINE--202/418-3300** or write to: The United States Office of Personnel Management, Office of the Inspector General Fraud Hotline, 1900 E Street, NW, Room 6400, Washington, DC 20415.

Penalties for Fraud

Anyone who falsifies a claim to obtain FEHB Program benefits can be prosecuted for fraud. Also, the Inspector General may investigate anyone who uses an ID card if the person tries to obtain services for someone who is not an eligible family member, or is no longer enrolled in the Plan and tries to obtain benefits. Your agency may also take administrative action against you.

Index

Do not rely on this page; it is for your convenience and does not explain your benefit coverage.

Summary of benefits for the Panama Canal Area Benefit Plan - 2001

- **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 the FFS Option after we pay, you generally pay any difference between our allowance and the billed amount.
- If you are a POS member and receive your medical care through your primary care physician and other POS providers you can limit your out-of-pocket expenses.Please refer to Section 5 (benefits) for a complete list of POS benefits and your payment obligations under this option.

Benefits	You Pay	Page
Medical services provided by physicians: • Diagnostic and treatment services provided in the office	POS: $10 copayment FFS Panama: 50% of the Panama POS Fee schedule amount and any difference between the POS fee schedule and the billed amount FFS US: 50% of the US FFS Plan allowance and any difference between our allowance and the billed amount.	18
Services provided by a hospital: • Inpatient	POS: Nothing after the $75 per admission copayment FFS Panama: $125 per admission, then 50% of the Panama POS Fee schedule amount and any difference between the POS fee schedule and the billed amount FFS US: $125 per admission and 50% of all covered charges.	35
• Outpatient	POS: $75 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.	36

Emergency benefits: • Accidental injury ..... • Medical emergency.....	POS: $10 copayment FFS Panama: 50% of the Panama POS Fee schedule amount and any difference between the POS fee schedule and the billed amount FFS US: 50% of the US FFS Plan allowance and any difference between our allowance and the billed amount.	39 40
Mental health and substance abuse treatment.....	POS: Regular cost sharing FFS: Benefits are limited	41 43
Prescription drugs	50% of eligible charges after the $400 per member calendar year deductible has been met.	45
Dental Care	scheduled allowances	48
Protection against catastrophic costs (your out-of-pocket maximum)..... *Note: Applies only to FFS benefits only*	After the 50% for hospital inpatient and other expenses reaches $2,500 per member per year, we will pay the remaining hospital room and board and other charges at 100%. Some costs do not count toward this protection	14

Notes

2001 Rate Information for
Panama Canal Area Benefit Plan

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

		Non-Postal Premium			
		Biweekly		Monthly	
Type of Enrollment	Code	Gov't Share	Your Share	Gov't Share	Your Share
Self Only	431	$86.59	$37.69	$187.61	$81.66
Self and Family	432	$195.82	$73.71	$424.28	$159.70