Panama Canal Area Benefit Plan

www.pcabp.com.pa

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

2024

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

This plan's health coverage qualifies as minimum essential coverage and meets the minimum value standard for the benefits it provides. This Plan is accredited. See page 12.

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

Who may enroll in this Plan: Annuitants (retirees and/or survivors) who are eligible for coverage under the Federal Employees Health Benefits Program, reside in Panama and are members of The Association of Retirees of the Panama Canal Area (AJAC).

To become a member of the AJAC: NOTE: This is a closed plan. Only Federal Employees who worked for the Panama Canal Zone are elegible to become members of the association.

IMPORTANT
- Rates: Back Cover
- Changes for 2024: Page 14
- Summary of Benefits: Page 86

Enrollment codes for this Plan:

431 – Self Only
433 – Self Plus One
432 – Self and Family

FEHB
Federal Employees
Health Benefits Program

Authorized for distribution by the:

United States
Office of Personnel Management

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

RI 72-004

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

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

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

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

Please be advised

If you lose or drop your FEHB coverage and go 63 days or longer without prescription drug coverage that is at least as good as Medicare's prescription drug coverage, your monthly Medicare Part D premium will go up at least 1% per month for every month that you did not have that coverage. For example, if you go 19 months without Medicare Part D prescription drug coverage, your premium will always be at least 19 percent higher than what many other people pay. You will have to pay this higher premium as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the next Annual Coordinated Election Period (October 15 through December 7) to enroll in Medicare Part D.

Medicare's Low Income Benefits

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

Potential Additional Premium for Medicare's High Income Members

Income-Related Monthly Adjustment Amount (IRMAA)

The Medicare Income-Related Monthly Adjustment Amount (IRMAA) is an amount you may pay in addition to your FEHB premium to enroll in and maintain Medicare prescription drug coverage. **This additional premium is assessed only to those with higher incomes and is adjusted based on the income reported on your IRS tax return**. You do not make any IRMAA payments to your FEHB plan. Refer to the Part D-IRMAA section of the Medicare website:https://www.medicare.gov/drug-coverage-part-d/costs-for-medicare-drug-coverage/monthly-premium-for-drug-plans to see if you would be subject to this additional premium.

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

- Visit www.medicare.gov for personalized help,
- Call 800-MEDICARE (1-800-633-4227), (TTY: 1-877-486-2048).

Table of Contents

Introduction

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

Panama Canal Area Benefit Plan at AXA Assistance, Torre BICSA Financial Center, 48th Floor, Avenida Balboa y Alquilino de la Guardias. Panama City, Republic of Panama. We also have customer service offices at Clínica Hospital San Fernando, Centro Médico Paitilla and Centro Médico Caribe (Colon).

This brochure is the official statement of benefits. No verbal 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 Plus One or 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, 2024, unless those benefits are also shown in this brochure.

OPM negotiates benefits and rates for each plan annually. Benefit changes are effective January 1, 2024, and changes are summarized on page 14. Rates are shown at the end of this brochure.

Plain Language

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

- Except for necessary technical terms, we use common words. For instance, "you" means the enrollee and each covered 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.
- Our brochure and other FEHB plans' brochures have the same format and similar descriptions to help you compare plans.

Stop HealthCare Fraud!

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

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

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

- Do not give your plan identification (ID) number over the phone or to people you do not know, except for your healthcare provider, authorized health benefits plan, or OPM representative.
- Let only the appropriate medical professionals review your medical record or recommend services.
- Avoid using healthcare providers who say that an item or service is not usually covered, but they know how to bill us to get it paid.
- Carefully review explanations of benefits (EOBs) statements that you receive from us.
- Periodically review your claim history for accuracy to ensure we have not been billed for services you did not receive.
- Do not ask your doctor to make false entries on certificates, bills, or records in order to get us to pay for an item or service.
- If you suspect that a provider has charged you for services you did not receive, billed you twice for the same service, or misrepresented any information, do the following:
  - Call the provider and ask for an explanation. There may be an error.

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

CALL - THE HEALTHCARE FRAUD HOTLINE

877-499-7295

OR go to www.opm.gov/our-inspector-general/hotline-to-report-fraud-waste-or-abuse/complaint-form/

The online reporting form is the desired method of reporting fraud in order to ensure accuracy, and a quicker response time.

