Panama Canal Area Benefit Plan

http://www.healthnetworkamerica.com

2004

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

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

For changes in benefits see page 9.

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

URAC ACCREDITED HEALTH PLAN

This Plan has Full Health Plan accreditation from URAC. See the 2004 Guide for more information on accreditation.

Authorized for distribution by the:

United States
Office of Personnel Management

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

FEHB
Federal Employees Health Benefits Program

RI 72-004

UNITED STATES
OFFICE OF PERSONNEL MANAGEMENT
WASHINGTON, DC 20415-0001

OFFICE OF THE DIRECTOR

Dear Federal Employees Health Benefits Program Participant:

I am pleased to present this 2004 Federal Employees Health Benefits (FEHB) Program plan brochure. The brochure describes the benefits this plan offers you for 2004. Because benefits vary from year to year, you should review your plan's brochure every Open Season – especially Section 2, which explains how the plan changed.

It takes a lot of information to help a consumer make wise healthcare decisions. The information in this brochure, our FEHB Guide, and our web-based resources, make it easier than ever to get information about plans, to compare benefits and to read customer service satisfaction ratings for the national and local plans that may be of interest. Just click on www.opm.gov/insure!

The FEHB Program continues to be an enviable national model that offers exceptional choice, and uses private-sector competition to keep costs reasonable, ensure high-quality care, and spur innovation. The Program, which began in 1960, is sound and has stood the test of time. It enjoys one of the highest levels of customer satisfaction of any healthcare program in the country.

I continue to take aggressive steps to keep the FEHB Program on the cutting edge of emp loyer-sponsored health benefits. We demand cost-effective quality care from our FEHB carriers and we have encouraged Federal agencies and departments to pay the full FEHB health benefit premium for their employees called to active duty in the Reserve and National Guard so they can continue FEHB coverage for themselves and their families. Our carriers have also responded to my request to help our members to be prepared by making additional supplies of medications available for emergencies as well as call-up situations and you can help by getting an Emergency Preparedness Guide at www.opm.gov. OPM's *HealthierFeds* campaign is another way the carriers are working with us to ensure Federal employees and retirees are informed on healthy living and best-treatment strategies. You can help to contain healthcare costs and keep premiums down by living a healthy life style.

Open Season is your opportunity to review your choices and to become an educated consumer to meet your healthcare needs. Use this brochure, the FEHB Guide, and the web resources to make your choice an informed one. Finally, if you know someone interested in Federal employment, refer them to www.usajobs.opm.gov.

Sincerely,

Kay Coles James
Director

Notice of the United States Office of Personnel Management's

Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

By law, the United States Office of Personnel Management (OPM), which administers the Federal Employees Health Benefits (FEHB) Program, is required to protect the privacy of your personal medical information. OPM is also required to give you this notice to tell you how OPM may use and give out ("disclose") your personal medical information held by OPM.

OPM **will** use and give out your personal medical information:

- To you or someone who has the legal right to act for you (your personal representative),
- To the Secretary of the Department of Health and Human Services, if necessary, to make sure your privacy is protected,
- To law enforcement officials when investigating and/or prosecuting alleged or civil or criminal actions, and
- Where required by law.

OPM **has the right** to use and give out your personal medical information to administer the FEHB Program. For example:

- To communicate with your FEHB health plan when you or someone you have authorized to act on your behalf asks for our assistance regarding a benefit or customer service issue.
- To review, make a decision, or litigate your disputed claim.
- For OPM and the General Accounting Office when conducting audits.

OPM **may** use or give out your personal medical information for the following purposes under limited circumstances:

- For Government health care oversight activities (such as fraud and abuse investigations),
- For research studies that meet all privacy law requirements (such as for medical research or education), and
- To avoid a serious and imminent threat to health or safety.

By law, OPM must have your written permission (an "authorization") to use or give out your personal medical information for any purpose that is not set out in this notice. You may take back ("revoke") your written permission at any time, except if OPM has already acted based on your permission.

By law, you **have the right** to:

- See and get a copy of your personal medical information held by OPM.
- Amend any of your personal medical information created by OPM if you believe that it is wrong or if information is missing, and OPM agrees. If OPM disagrees, you may have a statement of your disagreement added to your personal medical information.
- Get a listing of those getting your personal medical information from OPM in the past 6 years. The listing will not cover your personal medical information that was given to you or your personal representative, any information that you authorized OPM to release, or that was given out for law enforcement purposes or to pay for your health care or a disputed claim.

- Ask OPM to communicate with you in a different manner or at a different place (for example, by sending materials to a P.O. Box instead of your home address).
- Ask OPM to limit how your personal medical information is used or given out. However, OPM may not be able to agree to your request if the information is used to conduct operations in the manner described above.
- Get a separate paper copy of this notice.

For more information on exercising your rights set out in this notice, look at www.opm.gov/insure on the Web. You may also call 202-606-0191 and ask for OPM's FEHB Program privacy official for this purpose.

If you believe OPM has violated your privacy rights set out in this notice, you may file a complaint with OPM at the following address:

Privacy Complaints
United States Office of Personnel Management
P.O. Box 707
Washington, DC 20004-0707

Filing a complaint will not affect your benefits under the FEHB Program. You also may file a complaint with the Secretary of the United States Department of Health and Human Services.

By law, OPM is required to follow the terms in this privacy notice. OPM has the right to change the way your personal medical information is used and given out. If OPM makes any changes, you will get a new notice by mail within 60 days of the change.

The privacy practices listed in this notice are effective April 14, 2003.

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- Centers of excellence for transplants

Introduction

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

Panama Canal Area Benefit Plan
Edificio Plaza Kosmina, Esquina de la Doble via Oeste y calle Cuarta El Dorado, frente a Nikos Café
Panama, Republica de Panama

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

If you are enrolled in this Plan, you are entitled to the benefits described in this brochure. If you are enrolled in Self and Family coverage, each eligible family member is also entitled to these benefits. You do not have a right to benefits that were available before January 1, 2004, unless those benefits are also shown in this brochure.

OPM negotiates benefits and rates with each plan annually. Benefit changes are effective January 1, 2004, and changes are summarized on page 9. Rates are shown on the back cover of this brochure.

Plain Language

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

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

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

Stop Health Care Fraud!

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

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

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

- Be wary of giving your plan identification (ID) number over the telephone or to people you do not know, except to your doctor, other provider, or authorized plan or OPM representative.
- Let only the appropriate medical professionals review your medical record or recommend services.

- Avoid using health care providers who say that an item or service is not usually covered, but they know how to bill us to get it paid.
- Carefully review explanations of benefits (EOBs) that you receive from us.
- Do not ask your doctor to make false entries on certificates, bills or records in order to get us to pay for an item or service.
- If you suspect that a provider has charged you for services you did not receive, billed you twice for the same service, or misrepresented any information, do the following:
    - Call the provider and ask for an explanation. There may be an error.
    - If the provider does not resolve the matter, call us at 800-548-8969 in the US or 279-8888 in Panama and explain the situation.
    - If we do not resolve the issue:

CALL -- HEALTH CARE FRAUD HOTLINE
202-418-3300

OR WRITE TO:
United States Office of Personnel Management
Office of the Inspector General Fraud Hotline
1900 E Street, NW, Room 6400
Washington, DC 20415-1100

- Do not maintain as a family member on your policy:
    - Your former spouse after a divorce decree or annulment is final (even if a court order stipulates otherwise); or
    - Your child over age 22 (unless he/she is disabled and incapable of self support).
- If you have any questions about the eligibility of a dependent, check with your personnel office if you are employed or your retirement office (such as OPM) if you are retired or with the National Finance Center if you are enrolled under Temporary Continuation of Coverage.
    - You can be prosecuted for fraud and your agency may take action against you if you falsify a claim to obtain FEHB benefits or try to obtain services for someone who is not an eligible family member or who is no longer enrolled in the Plan.

Preventing medical mistakes

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

1. **Ask questions if you have doubts or concerns.**
    - Ask questions and make sure you understand the answers.
    - Choose a doctor with whom you feel comfortable talking.
    - Take a relative or friend with you to help you ask questions and understand answers.
2. **Keep and bring a list of all the medicines you take.**
    - Give your doctor and pharmacist a list of all the medicines that you take, including non-prescription medicines.
    - Tell them about any drug allergies you have.
    - Ask about side effects and what to avoid while taking the medicine.
    - Read the label when you get your medicine, including all warnings.
    - Make sure your medicine is what the doctor ordered and know how to use it.
    - Ask the pharmacist about your medicine if it looks different than you expected.
3. **Get the results of any test or procedure.**
    - Ask when and how you will get the results of tests or procedures.
    - Don't assume the results are fine if you do not get them when expected, be it in person, by phone, or by mail.
    - Call your doctor and ask for your results.
    - Ask what the results mean for your care.