You can also write to:

United States Office of Personnel Management

Office of the Inspector General Fraud Hotline

1900 E Street NW Room 6400

Washington, DC 20415-1100

- Do not maintain as a family member on your policy

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

Your child age 26 or over (unless they were disabled and incapable of self-support prior to age 26).

A carrier may request that an enrollee verify the eligibility of any or all family members listed as covered under the enrollee's FEHB enrollment.

- If you have any questions about the eligibility of a dependent, check with your personnel office if you are employed, with your retirement office (such as OPM) if you are retired, or with the National Finance Center if you are enrolled under Temporary Continuation of Coverage (TCC).
- Fraud or intentional misrepresentation of material fact is prohibited under the Plan. You can be prosecuted for fraud and your agency may take action against you. Examples of fraud include falsifying a claim to obtain FEHB benefits, trying to or obtaining service or coverage for yourself or for someone else who is not eligible for coverage, or enrolling in the Plan when you are no longer eligible.
- If your enrollment continues after you are no longer eligible for coverage (i.e., you have separated from Federal service) and premiums are not paid, you will be responsible for all benefits paid during the period in which premiums were not paid. You may be billed by your provider for services received. You may be prosecuted for fraud for knowingly using health insurance benefits for which you have not paid premiums. It is your responsibility to know when you or a family member is no longer eligible to use your health insurance coverage.

Discrimination is Against the Law

The health benefits described in this brochure are consistent with applicable laws prohibiting discrimination.

Preventing Medical Mistakes

Medical mistakes continue to be a significant cause of preventable deaths within the United States. 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. Medical mistakes and their consequences also add significantly to the overall cost of healthcare. Hospitals and healthcare providers are being held accountable for the quality of care and reduction in medical mistakes by their accrediting bodies. You can also improve the quality and safety of your own healthcare and that of your family members by learning more about and understanding your risks. 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 take notes, ask questions and understand answers.

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

- Bring the actual medication or give your doctor and pharmacist a list of all the medication and dosage that you take, including non-prescription (over-the-counter) medications and nutritional supplements.
- Tell your doctor and pharmacist about any drug, food, and other allergies you have, such as latex.
- Ask about any risks or side effects of the medication and what to avoid while taking it. Be sure to write down what your doctor or pharmacist says.
- Make sure your medication is what the doctor ordered. Ask the pharmacist about your medicine if it looks different than you expected.
- Read the label and patient package insert when you get your medication, including all warnings and instructions.
- Know how to use your medication. Especially note the times and conditions when your medication should and should not be taken.
- Contact your doctor or pharmacist if you have any questions.
- Understanding both the generic and brand names of your medication. This helps ensure you do not receive double dosing from taking both a generic and a brand. It also helps prevent you from taking a medication to which you are allergic.

3. Get the results of any test or procedure.

- Ask when and how you will get the results of tests or procedures. Will it be in person, by phone, mail, or through the Plan or Provider’s portal?
- Don’t assume the results are fine if you do not get them when expected. Contact your healthcare provider and ask for your results.
- Ask what the results mean for your care.

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

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

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 or nutritional supplements you are taking.

Patient Safety Links

For more information on patient safety, please visit:

- www.jointcommission.org/speakup.aspx. The Joint Commission’s Speak Up™ patient safety program.
- www.jointcommission.org/topics/patient_safety.aspx. The Joint Commission helps healthcare organizations to improve the quality and safety of the care they deliver.
- www.ahrq.gov/patients-consumers/. 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 healthcare providers and improve the quality of care you receive.
- www.bemedwise.org. The National Council on Patient Information and Education is dedicated to improving communication about the safe, appropriate use of medications.
- 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 healthcare professionals working to improve patient safety.

Preventable Healthcare Acquired Conditions (“Never Events”)

When you enter the hospital for treatment of one medical problem, you do not expect to leave with additional injuries, infections, or other serious conditions that occur during the course of your stay. Although some of these complications may not be avoidable, patients do suffer from injuries or illnesses that could have been prevented if doctors or the hospital had taken proper precautions. Errors in medical care that are clearly identifiable, preventable and serious in their consequences for patients, can indicate a significant problem in the safety and credibility of a healthcare facility. These conditions and errors are sometimes called “Never Events” or “Serious Reportable Events.”

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

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

FEHB Facts

Coverage information

- **No pre-existing condition limitation**

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

- **Minimum essential coverage (MEC)**

  Coverage under this plan qualifies as minimum essential coverage. Please visit the Internal Revenue Service (IRS) website at www.irs.gov/uac/Questions-and-Answers-on-the-Individual-Shared-Responsibility-Provision for more information on the individual requirement for MEC.

- **Minimum value standard**

  Our health coverage meets the minimum value standard of 60% established by the ACA. This means that we provide benefits to cover at least 60% of the total allowed cost of essential health benefits. The 60% standard is an actuarial value; your specific out-of-pocket cost are determined as explained in this brochure.

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

  See www.opm.gov/healthcare-insurance 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 that 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, give you other plans brochures and other materials you need to make an informed decision about your FEHB coverage. These materials tell you:

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

  We do not determine who is eligible for coverage and, in most cases, cannot change your enrollment status without information from your employing or retirement office. For information on your premium deductions, disability leave, pensions, etc you must also contact your employing or retirement office.

  Once enrolled in your FEHB Program Plan, you should contact your carrier directly for the following address updates and questions about your benefit coverage.

- **Enrollment types available for you and your family**

  Self Only coverage is only for the enrollee. Self Plus One coverage is for the enrollee and one eligible family member. Self and Family coverage is for the enrollee and one or more eligible family members. Family members include your spouse and your dependent children under age 26, including any foster children authorized for coverage by your employing agency or retirement office. Under certain circumstances, you may also continue coverage for a disabled child 26 years of age or older who is incapable of self-support.

If you have a Self Only enrollment, you may change to a Self Plus One or 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 Plus One or 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 Plus One or 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 are married. A carrier may request that an enrollee verify the eligibility of any or all family members listed as covered under the enrollee's FEHB enrollment.

Contact your employing or retirement office if you want to change from Self Only to Self Plus One or Self and Family. If you have a Self and Family enrollment, you may contact us to add a family member.

Your employing or retirement office will **not** notify you when a family member is no longer eligible to receive benefits. Please tell us immediately of changes in family member status, including your marriage, divorce, annulment, or when your child reaches age 26.We will send written notice to you 60 days before we proactively disenroll your child on midnight of their 26th birthday unless your child is eligible for continued coverage because they are incapable of self-support due to a physical or mental disability that began before age 26.

If you or one of your family members is enrolled in one FEHB plan, you or they cannot be enrolled in or covered as a family member by another enrollee in another FEHB plan.

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

- **Family Member Coverage**

Family members covered under your Self and Family enrollment are your spouse (including your spouse by a valid common-law marriage from a state that recognizes common-law marriages) and children as described below. A Self Plus One enrollment covers you and your spouse, or one other eligible family member as described below.

Natural children, adopted children, and stepchildren
Coverage: Natural children, adopted children, and stepchildren are covered until their 26th birthday.

Foster children
Coverage: Foster children are eligible for coverage until their 26th birthday if you provide documentation of your regular and substantial support of the child and sign a certification stating that your foster child meets all the requirements. Contact your human resources office or retirement system for additional information.

Children incapable of self-support
Coverage: Children who are incapable of self-support because of a mental or physical disability that began before age 26 are eligible to continue coverage. Contact your human resources office or retirement system for additional information.

Married children
Coverage: Married children (but **NOT** their spouse or their own children) are covered until their 26th birthday.

Children with or eligible for employer-provided health insurance
Coverage: Children who are eligible for or have their own employer-provided health insurance are covered until their 26th birthday.

Newborns of covered children are insured only for routine nursery care during the covered portion of the mother's maternity stay.

You can find additional information at www.opm.gov/healthcare-insurance.

- **Children's Equity Act**

OPM implements the Federal Employees Health Benefits Children's Equity Act of 2000. This law mandates that you be enrolled for Self Plus One or 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 in Self Plus One or 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 Plus One or Self and Family coverage, as appropriate, in the lowest-cost nationwide plan option as determined by OPM;
- 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 Plus One or Self and Family, as appropriate, 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 Plus One or to Self and Family, as appropriate, in the lowest-cost nationwide plan option as determined by OPM.