4. **Talk to your doctor about which hospital is best for your health needs.**
   - Ask your doctor about which hospital has the best care and results for your condition if you have more than one hospital to choose from to get the health care you need.
   - Be sure you understand the instructions you get about follow-up care when you leave the hospital.
5. **Make sure you understand what will happen if you need surgery.**
   - Make sure you, your doctor, and your surgeon all agree on exactly what will be done during the operation.
   - Ask your doctor, "Who will manage my care when I am in the hospital?"
   - Ask your surgeon:
     Exactly what will you be doing?
     About how long will it take?
     What will happen after surgery?
     How can I expect to feel during recovery?
   - Tell the surgeon, anesthesiologist, and nurses about any allergies, bad reaction to anesthesia, and any medications you are taking.

Want more information on patient safety?

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

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

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

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

We 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 area: *The Republic of Panama.*

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

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

How we pay providers

Panama POS: We have contracted with individual physicians, hospitals, and providers within the Republic of Panama to provide you with all of your health care needs. These 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 have to pay your co-payments 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.

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

Your Rights

OPM requires that all FEHB Plans provide certain information to their FEHB members. You may get information about us, our networks, 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 of the Panama Canal Area is a legal Panamanian entity incorporated in June 1999. Before this date the Association (Panama Canal Area) was the Group Insurance Board which came into effect in 1960 as an entity appointed by the Panama Canal Commission to administer Federal Employees Health Benefits Contract CS 1066 (the Panama Canal Area Benefit Plan). All members of the Association (Panama Canal Area) have the right to review the by-laws of the Association.

If you want more information about us, call 800-548-8969 in the United States (732-676-2630 if outside the US or Panama) or 279-8888 within the Republic of Panama, or write to: Health Network America, Inc. (in the US or any country other then Panama)

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Health Network America, Inc.

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 732-676-2653 (in the United States) or 279-8877 (in Panama) or visit our Website at http://www.healthnetworkamerica.com or http://www.hnapanama.com

Section 2. How we change for 2004

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

Program-wide changes

- We added information regarding two new Federal Programs that complement FEHB benefits, the Federal Flexible Spending Account Program - *FSAFEDS* and the Federal Long Term Care Insurance Program. See page 66.
- We added information regarding preventing medical mistakes. See page 5.
- We added information regarding enrolling in Medicare. See page 19.
- We revised the Medicare Primary Payer Chart. See page 57.

Changes to this Plan

- Your share of the premium will increase by 5% for both Self Only and Self and Family.
- We added a benefit for routine osteoporosis screening for all women 65 and older and routine osteoporosis screening, beginning at age 60 for women who are at increased risk. See page 22.
- We revised the benefit for influenza vaccines to expand coverage for one annual influenza vaccine to all plan members age 50 and over. See page 23.
- We added a benefit for a colonoscopy and double contrast barium enema, once every five years, for all plan members beginning at age 50. See page 22.
- We added a benefit to provide all diabetics with specific prescription drugs and supplies, included on the Plan's formulary, to treat diabetes and its complications. See page 27.
- We clarified the vision services benefit to specifically identify the conditions under which we cover eyeglasses. See page 28.
- We clarified the hearing exam benefit to specifically describe what is included in the annual audiologist visit. See page 28.
- We clarified the prescription drug benefit to specifically state that only FDA approved prescribed drugs, or their equivalents, are covered under this plan. See page 46.
- We clarified that the Plan must be notified of all emergency admissions within two business days of the admission even if the patient has been discharged. See page 41.

Section 3. How you get care

Identification cards

We will send you an identification (ID) card when you enroll. You should carry your ID card with you at all times. You must show it whenever you receive services from a Plan provider, or fill a prescription at a Plan pharmacy. Until you receive your ID card, use your copy of the Health Benefits Election Form, SF-2809, your health benefits enrollment confirmation (for annuitants), or your 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 279-8836 within the Republic of Panama or write to us at:

Health Network America, Inc.
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 request replacement cards through our Website:
http://www.healthnetworkamerica.com or http://www.hnapanama.com

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 purpose of this FEHB brochure, the term doctor includes all of these providers when the services are performed within the scope of their license or certification.

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

Independent Consulting Doctor – An independent consulting doctor is a specialist who:
1. Is certified by the American Board of Medical Specialists in a field related to the proposed surgery;
2. Is independent of the doctor who first advised the surgery;
3. Does not perform the surgery for the insured person;
4. Makes a personal exam of the insured person; and
5. Sends the Plan a written report.

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

Medically underserved areas. Note: We cover any licensed medical practitioner for any covered service performed within the scope of that license in states OPM determines are "medically underserved." For 2004, the states are: Alabama, Idaho, Kentucky, Louisiana, Maine, Mississippi, Missouri, Montana, New Mexico, North Dakota, South Carolina, South Dakota, Texas, Utah, West Virginia and Wyoming.

- **Covered facilities**

Covered facilities include:

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

Hospice—A public or private agency or organization which:

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

Hospital

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

   In no event shall the term Hospital include a convalescent nursing home, or an institution or part thereof which:
   1. Is used principally as a convalescent facility, rest facility, or facility for the aged;
   2. Furnishes primarily domiciliary or custodial care, including training in the routine of daily living; or
   3. Is operated as a school.

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

Skilled Nursing Facility—An institution that (1) is operated pursuant to law and primarily engaged in providing the following services for patients recovering from an illness or injury: room, board and 24-hour-a-day nursing service by professional nurses;

(2) is under the full-time supervision of a doctor or registered nurse (R.N.); (3) maintains adequate medical records; and (4) has the services of a doctor available under an established agreement for 24 hours a day, if not supervised by a doctor.

What you must do to get covered care

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

Transitional care:

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

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

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

If you are in the second or third trimester of pregnancy and you lose access to your specialist based on the above circumstances, you can continue to see your specialist and any POS benefits continue 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, 279-8888 in Panama or 732-676-2630 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. If your plan terminates participation in the FEHB in whole or in part, or if OPM orders an enrollment change, this continuation of coverage provision does not apply. In such case, the hospitalized family member's benefits under the new plan begin on the effective date of enrollment.

How to Get Approval for…

· Your hospital stay

Pre-certification 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 pre-certification. Because you are still responsible for ensuring that we are asked to pre-certify 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 pre-certification. If the stay is not medically necessary, we will not pay any benefits.

How to pre-certify an admission:

We require both FFS and POS Plan members to pre-certify 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, 279-8888 in Panama or 732-676-2630 if you reside outside of the US and Panama, at least 24 hours before admission.

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

- Provide the following information:

  --Enrollee's name and Plan identification number;
  --Patient's name, birth date, and phone number;
  --Reason for hospitalization, proposed treatment, or surgery;
  --Name and phone number of admitting doctor;
  --Name of hospital or facility; and
  --Number of planned days of confinement.

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

Maternity care

You do not need to pre-certify 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 pre-certification of additional days. Further, if your baby stays after you are discharged, then your physician or the hospital must contact us for pre-certification of additional days for your baby.

If your hospital stay needs to be extended:

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

What happens when you do not follow the pre-certification rules

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 charges, less the $500 penalty.

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

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

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

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

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

Exceptions:

You do not need pre-certification 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 pre-certification.

· Other services

Some services require a referral, pre-certification, or prior authorization. These services are as follows:

- All surgeries, both inpatient and outpatient must be pre-certified.
- 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 pre-certification, 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 34 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 pre-certified your admission
- We require you to obtain pre-certification on both an inpatient and outpatient basis for specifically designated, non-routine diagnostic procedures that are high cost, involve high technology or that may be over-utilized. These tests include Cat scans, MRIs, Nuclear Medicine Studies (e.g. Thallium Cardiac Studies), certain Arteriographies, Genetic Studies and other similar procedures. If you fail to comply with this requirement, we will limit our payment for outpatient services to 50% of our Plan allowance and impose a $500 penalty for inpatient charges.

Section 4. Your costs for covered services

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

· **Co-payments**

A co-payment is a fixed amount of money you pay to the provider, facility, pharmacy, etc., when you receive services.

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

· **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. Co-payments do not count toward any deductible.

- The calendar year deductible for prescription drugs is $400 per enrollee (see page 46). 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 co-payments, deductibles, or coinsurance, the provider is misstating the fee and may be violating the law. In this case, when we calculate our share, we will reduce the provider's fee by the amount waived.