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 does not 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 does not serve the area in which your children live as long as the court/administrative order is in effect. Similarly, you cannot change to Self Plus One if the court/ administrative order identifies more than one child. Contact your employing office for further information.

- **When benefits and premiums start**

The benefits in this brochure are effective January 1. If you joined this Plan during Open Season, your coverage begins on the first day of your first pay period that starts on or after January 1. **If you changed plans or plan options during Open Season and you receive care between January 1 and the effective date of coverage under your new plan or option, your claims will be processed according to the 2024 benefits of your prior plan or option.** If you have met (or pay cost-sharing that results in your meeting) the out-of-pocket maximum under the prior plan or option, you will not pay cost-sharing for services covered between January 1 and the effective date of coverage under your new plan or option. However, if your prior plan left the FEHB Program at the end of the year, you are covered under that plan's 2023 benefits until the effective date of your coverage with your new plan. Annuitants' coverage and premiums begin on January 1. If you joined at any other time during the year, your employing office will tell you the effective date of coverage.

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

- **When you retire**

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

When you lose benefits

- **When FEHB coverage ends**

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

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

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

  You may be eligible for spouse equity coverage or assistance with enrolling in a conversion policy (a non-FEHB individual policy).

- **Upon divorce**

  If you are an enrollee, and your divorce or annulment is final, your ex-spouse cannot remain covered as a family member under your Self Plus One or Self and Family enrollment. You must contact us to let us know the date of the divorce or annulment and have us remove your ex-spouse. We may ask for a copy of the divorce decree as proof. In order to change enrollment type, you must contact your employing or retirement office. A change will not automatically be made.

  If you were married to an enrollee and your divorce or annulment is final, you may not remain covered as a family member under your former spouse's enrollment. This is the case even when the court has ordered your former spouse to provide health coverage for you. However, you may be eligible for your own FEHB coverage under either the spouse equity law or Temporary Continuation of Coverage (TCC). If you are recently divorced or are anticipating a divorce, contact your ex-spouse's employing or retirement office to get additional information about your coverage choices, https://www.opm.gov/healthcare-insurance/life-events/memy-family/im-separated-or-im-getting-divorced/#url=Health. We may request that you verify the eligibility of any or all family members listed as covered under the enrollee's FEHB enrollment.

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

  If you leave Federal service, Tribal Employment 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 or if you are a covered child and you turn age 26, regardless of marital status, etc.

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

  Enrolling in TCC. Get the RI 79-27, which describes TCC from your employing or retirement office or fromwww.opm.gov/healthcare-insurance/healthcare/plan-information/guides. It explains what you have to do to enroll.

  Alternatively, you can buy coverage through the Health Insurance Marketplace where depending on your income, you could be eligible for a tax credit that lowers your monthly premiums. Visit www.HealthCare.gov to compare plans and see what your premium, deductible, and out-of-pocket cost would be before you make a decision to enroll. Finally, if you qualify for a coverage under another group health plan (such as your spouse's plan), you may be able to enroll in that plan, as long as you apply within 30 days of losing FEHB Program coverage.

- **Converting to individual coverage**

  Finding Replacement Coverage

  We will provide you with assistance in finding a non-group contract available inside or outside the Marketplace 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 decide 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.

You must contact us in writing within 31 days after you are no longer eligible for coverage. For assistance in finding coverage, please contact us at 507-366-1400 in Panama, and 800-424-8196 or 312-935-3671 in the United States.

Benefits and rates under the replacement coverage will differ from benefits and rates 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.

- **Health Insurance Marketplace** — If you would like to purchase health insurance through the ACA's Health Insurance Marketplace, please visit www.HealthCare.gov. This is a website provided by the U.S. Department of Health and Human Services that provides up-to-date information on the Marketplace.

Section 1. How This Plan Works

This Plan is a fee-for-service (FFS) plan. OPM requires that FEHB plans be accredited to validate that plan operations and/or care management meet or exceed nationally recognized standards. The Panama Canal Area Benefit Plan-AJAC administered by AXA Assistance holds an accreditation with the Accreditation Association for Ambulatory Health Care (AAAHC) standards for Health Plans. To learn more about this plan's accreditation, please visit the following websites: www.aaahc.org. You can choose your own physicians, hospitals, and other healthcare 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.

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

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

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

Contact us for the names of POS providers and to verify their continued participation. You can also go to our website at www.pcabp.com.pa. Do not call OPM or your agency for our provider directory.

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

How we pay providers

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

POS benefits do not apply to services that are performed outside of the Republic of Panama unless it's a medical emergency, or to providers that are not part of the POS network. We will apply fee-for-service (FFS) benefits to services that you receive outside the POS network.

FFS: If you live in Panama and select the Fee-for-Service (FFS) option, or if you live anywhere outside of Panama, you will usually have to pay for the medical services provided to you and then we will reimburse you according to the benefits described in this brochure. However, if the provider agrees to file the claim directly to the Plan, he/she should send a completed Claim Form and the itemized bills to the Panama Canal Area Benefit Plan at AXA Assistance, PO Box 31-0940, Miami Florida 33231-0940 (if services were provided anywhere outside of Panama) or to the Panama Canal Area Benefit Plan at AXA Assistance, Torre BICSA Financial Center, 48th Floor, Avenida Balboa y Alquilino de la Guardias. Panama City, Republic of Panama (if services were provided in Panama). We also have customer service offices at Clínica Hospital San Fernando, Centro Médico Paitilla and Centro Médico Caribe (Colon).

For claims incurred in the United States or any country outside of Panama, we will reimburse you 50% of the plan allowance.

Your Rights and responsibilities

OPM requires that all FEHB plans provide certain information to their FEHB members. You may get information about us, our networks, and our providers. OPM's FEHB website (www.opm.gov/insure) lists the specific types of information that we must make available to you. The Association of Retirees of the Panama Canal Area is a legal non-profit retired employee organization 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, call the Association of Retirees of the Panama Canal Area (AJAC) at 507-229-3822/3026/4393 in Panama. You may also write to AJAC in Panama at:

Association of Retirees from the Canal Area

PTY7615

1601 NW 97TH AVE

P. O. BOX 025207

MIAMI, FL 33102

You are also entitled to a wide range of consumer protections and have specific responsibilities as a member of this Plan. You can view the complete list of these rights and responsibilities by visiting our website, Panama Canal Area Benefit Plan at www.pcabp.com.pa/members/services-1/plan-brochure.aspx. You can also contact us to request that we mail a copy to you.

By law, you have the right to access your protected health information (PHI). For more information regarding access to PHI, visit our website Panama Canal Area Benefit Plan at www.pcabp.com.pa/members/privacy-security.aspx to obtain our Notice of Privacy Practices. You can also contact us to request that we mail you a copy of that Notice.