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

· **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 co-payment. Here is an example about co-payment: You see a POS physician who charges $50, but our allowance is $30. You are only responsible for your co-payment amount. That is, you pay just -- $10 of our $30 allowance. Because of the agreement, your POS physician will not bill you for the $20 difference between our allowance and his bill.

- **FFS providers**, on the other hand, have no agreement to limit what they will bill you. When you use a FFS provider, you will pay your co-insurance -- **plus** any difference between our allowance and charges on the bill. Here is an example: You see a FFS physician who charges $50 and our allowance is again $30. You are responsible for your coinsurance, so you pay 50% of our $30 allowance ($15). Plus, because there is no agreement between the FFS physician and us, 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	$10 co-payment: 10	50% of our allowance: 15
+Difference up to charge?	No: 0	Yes: 20
TOTAL YOU PAY	$10	$35

Your FFS Catastrophic Protection out-of-pocket maximum for hospital coinsurance

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

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

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

- Expenses in excess of our Plan allowances and maximum benefit limitations;
- Expenses for mental conditions, substance abuse, dental care or prescription drugs;
- Any amounts you pay because benefits have been reduced for non-compliance with this plan´s cost containment requirements (see pages 12-14); and
- The $125 co-payment 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 you

We will make diligent efforts to recover benefit payments we made in error but in good faith. We may reduce subsequent benefit payments to offset overpayments.

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

Under the FEHB law, we must limit our payments for **inpatient hospital care** and **physician care** to 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. You and the FEHB benefit from these payment limits. Outpatient hospital care is not covered by this law; regular Plan benefits apply. The following chart has more information about the limits.

If you…

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

Then, for your inpatient hospital care,

- the law requires us to base our payment on an amount -- the "equivalent Medicare amount" -- set by Medicare's rules for what Medicare would pay, not on the actual charge;
- you are responsible for your applicable deductibles, coinsurance, or co-payments 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 (EOB) form that we send you; 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 co-payments, and any balances up to the Medicare approved amount;
Does not participate with Medicare,	your coinsurance or co-payments, and any balance up to 115% of the Medicare approved amount

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

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

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

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

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

- If your physician **accepts** Medicare assignment, then you pay nothing for covered charges.

- If your physician **does not accept** Medicare assignment, then you pay the difference between the "limiting charge" or the physician's charge (whichever is less) and our payment combined with Medicare's payment and the charge.

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

Should I enroll in Medicare?

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

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

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

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

Section 5. Benefits -- OVERVIEW

(See page 9 for how our benefits changed this year and page 71 for a benefits summary.)

Note: This benefits section is divided 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 claim forms, claims filing advice, or more information about our benefits, contact us at *800-548-8969 in the United States or 279-8888 in the Republic of Panama* or at our Website at 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 benefits 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.
- The FFS benefits are the standard benefits of this Plan. POS benefits apply only when you use a POS provider. When no POS provider is available, FFS benefits apply.
- Be sure to read Section 4, *your costs for covered services*, for valuable information about how cost sharing works, with special sections for members who are age 65 or over. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

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 co-payment FFS Panama: 50% of the Panama POS Fee schedule amount and any difference between the POS Fee schedule and the billed amount FFS US: 50% of the US FFS Plan allowance (see pg 61 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
Tests, such as: • Blood tests • Urinalysis • Non-routine pap tests • Pathology • X-rays • Non-routine Mammograms • CAT Scans/MRI • Ultrasound • Electrocardiogram and EEG	POS: Nothing FFS Panama: 50% of the Panama POS Fee schedule amount and any difference between the POS Fee schedule and the billed amount FFS US: 50% of the US FFS Plan allowance and any difference between our allowance and the billed amount Note: If your POS provider uses a FFS lab or radiologist, we will pay FFS benefits for those lab and X-ray charges.
Preventive care, adult	
Routine Medical Check-up every 6 months by your primary care physician Note: These routine check-ups include toe nail clipping for diabetics, and annual digital prostate exam (rectal exam) for men age 40 and over.	POS: Nothing FFS Panama: All charges FFS US: All charges
Routine screenings, limited to: • Total Blood Cholesterol – once every three years or fasting lipoprotein profile, once every five years • Chlamydial infection • Colorectal Cancer Screening, including --Fecal occult blood test, once annually --Sigmoidoscopy, screening – every five years starting at age 50 • Colonoscopy and double contrast barium enema (DCBE), once every five years, beginning at age 50 • One routine osteoporosis screening for wo men 65 and older • One routine osteoporosis screening, beginning at age 60 for women who are at increased risk	POS: Nothing FFS Panama: 50% of the Panama POS Fee schedule amount and any difference between the POS Fee schedule and the billed amount (No outpatient maximum) FFS US: 50% of the US FFS Plan allowance and any difference between our allowance and the billed amount (No outpatient maximum)

Routine Prostate Specific Antigen (PSA) test – one annually for men age 40 and older	POS: Nothing FFS Panama: 50% of the Panama POS Fee schedule amount and any difference between the POS Fee schedule and the billed amount (No outpatient maximum) FFS US: 50% of the US FFS Plan allowance and any difference between our allowance and the billed amount (No outpatient maximum)
Routine annual gynecological examination, including 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 vaccine, annually, age 50 and over • Pneumococcal vaccine, every 5 years, age 65 and older	POS: Nothing FFS Panama: Not a covered benefit. You pay all billed charges. FFS US: Not a covered benefit. You pay all billed charges.
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Preventive care, children	
• Childhood immunizations for dependent children under the age of 22 as follows: DPT (diphtheria, tetanus, pertussis vaccine); OPV (oral polio vaccine); Hepatitis B Vaccine; Haemophilus influenza type b vaccine (flu shot); MMR (measles, mumps, rubella vaccine); and Td (tetanus diphtheria toxoid booster)	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 22.	POS: Nothing FFS Panama: 50% of the Panama POS Fee schedule amount and any difference between the POS Fee schedule and the billed amount (No outpatient maximum) FFS US: 50% of the US FFS Plan allowance and any difference between our allowance and the billed amount (No outpatient maximum)
• Examinations, limited to: --Examinations for amblyopia and strabismus – limited to one screening examination (ages 2 through 6) --Examinations done on the day of immunizations (ages 3 up to age 22) 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 (No outpatient maximum) FFS US: 50% of the US FFS Plan allowance and any difference between our allowance and the billed amount (No outpatient maximum)
Maternity care	
Complete maternity (obstetrical) care, such as: • Prenatal care • Delivery • Postnatal care Note: Here are some things to keep in mind: • You do not need to pre-certify your normal delivery; however you must obtain pre-certification 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, your representative, your doctor, or your hospital must pre-certify.	POS: $10 co-payment for all office visits FFS Panama: 50% of the Panama POS Fee schedule amount and any difference between the POS Fee schedule and the billed amount FFS US: 50% of the US FFS Plan allowance and any difference between our allowance and the billed amount.

Maternity care -- continued on next page.

Maternity care *(continued)*	**You pay**
• We cover routine nursery care of the newborn child during the covered portion of the mother's maternity stay. We will cover other care of an infant who requires non-routine treatment if we cover the infant under a Self and Family enrollment. See Hospital benefits (Section 5(c)) and Surgery benefits (Section 5(b)). • Circumcision is covered under Surgery benefits. (Section 5(b)). • We pay hospitalization and surgeon services (delivery) the same as for illness and injury. See Hospital benefits (Section 5c) and Surgery benefits (Section 5b).	*(see above)*
Not covered: Routine sonograms to determine fetal age, size or sex	*All charges.*
Family planning	
A range of voluntary family planning services, limited to: • Voluntary sterilization (See Surgical procedures Section 5 (b)) • Surgically implanted contraceptives • Injectable contraceptive drugs (such as Depo-provera) • Intrauterine devices (IUDs) • Diaphragms Note: We cover oral contraceptives under the prescription drug benefit (Section 5(f)).	POS: Nothing FFS Panama: 50% of the Panama POS Fee schedule amount and any difference between the POS Fee schedule and the billed amount FFS US: 50% of the US FFS Plan allowance and any difference between our allowance and the billed amount
Not covered: reversal of voluntary surgical sterilization, genetic counseling,	*All charges.*