Your medical and claims records are confidential

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

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

Section 2. Changes for 2024

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

Changes to this Plan

- Your share of the premium rate will increase for Self Only, Self Plus One, and Self and Family. Please refer to the back cover of this brochure.
- We have increased the member cost share for brand name drugs to 30% for all members. Members will continue to pay 20% for generic drugs. FDA and Plan approved medications for diabetes, cancer, aplastic anemia, sickle-cell anemia, inhaler based medications for asthma and chronic obstructive pulmonary disease (COPD) and myelodysplasia syndrome, will be maintained at 100% coverage for generic and brand name drugs. See Section 5(f) Prescription drugs.
- The out-of-pocket limit or catastrophic maximum for this plan has both extended to all Essential Health Benefits and increased to $8,200 for Self Only enrollment, and $12,000 for Self Plus One and Self and Family. Only out-of-pocket expenses from in-network providers count toward those limits. See page 24.
- We have added coverage for Dapagliflozin tablets 5mg and 10 mg as part of the diabetes management program formulary with no cost share. The Plan's diabetes management program formulary is available in the plan website.
- We are now covering Artificial insemination (AI) procedures. See page 33.
- We have extended coverage to cover medically necessary gender affirming care services in accordance with the recommended guidelines set by the World Professional Association for Transgender Health (WPATH) detailed in Standards of Care Version 8. See page 42.
- We have updated preventive care to include new or extended coverage following recommendations by the U.S. Preventive Service Task Force (USPSTF) concerning Statin for the primary prevention of cardiovascular disease (CVD) for adults, screenings for anxiety in children and adolescents, for major depression disorder (MDD) in adolescents. for syphilis infection in persons who are at increased risk for infection, and for latent tuberculosis infection (LTBI) in populations at increased risk. There is no cost sharing under the POS option, and under the FFS US option. See Section 5(a) under Preventive Care, adult.
- We have updated Women's Preventive Services to include new or extended coverage following recommendations by the Health Resources and Services Administration (HRSA) concerning screenings of pregnant women for gestational diabetes mellitus and for type 2 diabetes in women with a history of gestational diabetes mellitus (GDM) who are not currently pregnant and who have not previously been diagnosed with type 2 diabetes. There is no cost sharing when received from an in-network provider under the POS option, and under the FFS US option. See Section 5(a) under Preventive Care, adult.
- We have updated vaccine coverage under Section 5(a) Preventive Care, for children and adults based on the recommendations from the Advisory Committee on Immunization Practices (ACIP) and Center for Disease Control and Prevention, including but not limited to Hepatitis A and B vaccines in adults, Herpes Zoster (Shingles) for adults of certain age, Tdap vaccine and a booster for adults of certain age during pregnancy, Influenza vaccines, COVID-19 for adults, children and adolescents, Polio for adults at increased risk, Meningococcal vaccine for children of certain age at an increased risk, Pneumococcal vaccines for children of certain age at an increased risk, and Dengue for children and adolescents in endemic areas only. There is no cost sharing for covered vaccines for POS members and for enrollees who reside in the United States under FFS US option. See Section 5(a) under Preventive Care, adult.

Clarifications to this Plan

- We have clarified that the coverage for donor test for blood transfusions for inpatient and outpatient hospital services. See page 42.
- We have clarified how claims are paid outside of the United States and Panama; the Plan will reimburse members 50% of the Plan allowance. See Section 1 How This Plan Works.

Section 3. How You Get Care

Identification cards

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

If you do not receive your ID card within 30 days after the effective date of your enrollment, or if you need replacement cards, call us at 507-366-1400 in Panama, and 800-424-8196 or 312-935-3671 in the United States. You may also request replacement cards through our website: www.pcabp.com.pa.

Where you get covered care

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

Balance Billing Protection

FEHB Carriers must have clauses in their in-network (participating) providers agreements. These clauses provide that, for a service that is a covered benefit in the plan brochure or for services determined not medically necessary, the in-network provider agrees to hold the covered individual harmless (and may not bill) for the difference between the billed charge and the in network contracted amount. If an in-network provider bills you for covered services over your normal cost share (deductible, copay, co-insurance) contact your Carrier to enforce the terms of its provider contract.

- **Covered providers**

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

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

When we use the term doctor, we mean the following providers when the services are performed within the scope of their license or certification.

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

Independent Consulting Doctor - An independent consulting doctor is a specialist who:

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

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

Benefits are provided under this Plan for the services of covered providers, in accordance with Section 2706(a) of the Public Health Service Act. Coverage of practitioners is not determined by your state's designation as a medically underserved area.

We list network-contracted covered providers in our network provider directory, which we update periodically, and make available on our website.

This plan recognizes that transgender, non-binary, and other gender diverse members require health care delivered by healthcare providers experienced in gender affirming health. Benefits described in this brochure are available to all members meeting medical necessity guidelines regardless of race, color, national origin, age, disability, religion, sex or gender.

This plan provides Care Coordinators for complex conditions and can be reached at 507-366-1400 in Panama, and 800-424-8196 or 312-935-3671 in the United States for assistance.

- **Covered facilities**

Covered facilities include:

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

Hospice - A public or private agency or organization which administers and provides hospice care; and is:

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

Hospital - a facility that is:

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

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

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

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

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

What you must do to get covered care

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

- **Primary care**

If you have enrolled in the Point of Service option in Panama you must select a primary care provider. Your primary care provider will provide or coordinate most of your healthcare. If you want to change your primary care provider call us in Panama at 507-366-1400.

- **Specialty care**

If you have enrolled in the Point of Service option in Panama, your primary care provider will refer you to a specialist for needed care. You must receive a referral form from your primary care provider and present it to the specialist for Point of Service benefits to be applicable. The specialist must request and receive authorization from AXA prior to additional consultations and/or treatment.