Infertility services	You pay
Diagnosis and treatment of infertility including fertility drugs, except as shown in *Not covered.*	POS: $10 co-payment per consultation FFS Panama: 50% of the Panama POS Fee schedule amount and any difference between the POS Fee schedule and the billed amount FFS US: 50% of the US FFS Plan allowance and any difference between our allowance and the billed amount.
Not covered: • *Infertility services after voluntary sterilization* • *Fertility drugs* • *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.* • *Cost of donor sperm* • *Cost of donor egg*	*All charges.*
Allergy care	
Testing and treatment, including materials (such as allergy serum) and allergy injections	POS: $10 co-payment 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.
Allergy injections (without office consultation)	POS: Nothing FFS Panama: 50% of the Panama POS Fee schedule amount and any difference between the POS Fee schedule and the billed amount FFS US: 50% of the US FFS Plan allowance and any difference between our allowance and the billed amount
Not covered: provocative food testing and sublingual allergy desensitization	*All charges*

Treatment therapies	You pay
• Chemotherapy and radiation therapy including medications used directly with the chemotherapy and radiation treatment Note: High dose chemotherapy in association with autologous bone marrow transplants is limited to those transplants listed on page 35. • Medications to treat diabetes and its complications as specifically approved by the Plan Note: This benefit is only available to POS members in the Republic of Panama and only covers those specific diabetes medications listed on the Plan's formulary. All other eligible medications are covered under the prescription drug benefit described on page 46. • Dialysis – Hemodialysis and peritoneal dialysis including medications used directly with the dialysis treatment • Intravenous (IV)/Infusion Therapy – Home IV and antibiotic therapy • Growth hormone therapy (GHT) Note: Growth hormone is covered under the prescription drug benefit. Note: – We only cover GHT when we preauthorize the treatment. Call 800-548-8969 in the US or 279-8888 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 *Other services* under *How to get approval for …* in Section 3. • Respiratory and inhalation therapies	POS: Nothing FFS Panama: 50% of the Panama POS Fee schedule amount and any difference between the POS Fee schedule and the billed amount (No outpatient maximum) FFS US: 50% of the US FFS Plan allowance and any difference between our allowance and the billed amount (No outpatient maximum)
Physical and occupational therapies	
Short-term rehabilitative physical therapy (POS) or physical and occupational therapy (FFS) is provided on an inpatient or outpatient basis for up to $300 per condition (POS) and $250 per condition (FFS), if significant improvement can be expected within two months. Physical therapy is limited to services that assist the member to achieve and maintain self-care and improved functioning in other activities of daily living Note: The annual benefit limit for FFS option is $250.00	POS: $10 co-payment for first visit in an authorized series and all charges over the $300 annual benefit maximum. FFS Panama: 50% of the Panama POS Fee schedule amount and any difference between the POS Fee schedule and the billed amount and all charges over the $250 annual benefit maximum FFS US: 50% of the US FFS Plan allowance and any difference between our allowance and the billed amount and all charges over the $250 annual benefit maximum.
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.	

Not covered: • *long-term rehabilitative therapy* • *exercise programs* • *occupational therapy (POS)*	*All charges.*
Speech therapy	**You pay**
• Speech therapy is covered up to $250 annually in all situations where it is medically necessary.	POS: $10 co-payment for first visit in an authorized series and all charges over the $250 annual benefit maximum. FFS Panama: 50% of the Panama POS Fee schedule amount and any difference between the POS Fee schedule and the billed amount and all charges over the $250 annual benefit maximum FFS US: 50% of the US FFS Plan allowance and any difference between our allowance and the billed amount and all charges over the $250 annual benefit maximum.
Hearing services (testing, treatment, and supplies)	
Hearing Exam – annual audiologic screening test	POS: $10 co-payment FFS Panama: Not a covered benefit. You must pay all billed charges FFS US: Not a covered benefit. 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) Note: Eyeglasses or contact lenses are only covered after intraocular surgery (such as cataracts) or after suffering an ocular injury, IF the intraocular lens inserted during the surgery does not correct your vision.	POS: Nothing FFS Panama: 50% of the Panama POS Fee schedule amount and any difference between the POS Fee schedule and the billed amount FFS US: 50% of the US FFS Plan allowance and any difference between our allowance and the billed amount

Not covered: • *Eyeglasses or contact lenses and examinations for them* • *Eye exercises and orthoptics* • *Radial keratotomy and other refractive surgery*	*All charges.*
Foot care	
Routine foot care when you are under active treatment for a metabolic or peripheral vascular disease, such as diabetes. Note: See orthopedic and prosthetic devices for information on podiatric shoe inserts.	POS: $10 co-payment 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 imp lanted 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: • *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 visits per calendar year up to the Plan allowable amount when: • 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;* • *Home care primarily for personal assistance that does not include a medical component and is not diagnostic, therapeutic, or rehabilitative*	*All charges.*

Chiropractic	You pay
Chiropractic Services – By a physician or licensed doctor of chiropractic medicine for pain management, asthma and arthritis up to the benefit maximum of $250 per calendar year • Manipulation of the spine and extremities • Adjunctive procedures such as ultrasound, electrical muscle stimulation, vibratory therapy, and cold pack application	POS: $10 co-payment for first visit in an authorized series and all charges over the $250 annual benefit maximum. FFS Panama: 50% of the Panama POS Fee schedule amount and any difference between the POS Fee schedule and the billed amount and all charges over the $250 annual benefit maximum FFS US: 50% of the US FFS Plan allowance and any difference between our allowance and the billed amount and all charges over the $250 annual benefit maximum.
Alternative treatments	
Acupuncture – by a doctor of medicine or osteopathy for: anesthesia or pain relief, up to the benefit maximum of $250 per calendar year	POS: $10 co-payment for first visit in an authorized series and all charges over the $250 annual benefit maximum. FFS Panama: 50% of the Panama POS Fee schedule amount and any difference between the POS Fee schedule and the billed amount and all charges over the $250 annual benefit maximum FFS US: 50% of the US FFS Plan allowance and any difference between our allowance and the billed amount and all charges over the $250 annual benefit maximum.
Not covered: • *Naturopathic services* (Note: benefits of certain alternative treatment providers may be covered in medically underserved areas; see page 11)	*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 FFS members will be asked to share the costs of the procedures in the form of a co-payment or coinsurance. In some cases, FFS benefits may be applied to a FFS outpatient maximum of $650 for self only and $1500 for self and family. When the benefits apply to the FFS outpatient maximum, we say (Outpatient maximum applies)
- The FFS benefits are the standard benefits of this Plan. POS benefits apply only when you use a POS provider. When no POS provider is available, FFS benefits apply.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works, with special sections for members who are age 65 or over. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- The amounts listed below are for the charges billed by a physician or other health care professional for your surgical care. Look in Section 5(c) for charges associated with the facility (i.e. hospital, surgical center, etc.).
- **YOU MUST GET PRE-CERTIFICATION OF SOME SURGICAL PROCEDURES. Please refer to the pre-certification information shown in Section 3 to be sure which services require pre-certification.**

IMPORTANT

Benefit Description	You pay
Surgical procedures	
A comprehensive range of services, such as: • Operative procedures • Treatment of fractures, including casting • Normal pre- and post-operative care by the surgeon • Correction of amblyopia and strabismus • Endoscopy procedures • Biopsy procedures • Electroconvulsive therapy	POS: Nothing FFS Panama: 50% of the Panama POS Fee schedule amount and any difference between the POS fee schedule and the billed amount FFS US: 50% of the US FFS Plan allowance and any difference between our allowance and the billed amount. Note: For plan allowances please see page 61.

Surgical procedures - continued on next page.

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 prosthetic devices. See 5(a) – Orthopedic and prosthetic devices for device coverage information • Voluntary sterilization (e.g., Tubal ligation, Vasectomy) • Surgically implanted contraceptives • Intrauterine devices (IUDs) • Eye Surgery • Treatment of burns Note: You must pre-certify 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 279-8808 in Panama to pre-certify and determine whether or not we require a second opinion for your specific procedure. If you do not pre-certify 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
Not covered: • *Reversal of voluntary sterilization* • *Services of an assistant surgeon, except when required by law* • *Services of a standby surgeon, except during angioplasty or other high risk procedures when we determine standbys are medically necessary* • *Routine treatment of conditions of the foot; see Foot care*	*All charges.*

Note: We have designated the following as outpatient surgical procedures. If you undergo one of the following procedures inpatient without explicit approval from us, we will apply a $500.00 penalty: • Arthroscopy (internal exam of a joint) • Breast Biopsy • Bronchoscopy (internal exam of lung), adult, with or without biopsy • Cataract removal • Cystourethroscopy • Digestive tract endoscopy (internal exam of esophagus, stomach, colon or rectum) • Dilation and curettage of uterus (D&C) • Excision of pilonidal cyst, simple • Laparoscopy (internal exam of abdomen) with or without tubal ligation (female sterilization) • Laryngoscopy and tracheoscopy (internal exam of larynx and windpipe) • Myringotomy (incision of the membrane in ear) • Prostate biopsy • Reduction of nasal fracture, open or closed • Vasectomy (male sterilization).	

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 deformities; cleft lip; cleft palate; birth marks; and webbed fingers and toes. • All stages of breast reconstruction surgery following a mastectomy, such as: --Surgery to produce a symmetrical appearance of breasts; --treatment of any physical complications, such as lymphedemas; --breast prostheses; and surgical bras and replacements (see Prosthetic devices for coverage)	POS: Nothing FFS Panama: 50% of the Panama POS Fee schedule amount and any difference between the POS Fee schedule and the billed amount FFS US: 50% of the US FFS Plan allowance and any difference between our allowance and the billed amount
Note: We pay for internal breast prostheses as hospital benefits. Note: If you need a mastectomy, you may choose to have the procedure performed on an inpatient basis and remain in the hospital up to 48 hours after the procedure.	
Not covered: • *Cosmetic surgery – any surgical procedure (or any portion of a procedure) performed primarily to improve physical appearance through change in bodily form, except repair of accidental injury* • *Surgeries related to sex transformation or sexual dysfunction*	*All charges.*

Oral and maxillofacial surgery	
Oral surgical procedures, limited to: • Reduction of fractures of the jaws or facial bones • Surgical correction of cleft lip, cleft palate or severe functional malocclusion • Removal of stones from salivary ducts • Excision of leukoplakia or malignancies • Excision of cysts and incision of abscesses when done as independent procedures • 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	You pay
Limited to: • Cornea • Heart • Heart/lung • Kidney • Kidney/Pancreas • Liver • Lung: Single – only for the following end-stage pulmonary diseases: pulmonary 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. • Autologous tandem transplants for testicular and other germ cell tumors • Intestinal transplants (small intestine) and the small intestine with the liver or small intestine with multiple organs such as the liver, stomach, and pancreas 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	
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 those 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 $50 per admission co-payment for POS members and a $125 per admission co-payment for FFS members applies to only a few benefits
- The FFS benefits are the standard benefits of this Plan. POS benefits apply only when you use a POS provider. When no POS provider is available, FFS benefits apply.
- Be sure to read Section 4, *Your costs for covered services* for valuable information about how cost sharing works, with special sections for members who are age 65 or over. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- The amounts listed below are for the charges billed by the facility (i.e. hospital or surgical center) or ambulance service for your surgery or care. Any costs associated with the professional charge (i.e. physicians, etc.) are in Sections 5(a) or (b).
- **YOU MUST GET PRE-CERTIFICATION OF HOSPITAL STAYS; FAILURE TO DO SO WILL RESULT IN A MINIMUM $500 PENALTY.** Please refer to the pre-certification information shown in Section 3 to be sure which services require pre-certification.

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 FFS hospital bills a flat rate, we prorate the charges to determine how to pay them, as follows: 30% room and board and 70% other charges.	POS: Nothing after the $50 per admission co-payment FFS Panama: $125 per admission, then 50% of the Panama POS fee schedule amount and any difference between the POS Fee schedule and the billed amount FFS US: $125 per admission and 50% of the covered charges Note: When you select the POS option and are readmitted to a participating hospital with the same diagnosis within 30 days of being discharged, we will waive the $50 co-payment for the readmission

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 • 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 • Prescribed drugs and medicines • Diagnostic laboratory tests, X-rays, and pathology services • Administration of blood, blood plasma, and other biologicals • Blood and blood plasma, if not donated or replaced • Pre-surgical testing • Dressings, casts, and sterile tray services • Medical supplies, including oxygen • Anesthetics and anesthesia service Note: – We cover hospital services and supplies related to dental procedures when necessitated by a non-dental physical impairment. We do not cover the dental procedures.	POS: $50 co-payment 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
Skilled nursing facility (SNF): We cover semiprivate room, board, services and supplies in a SNF for up to 60 days per confinement when: 1) You are admitted directly from a pre-certified hospital stay of at least 3 consecutive days; and 2) You are admitted for the same condition as the hospital stay; and 3) Your skilled nursing care is supervised by a physician and provided by an R.N., L.P.N., or L.V.N.; and 4) SNF care is medically appropriate.	POS: Nothing FFS Panama: 50% of the Panama POS Fee schedule amount and any difference between the POS fee schedule and the billed amount FFS US: 50% of the US FFS Plan allowance and any difference between our allowance and the billed amount.
Extended care benefit: Sub-Acute Care: We cover room, board 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
• Professional ambulance service when medically appropriate. • Under the POS option, we pay a maximum of $100 per incident for intra-province ambulance service that results in transfer between medical facilities or medical facility and patient's home. • Under the POS option, we pay a maximum of $200 per incident for inter-province ambulance service that results in transfer between medical facilities or medical facility and patient's home. • Under the FFS option, we pay a maximum of $100 per incident that results in transfer between medical facilities or medical facility and patient's home. • We require you to pre-authorize the use of an ambulance if it is not an emergency situation. NOTE: Under FFS benefits, we make no distinction between intra and inter-province ambulance use. The FFS benefit maximum is $100.	POS: Nothing. All charges after $100 maximum for intra-province ambulance use and $200 for inter-province ambulance use. FFS Panama: 50% of the Panama POS Fee schedule amount and any difference between the POS fee schedule and the billed amount. All charges after the $100 maximum FFS US: 50% of the US FFS Plan allowance and any difference between our allowance and the billed amount. All charges after the $100 maximum

Section 5 (d). Emergency services/accidents

IMPORTANT

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.
- Please remember, *we require both FFS and POS Plan members to precertify all admissions to evaluate the medical necessity of your proposed admissions and the number of hospital days you will need.*
- 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.
- The FFS benefits are the standard benefits of this Plan. POS benefits apply only when you use a POS provider. When no POS provider is available, FFS benefits apply.
- If you have an emergency admission due to a condition that you reasonably believe puts your life in danger or could cause serious damage to bodily function, you, your representative, the doctor, or the hospital must telephone us within two business days following the day of the emergency admission, even if you have been discharged from the hospital.
- Be sure to read Section 4, *Your costs for covered services* for valuable information about how cost sharing works, with special sections for members who are age 65 or over. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

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

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 co-payment 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	**You pay**
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 Medical services received while traveling outside of the service area for conditions not serious enough to be classified as emergencies, will be reimbursed under the FFS benefit provisions.	POS: $10 facility co-payment for emergency room visit or office visit. FFS Panama: 50% of the Panama POS Fee schedule amount and any difference between the POS fee schedule and the billed amount FFS US: 50% of the US FFS Plan allowance and any difference between our allowance and the billed amount.
Ambulance	
We pay reasonable and customary charges up to $100 per incident for intra-province ambulance use and $200 for inter-province ambulance use that results in admission to a hospital or transfer between medical facilities, when 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 reasonable and customary charges. NOTE: Under FFS benefits, we make no distinction between intra and inter-province ambulance use. The FFS benefit maximum is $100. Note: See 5 (c) for non-emergent service	POS: Nothing. All charges after $100 maximum for intra-province ambulance use and $200 for inter-province ambulance use FFS Panama: 50% of the Panama POS Fee schedule amount and any difference between the POS fee schedule and the billed amount. All charges after $100 maximum FFS US: 50% of the US FFS Plan allowance and any difference between our allowance and the billed amount. All charges after $100 maximum
Air Ambulance In certain extreme emergency situations we may pay for air ambulance services to transfer a Panama member either from outlying areas in the Republic of Panama to Panama City, or from Panama to the United States if you require care that we determine cannot be adequately provided in the Republic of Panama.	POS: Nothing FFS Panama: 50% of the Panama POS Fee schedule amount and any difference between the POS fee schedule and the billed amount FFS US: Not an eligible benefit

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

IMPORTANT

You may choose to get care as Point-of-Service or Fee-for-Service. 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 and are payable only when we determine they are medically necessary.
- The outpatient and inpatient co-payments apply to almost all benefits in this Section. We added (No co-payment) to show when a co-payment 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 OF THESE SERVICES.** See the instructions after the benefits descriptions below.
- POS mental health and substance abuse benefits are below, then Fee-for-Service benefits begin on page 44.

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 co-payment per visit
• Diagnostic tests	Nothing
• Services provided by a hospital or other facility • Services in approved alternative care settings such as partial hospitalization, half-way house, residential treatment, full-day hospitalization, facility based intensive outpatient treatment	$50 per admission co-payment or $10 co-payment per office visit

Not covered: Services we have not approved. *Note: OPM will base its review of disputes about treatment plans on the treatment plan's clinical appropriateness. OPM will generally not order us to pay or provide one clinically appropriate treatment plan in favor of another.*	*All charges.*

Preauthorization

To be eligible to receive these enhanced mental health and substance abuse benefits you must obtain a treatment plan and follow all of the 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, your representative, your doctor or the hospital must contact us within 48 hours so that we may coordinate a treatment Plan with you and your mental health provider.