- **Transitional care**

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

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

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

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

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

We pay for covered services from the effective date of your enrollment. However, if you are in the hospital when your enrollment in our Plan begins, call our Customer Service Department immediately at 507-366-1400 in Panama, and 800-424-8196 or 312-935-3671 in the United States. If you are new to the FEHB Program, we will reimburse you for your covered services while you are in the hospital beginning on the effective date of your coverage.

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

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

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

You need prior Plan approval for certain services

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

You must get prior approval for certain services. Failure to do so will result in us limiting our payment for outpatient services to 50% of our plan allowance and applying a $500 penalty for inpatient charges.

- **Warning:**

We will reduce our benefits for the inpatient hospital stay by $500 if no one contacts us for precertification. If the stay is not medically necessary, we will only pay for any covered medical services and supplies that are otherwise payable on an outpatient basis.

- **Exceptions**

You do not need precertification in these cases:

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

- **Inpatient hospital admission**

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

In most cases, your physician or hospital will take care of requesting precertification. Because you are still responsible for ensuring that your care is precertified, you should always ask your physician or hospital whether or not they have contacted us.

- **Other Services**

You must obtain prior authorization as follows.

- All inpatient and/or outpatient surgeries (including organ/tissue transplants) must be precertified.
- For all elective (non-emergency) surgical procedures, we may require a second surgical opinion. If you fail to comply with this requirement, we will limit our payment to 50% of our Plan allowance for these surgery charges.
- For all in hospital surgical procedures not related to the original diagnosis for which you obtained precertification, we may require you to get a second surgical opinion. If you fail to comply with this requirement, we will limit our payment to 50% of our Plan allowance for these surgery charges if medical necessity can be determined.
- Growth hormone therapy (GHT) must be preauthorized.
- Durable Medical Equipment (DME).
- Gender Affirming Surgery.
- Orthopedic and prosthetic devices such as artificial limbs and eyes.

- If designated outpatient surgical procedures (see page 44 for a complete listing) are performed on an inpatient basis, we will limit our payment to 50% of our Plan allowance. However, if it is medically necessary that you be hospitalized for the surgical procedure, we will pay our regular benefits if you have precertified your admission.
- We require you to obtain precertification on both an inpatient and outpatient basis for specifically designated, non-routine diagnostic procedures that are high cost, involve high technology or that may be over-utilized. These tests include CAT scans, MRIs, Nuclear Medicine Studies (e.g. Thallium Cardiac Studies), certain Arteriographies, Genetic Studies and other similar procedures. If you fail to comply with this requirement, we will limit our payment for outpatient services to 50% of our Plan allowance and impose a $500 penalty for inpatient charges.
- All dental surgery, periodontics, endodontics require prior approval.

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

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

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

Next, provide the following information:

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

- **Non-urgent care claims**

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

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

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

- **Urgent care claims**

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

If you fail to provide sufficient information, we will contact you within 24 hours after we receive the claim to let you know what information we need to complete our review of the claim. You will then have up to 48 hours from the receipt of this notice to provide the required information. We will make our decision on the claim within 48 hours of (1) the time we received the additional information or (2) theend of time frame, whichever is earlier.

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

You may request that your urgent care claim on appeal be reviewed simultaneously by us and OPM. Please let us know that you would like a simultaneous review of your urgent care claim by OPM either in writing at the time you appeal our initial decision, or by calling us at 507-366-1400 in Panama, and 800-424-8196 or 312-935-3671 in the United States. You may also call OPM's FEHB 2 at (202) 606-3818 between 8 a.m. and 5 p.m. Eastern Time to ask for the simultaneous review. We will cooperate with OPM so they can quickly review your claim on appeal. In addition, if you did not indicate that your claim was a claim for urgent care, call us at 507-366-1400 in Panama, and 800-424-8196 or 312-935-3671 in the United States. If it is determined that your claim is an urgent care claim, we will expedite our review (if we have not yet responded to your claim).

- **Concurrent care claims**

A concurrent care claim involves care provided over a period of time or over a number of treatments. We will treat any reduction or termination of our pre-approved course of treatment before the end of the approved period of time or number of treatments as an appealable decision. This does not include reduction or termination due to benefit changes or if your enrollment ends. If we believe a reduction or termination is warranted, we will allow you sufficient time to appeal and obtain a decision from us before the reduction or termination takes effect.