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

Network limitation

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

Fee-for-Service Benefit

Mental Health and Substance Abuse Benefit

Description	You pay
Outpatient Care *Mental Health:* We pay for a maximum of 30 visits per calendar year. This benefit is subject to the outpatient maximum limits of $650 (self only) and $1500 (self and family).	FFS Panama: 50% of the Panama POS Fee schedule amount and any difference between the POS fee schedule and the billed amount FFS US: 50% of the US FFS Plan allowance and any difference between our allowance and the billed amount
Substance Abuse: We pay a maximum of $30 per session with a licensed psychologist or clinical social worker. This benefit has a $600 calendar year maximum and is subject to the outpatient maximum.	FFS Panama: 50% of the Panama POS Fee schedule amount and any difference between the POS fee schedule and the billed amount FFS US: 50% of the US FFS Plan allowance and any difference between our allowance and the billed amount.

Inpatient hospital *Mental Health*: We pay for up to 90 days per calendar year *Substance Abuse*: We pay for up to 30 days per calendar year up to a Plan limit of $700.	FFS Panama: 50% of Panama POS Fee schedule amount and any difference between the POS fee schedule and the billed amount. $125 per admission deductible applies. FFS US: 50% of US FFS Plan allowance and any difference between our allowance and the billed amount. $125 per admission deductible applies.
Inpatient professional charges: We pay our allowance for a maximum of one visit per day per doctor.	FFS Panama: You pay all charges in excess of $35 per doctor per day. FFS US: You pay all charges in excess of $35 per doctor per day.
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.*

Pre-certification

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

See 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 FDA approved prescribed drugs and medications (and their equivalents), 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

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

- **Who can write your prescription.** A licensed physician or licensed dentist must write the prescription.
- **Where you can obtain them.** You may fill the prescription at any pharmacy, 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 patient's name, prescription number, name of drug, prescribing doctor's name, date and charge.

Benefit Description	You pay After you meet the prescription drug 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 those listed as *Not covered* • Insulin • Needles and syringes for the administration of covered medications • FDA approved prescription drugs and devices for birth control. NOTE: We cover approved medications for treatment of cancers, aplastic anemia, sickle-cell anemia, and myelodysplasia syndrome at 100% with no deductible. Pre-authorization is required.	POS: 50% of charges plus any non-covered expenses after you meet the prescription drug deductible. FFS Panama: 50% of charges plus any non-covered expenses after you meet the prescription drug deductible. FFS US: 50% of charges plus any non-covered expenses after you meet the prescription drug deductible.

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.*

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

Section 5 (g). Special features

Special feature	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	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 or in Panama 279-8808.

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. See Section 5 (c) for inpatient hospital benefits.

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.

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

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

Section 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; or
- Services, drugs, or supplies you receive without charge while in active military service.
- Any portion of a provider's fee or charge that is ordinarily due from the enrollee but has been waived. If a provider routinely waives (does not require the enrollee to pay) a deductible or coinsurance, the Plan will calculate the actual provider fee or charge by reducing the fee or charge of the waived amount.
- Charges the enrollee or Plan has no legal obligation to pay, such as: excess charges for an annuitant age 65 or older who is not covered by Medicare parts A and/or B (see page 18), 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 19), or State premium taxes however applied;
- Private duty nursing care services, in or out of hospital;
- Expenses to the extent they exceed the Plan allowance for the service or supply;
- Weight control or any treatment of obesity, except surgery for morbid obesity;
- Any facility not included in the definition of hospital or clinic;
- Services of any practitioner not included in the definition of covered provider, with the exception of a physical, speech or occupational therapist; or
- Eye refractions, eyeglasses and contact lenses.

Benefits will not be paid for services and supplies when:

- No charge would be made if the covered individual had no health insurance coverage;
- Furnished by immediate relatives or household members, such as spouse, parent, child, brother or sister by blood, marriage or adoption;
- Furnished or billed by a non-covered facility, except that medically necessary prescription drugs are covered;
- For or related to sex transformation, sexual dysfunction or sexual inadequacy;
- Not specifically listed as covered;
- Investigational or experimental: or
- Not provided in accordance with accepted professional medical standards in the United States and/or Panama.

Section 7. Filing a claim for covered services

How to claim benefits

To obtain claim forms or other claims filing advice or answers about our benefits, contact us at 800-548-8969 in the US, 279-8888 in Panama or 732-676-2630 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, 279-8888 in Panama or 732-676-2630 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 speech, physical and occupational therapy require a written statement from the physician specifying the medical necessity for the service or supply and the length of time needed.
- Claims for prescription drugs and supplies must include receipts that include the patient's name, prescription number, name of drug or supply, prescribing physician's name, date, and charge.
- You must provide translation and currency conversion services for claims for overseas (foreign) services.

Records

Keep a separate record of the medical expenses of each covered family member as 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 of the 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 reissuance 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 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 Claim Forms fromthe 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 Plaza Kosmina, Esquina de la Doble via Oeste y Calle Cuarta, El Dorado, in Panama City, or HNA Panama, S. A., Appeals Department, Apartado Postal 0832-1240 World Trade Center, Panama; and (c) Include a statement about why you believe our initial decision was wrong, based on specific benefit provisions in this brochure; and (d) Include copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms.
2	We have 30 days from the date we receive your request to: (a) Pay the claim (or, if applicable, arrange for the health care provider to give you the care); or (b) Write to you and maintain our denial -- go to step 4; or (c) Ask you or your provider for more information. If we ask your provider, we will send you a copy of our request -- go to step 3.
3	You or your provider must send the information so that we receive it within 60 days of our request. We will then decide within 30 more days. If we do not receive the information within 60 days, we will decide within 30 days of the date the information was due. We will base our decision on the information we already have. We will write to you with our decision.
4	If you do not agree with our decision, you may ask OPM to review it. You must write to OPM within: • 90 days after the date of our letter upholding our initial decision; or • 120 days after you first wrote to us -- if we did not answer that request in some way within 30 days; or • 120 days after we asked for additional information. Write to OPM at: Office of Personnel Management, Insurance Services Programs, Health Insurance Group II, 1900 E Street, NW, Washington, DC 20415-3620.

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 more than one claim, you must clearly identify which documents apply to which claim.

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

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

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

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

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

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

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

(a) We haven't responded yet to your initial request for care or preauthorization/prior approval, then call us at 800-548-8969 (in the US), 279-8888 (within the Republic of Panama) or 732-676-2630 (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 may call OPM's Health Insurance Group II at 202/606-3818 between 8 a.m. and 5 p.m. eastern time.

Section 9. Coordinating benefits with other coverage

When you have other health coverage

You must tell us if you or a covered family member have coverage 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. If you or your spouse worked for at least 10 years in Medicare-covered employment, you should be able to qualify for premium-free Part A insurance. (Someone who was a Federal employee on January 1, 1983 or since automatically qualifies.) Otherwise, if you are age 65 or older, you may be able to buy it. Contact 1-800-MEDICARE for more information.
- Part B (Medical Insurance). Most people pay monthly for Part B. Generally, Part B premiums are withheld from your monthly Social Security check or your retirement check.

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 (Part A or Part B)

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

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

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

- When Original Medicare is the primary payer, Medicare processes your claim first. In most cases, your claim will be coordinated automatically and we will then provide secondary benefits for covered charges. You will not need to do anything. To find out if you need to do something to file your claim, call us at 800-548-8969 in the US or 279-8888 in Panama or visit our Website at http://www.healthnetworkamerica.com

We waive some costs if the Original Medicare Plan is your primary payer

When Original 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 co-payments and coinsurance amounts.

- Hospital inpatient room and board and other charges. If you are enrolled in Medicare Part A, we waive your co-payment and coinsurance amounts.

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

Primary Payer Chart

A. When you -- or your covered spouse -- are age 65 or over and have Medicare and you…	The primary payer for the individual with Medicare is	
	Medicare	**This Plan**
1) Are an active employee with the Federal government and…		
• You have FEHB coverage on your own or through your spouse who is also an active employee		✓
• You have FEHB coverage through your spouse who is an annuitant	✓	
2) Are an annuitant and…		
• You have FEHB coverage on your own or through your spouse who is also an annuitant	✓	
• You have FEHB coverage through your spouse who is an active employee		✓
3) Are a reemployed annuitant with the Federal government and your position is excluded from the FEHB (your employing office will know if this is the case)	✓*	
4) Are a reemployed annuitant with the Federal government and your position is not excluded from the FEHB (your employing office will know if this is the case) and…		
• You have FEHB coverage on your own or through your spouse who is also an active employee		✓
• You have FEHB coverage through your spouse who is an annuitant	✓	
5) 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),	✓*	
6) Are enrolled in Part B only, regardless of your employment status,	✓ for Part B Services	✓ for other services
7) 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,	✓**	
B. When you or a covered family member…		
1) Have Medicare solely based on end stage renal disease (ESRD) and…		
• It is within the first 30 months of eligibility for entitlement to Medicare due to ESRD (30-month coordination period).		✓
• It is beyond the 30-month coordination period and you or a family member are still entitled to Medicare due to ESRD	✓	
2) Become eligible for Medicare due to ESRD while already a Medicare beneficiary and…		
• This Plan was the primary payer before eligibility due to ESRD		✓ for 30-month coordination period
• Medicare was the primary payer before eligibility due to ESRD	✓	
C. When either you or your spouse are eligible for Medicare solely due to disability and you		
1) Are an active employee with the Federal government and…		
• You have FEHB coverage on your own or through your spouse who is also an active employee		✓
• You have FEHB coverage though your spouse who is an annuitant	✓	
2) Are an annuitant and…		
• You have FEHB coverage on your own or through your spouse who is also an annuitant	✓	
• You have FEHB coverage through your spouse who is an active employee		✓
D. Are covered under the FEHB Spouse Equity provision as a former spouse	✓	

* Unless you have FEHB coverage through your spouse who is an active employee

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

· **Medicare + Choice**

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

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

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

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

•**Private Contract with your physician**

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

TRICARE and CHAMPVA

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

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

Workers' Compensation

We do not cover services that:

- you need because of a workplace-related illness or injury that the Office of Workers' Compensation Programs (OWCP) or a similar Federal or State agency determines they must provide; or

- OWCP or a similar agency pays for through a third-party injury settlement or other similar proceeding that is based on a claim you filed under OWCP or similar laws.

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

Medicaid

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

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

When other Government agencies are responsible for your care

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

When others are responsible for injuries

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

If you do not seek damages, you must agree to let us try. This is called subrogation. 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.

Coinsurance

Coinsurance is the percentage of our allowance that you must pay for your care. You may also be responsible for additional amounts. See page 15.

Co-payment

A co-payment is a fixed amount of money you pay when you receive covered services. See page 15.

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 15.

Emergency
for definition of medical emergency

See page 42

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 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 Panama Canal Area Benefit Plan

You

You refers to the enrollee and each covered family member.

Section 11. FEHB facts

Coverage Information

- **No pre-existing condition limitation**

We will not refuse to cover the treatment of a condition 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/health for enrollment information as well as:

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

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

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

- **Children's Equity Act**

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

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

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

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

- **When benefits and premiums start**

The benefits in this brochure are effective on January 1. If you joined this Plan during Open Season, your coverage begins on the first day of your first pay period that starts on or after January 1. If you changed plans or plan options during Open Season and you receive care between January 1 and the effective date of coverage under your new plan or option, your claims will be paid according to the 2004 benefits of your old plan or option. However, if your old plan left the FEHB Program at the end of the year, you are covered under that plan's 2003 benefits until the effective date of your coverage with your new plan. Annuitants' coverage and premiums begin on January 1. If you joined at any other time during the year, your employing office will tell you the effective date of coverage.

- **When you retire**

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

When you lose benefits

- **When FEHB coverage ends**

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

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

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

- **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. This is the case even when the court has ordered your former spouse to provide health coverage to you. But, you may be eligible for your own FEHB coverage under the spouse equity law or Temporary Continuation of Coverage (TCC). If you are recently divorced or are anticipating a divorce, contact your ex-spouse's employing or retirement office to get RI 70-5, the *Guide to Federal Employees Health Benefits Plans for Temporary Continuation of Coverage and Former Spouse Enrollees*, or other information about your coverage choices. You can also download the guide from OPM's Website, www.opm.gov/insure.

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

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

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

Enrolling in TCC. Get the RI 79-27, which describes TCC, and the RI 70-5, the *Guide to Federal 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. It explains what you have to do to enroll.

- **Converting to individual coverage**

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

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

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

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

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

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

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

Two new Federal Programs complement FEHB benefits

Important information

OPM wants to be sure you know about two new Federal programs that complement the FEHB Program. First, the **Flexible Spending Account (FSA) Program**, also known as **FSAFEDS,** lets you set aside tax-free money to pay for health and dependent care expenses. The result can be a discount of 20 to more than 40 percent on services you routinely pay for out-of-pocket. Second, the **Federal Long Term Care Insurance Program** (FLTCIP) covers long term care costs not covered under the FEHB.

The Federal Flexible Spending Account Program - *FSAFEDS*

- **What is an FSA?**

It is a tax-favored benefit that allows you to set aside pre-tax money from your paychecks to pay for a variety of eligible expenses. *By using an FSA, you can reduce your taxes while paying for services you would have to pay for anyway, producing a discount that can be over 40%!!*

There are two types of FSAs offered by the FSAFEDS Program**:**

Health Care Flexible Spending Account (HCFSA)

- Covers eligible health care expenses not reimbursed by this Plan, or any other medical, dental, or vision care plan you or your dependents may have
- Eligible dependents for this account include anyone you claim on your Federal income tax return as a qualified dependent under the U.S. Internal Revenue Service (IRS) definition and/or with whom you jointly file your Federal income tax return, even if you don't have self and family health benefits coverage. ***Note:*** The IRS has a broader definition than that of a "family member" than is used under the FEHB Program to provide benefits by your FEHB Plan.
- The maximum amount that can be allotted for the HCFSA is $3,000 annually. The minimum amount is $250 annually.

Dependent Care Flexible Spending Account (DCFSA)

- Covers eligible dependent care expenses incurred so you can work, or if you are married, so you and your spouse can work, or your spouse can look for work or attend school full-time.
- Eligible dependents for this account include anyone you claim on your Federal income tax return as a qualified IRS dependent and/or with whom you jointly file your Federal income tax return.
- The maximum that can be allotted for the DCFSA is $5,000 annually. The minimum amount is $250 annually. ***Note:*** The IRS limits contributions to a Dependent Care FSA. For single taxpayers and taxpayers filing a joint return, the maximum is $5,000 per year. For taxpayers who file their taxes separately with a spouse, the maximum is $2,500 per year. The limit includes any child care subsidy you may receive.

- **Enroll during Open Season**

You **must make an election** to enroll in an FSA during the FEHB Open Season. Even if you enrolled during the initial Open Season for 2003, you must make a new election to continue participating in 2004. Enrollment is easy!

- Enroll online anytime during Open Season (November 10 through December 8, 2003) at **www.fsafeds.com**.
- Call the toll –free number 1-877-FSAFEDS (372-3337) Monday through Friday, from 9 a.m. until 9 p.m. eastern time and a FSAFEDS Benefit Counselor will help you enroll.

What is SHPS?

SHPS is a third-party administrator hired by OPM to manage the FSAFEDS Program. SHPS is the largest FSA administrator in the nation and will be responsible for enrollment, claims processing, customer service, and day-to-day operations of FSAFEDS.

Who is eligible to enroll?

If you are a Federal employee eligible for FEHB – even if you're not enrolled in FEHB– you can choose to participate in either, or both, of the flexible spending accounts. If you are not eligible for FEHB, you are not eligible to enroll for a Health Care FSA. However, almost all Federal employees are eligible to enroll for the Dependent Care FSA. The only exception is intermittent (also called when actually employed [WAE]) employees expected to work less than 180 days during the year.

Note: FSAFEDS is the FSA Program established for all Executive Branch employees and Legislative Branch employees whose employers signed on. Under IRS law, FSAs are not available to annuitants. In addition, the U.S. Postal Service and the Judicial Branch, among others, are Federal agencies that have their own plans with slightly different rules, but the advantages of having an FSA are the same no matter what agency you work for.

- **How much should I contribute to my FSA?**

Plan carefully when deciding how much to contribute to an FSA. Because of the tax benefits of an FSA, the IRS places strict guidelines on them. You need to estimate how much you want to allocate to an FSA because current IRS regulations require you to forfeit any funds remaining in your account(s) at the end of the FSA plan year. This is referred to as the "use-it-or-lose-it" rule. You will have until April 29, 2004 to submit claims for your eligible expenses incurred during 2003 if you enrolled in FSAFEDS when it was initially offered. You will have until April 30, 2005 to submit claims for your eligible expenses incurred from January 1 through December 31, 2004 if you elect FSAFEDS during this Open Season.

The **FSAFEDS Calculator** at www.fsafeds.com will help you plan your FSA allocations and provide an estimate of your tax savings based on your individual situation.

- **What can my HCFSA pay for?**

Every FEHB health plan includes cost sharing features, such as deductibles you must meet before the Plan provides benefits, coinsurance or copayments that you pay when you and the Plan share costs, and medical services and supplies that are not covered by the Plan and for which you must pay. These out-of-pocket costs are summarized on page 16 and detailed throughout this brochure. Your HCFSA will reimburse you for such costs when they are for tax deductible medical care for you and your dependents that is NOT covered by this FEHB Plan or any other coverage that you have.

Under this Plan, typical out-of-pocket expenses include: the co-payment for office consultations, ambulatory procedures, and hospital admissions, your prescription drug deductible, and the co-insurance applied to most FFS benefits. Your HCFSA will also reimburse you for some things your health plan does not cover such as durable medical equipment, eyeglasses, and private duty nursing services.

The IRS governs expenses reimbursable by a HCFSA. See Publication 502 for a comprehensive list of tax-deductible medical expenses. **Note: While you will see insurance premiums listed in Publication 502, they are NOT a reimbursable expense for FSA purposes**. Publication 502 can be found on the IRS Web site at http://www.irs.gov/pub/irs-pdf/p502.pdf. If you do not see your service or expense listed in Publication 502, please call a FSAFEDS Benefit Counselor at 1-877-FSAFEDS (372-3337), who will be able to answer your specific questions.

- **Tax savings with an FSA**

An FSA lets you allot money for eligible expenses ***before*** your agency deducts taxes from your paycheck. This means the amount of income that your taxes are based on will be lower, so your tax liability will also be lower. Without an FSA, you would still pay for these expenses, but you would do so using money remaining in your paycheck after Federal (and often state and local) taxes are deducted. The following chart illustrates a typical tax savings example:

Annual Tax Savings Example	With FSA	Without FSA
If your taxable income is:	$50,000	$50,000
And you deposit this amount into a FSA:	$ 2,000	-$0-
Your taxable income is now:	$48,000	$50,000
Subtract Federal & Social Security taxes:	$13,807	$14,383
If you spend after-tax dollars for expenses:	-$0-	$ 2,000
Your real spendable income is:	$34,193	$33,617
Your tax savings:	**$576**	**-$0-**

Note: This example is intended to demonstrate a typical tax savings based on 27% Federal and 7.65% FICA taxes. Actual savings will vary based upon in which retirement system you are enrolled (CSRS or FERS), as well as your individual tax situation. In this example, the individual received $2,000 in services for $1,424, a discount of almost 36%! You may also wish to consult a tax professional for more information on the tax implications of an FSA.

- **Tax credits and deductions**

You *cannot* claim expenses on your Federal income tax return if you receive reimbursement for them from your HCFSA or DCFSA. Below are some guidelines that may help you decide whether to participate in FSAFEDS.

Health care expenses

The HCFSA is tax-free from the first dollar. In addition, you may be reimbursed from the HCFSA at any time during the year for expenses up to the annual amount you've elected to contribute.

Only health care expenses exceeding 7.5% of your adjusted gross income are eligible to be deducted on your Federal income tax return. Using the example listed in the above chart, only health care expenses exceeding $3,750 (7.5% of $50,000) would be eligible to be deducted on your Federal income tax return. In addition, money set aside through a HCFSA is also exempt from FICA taxes. This exemption is not available on your Federal income tax return.

Dependent care expenses

The DCFSA generally allows many families to save more than they would with the Federal tax credit for dependent care expenses. Note that you may only be reimbursed from the DCFSA up to your current account balance. If you file a claim for more than your current balance, it will be held until additional payroll allotments have been added to your account.

Visit www.fsafeds.com and download the Dependent Care Tax Credit Worksheet from the Quick Links box to help you determine what is best for your situation. You may also wish to consult a tax professional for more details.

- **Does it cost me anything to participate in FSAFEDS?**

Probably not. While there is an administrative fee of $4.00 per month for an HCFSA and 1.5% of the annual election for a DCFSA, most agencies have elected to pay these fees out of their share of employment tax savings. To be sure, check the FSAFEDS.com Web site or call 1-877-FSAFEDS (372-3337). Also, remember that participating in FSAFEDS can cost you money if you don't spend your entire account balance by the end

of the plan year and wind up forfeiting your end of year account balance, per the IRS "use-it-or-lose-it" rule.

- **Contact us**

To find out more or to enroll, please visit the **FSAFEDS Web site** at **www.fsafeds.com**, or contact SHPS by email or by phone**.** SHPS Benefit Counselors are available from 9:00 a.m. until 9:00 p.m. eastern time, Monday through Friday.

- E-mail: fsafeds@shps.net
- Telephone: 1-877-FSAFEDS (372-3337)
- TTY: 1-800-952-0450 (for hearing impaired individuals that would like to utilize a text messaging service)

The Federal Long Term Care Insurance Program

It's important protection

Here's why you should consider enrolling in the Federal Long Term Care Insurance Program:

- **FEHB plans do not cover the cost of long term care.** Also called "custodial care," long term care is help you receive when you need assistance performing activities of daily living – such as bathing or dressing yourself. This need can strike anyone at any age and the cost of care can be substantial.
- **The Federal Long Term Care Insurance Program can help protect you from the potentially high cost of long term care**. This coverage gives you control over the type of care you receive and where you receive it. It can also help you remain independent, so you won't have to worry about being a burden to your loved ones.
- **It's to your advantage to apply sooner rather than later**. Long term care insurance is something you must apply for, and pass a medical screening (called underwriting) in order to be enrolled. Certain medical conditions will prevent some people from being approved for coverage. By applying while you're in good health, you could avoid the risk of having a change in health disqualify you from obtaining coverage. Also, the younger you are when you apply, the lower your premiums.
- **You don't have to wait for an open season to apply**. The Federal Long Term Care Insurance Program accepts applications from eligible persons at any time. You will have to complete a full underwriting application, which asks a number of questions about your health. However, if you are a new or newly eligible employee, you (and your spouse, if applicable) have a limited opportunity to apply using the abbreviated underwriting application, which asks fewer questions. If you marry, your new spouse will also have a limited opportunity to apply using abbreviated underwriting. Qualified relatives are also eligible to apply with full underwriting.

To find out more and to request an application

Call 1-800-LTC-FEDS (1-800-582-3337) (TTY 1-800-843-3557)
or visit www.ltcfeds.com.

Index

Do not rely on this page; it is for your convenience and may not show all pages where the terms appear.

Summary of benefits for the Panama Canal Area Benefit Plan - 2004

- **Do not rely on this chart alone.** All benefits are subject to the definitions, limitations, and exclusions in this brochure. On this page we summarize specific expenses we cover; for more detail, look inside.
- If you want to enroll or change your enrollment in this Plan, be sure to put the correct enrollment code from the cover on your enrollment form.
- Under FFS Option after we pay, you generally pay any difference between our allowance and the billed amount.
- If you are a POS member and receive your medical care through your primary care physician and other POS providers you can limit your out-of-pocket expenses. Please refer to Section 5 (benefits) for a complete list of POS benefits and your payment obligations under this option.

Benefits	You pay	Page
Medical services provided by physicians: • Diagnostic and treatment services provided in the office	POS: $10 co-payment 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	21
Services provided by a hospital: • Inpatient.....	POS: Nothing after the $50 per admission co-payment 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	37
• Outpatient.....	POS: $50 co-payment 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	38

Emergency benefits: • Accidental injury (after 72 hours)..... • Medical emergency	POS: $10 co-payment 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	41 42
Mental health and substance abuse treatment	POS: Regular cost sharing FFS: Benefits are limited	43
Prescription drugs.....	50% of eligible charges after the $400 per member calendar year deductible has been met	46
Dental Care	Scheduled allowances	49
Protection against catastrophic costs (your catastrophic protection out-of-pocket maximum) ..... *Note: Applies only to FFS benefits*	After the 50% for hospital inpatient room and board and other expenses reaches $2500 per member per year, we will pay the remaining hospital room and board and other charges at 100% Some costs do not count toward this protection	16

2004 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**	**$114.16**	**$38.05**	**$247.34**	**$82.45**
Self & Family	**432**	**$238.29**	**$79.43**	**$516.29**	**$172.10**