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

- **Emergency inpatient admission**

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

- **Maternity care**

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

Note: When a newborn requires definitive treatment during or after the mother's hospital stay, the newborn is considered a patient in their own right. If the newborn is eligible for coverage, regular medical or surgical benefits apply rather than maternity benefits.

- **If your hospital stay needs to be extended**

If your hospital stay - including for maternity care - needs to be extended, you, your representative, your doctor or the hospital must ask us to approve the additional days. If you remain in the hospital beyond the number of days we approved and did not get the additional days precertified, then

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

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

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

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

If you disagree with our pre-service claim decision

If you have a **pre-service claim** and you do not agree with our decision regarding precertification of an inpatient admission or prior approval of other services, you may request a review in accord with the procedures detailed below. If your claim is in reference to a contraceptive, call 507-366-1400 in Panama, and 800-424-8196 or 312-935-3671 in the United States.

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

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

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

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

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

- **To reconsider an urgent care claim**

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

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

- **To file an appeal with OPM**

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

Section 4. Your Costs for Covered Services

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

Cost-sharing	Cost-sharing is the general term used to refer to your out-of-pocket costs (e.g., deductible, coinsurance, and copayments) for the covered care you receive.
Copayments	A copayment is a fixed amount of money you pay to the provider, facility, etc., when you receive certain services. Example: When you see a participating physician, you pay a copayment of $5 per visit and when you go to a participating hospital, you pay $25 per admission if you belong to the POS plan. If you are a FFS member, or are a POS member and choose to go to a non-participating hospital, you pay $100 per admission. Note: If the billed amount (or the Plan allowance that providers we contract with have agreed to accept as payment in full) is less than your copayment, you pay the lower amount.
Deductible	A deductible is a fixed amount of covered expenses you must incur for certain covered services and supplies before we start paying benefits for them. Copayments and coinsurance amounts do not count toward any deductible. When a covered service or supply is subject to a deductible, only the Plan allowance for the service or supply counts toward the deductible. Note: If you change plans during Open Season and the effective date of your new plan is after January 1 of the next year, you do not have to start a new deductible under your prior plan between January 1 and the effective date of your new plan. If you change plans at another time during the year, you must begin a new deductible under your new plan. Note: This Plan does not have any deductibles
Coinsurance	Coinsurance is the percentage of our allowance that you must pay for your care. Coinsurance does not begin until you have met your calendar year deductible. Example: FFS members pay a 50% coinsurance for all medical services.
If your provider routinely waives your cost	If your provider routinely waives (does not require you to pay) your copayments, deductibles, or coinsurance, the provider is misstating the fee and may be violating the law. In this case, when we calculate our share, we will reduce the provider's fee by the amount waived. For example, in the US, if your physician ordinarily charges $100 for a service but routinely waives your 50% coinsurance, the actual charge is $50. We will pay $25 (50% of the actual charge of $50).
Waivers	In some instances, a Panama Canal Area Benefit Plan provider may ask you to sign a "waiver" prior to receiving care. This waiver may state that you accept responsibility for the total charge for any care that is not covered by your health plan. If you sign such a waiver, whether or not you are responsible for the total charge depends on the contracts that the Plan has with its providers. If you are asked to sign this type of waiver, please be aware that, if benefits are denied for the services, you could be legally liable for the related expenses. If you would like more information about waivers, please contact us at 507-366-1400 in Panama, and 1-800-424-8196 or 312-935-3671 in the United States
Differences between our allowance and the bill	Our "Plan allowance" is the amount we use to calculate our payment for covered services. Fee-for-service plans arrive at their allowances in different ways, so their allowances vary. For more information about how we determine our Plan allowance, see the definition of Plan allowance in Section 10.

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

- **POS providers** agree to limit what they will bill you. Because of that, when you use a POS provider, you are only responsible for your copayment. Here is an example about copayment: You see a POS physician who charges $50, but our allowance is $45. You are only responsible for your copayment amount. That is, you pay just -- $5 of our $45 allowance. Because of the agreement, your POS physician will not bill you for the $5 difference between our allowance and the bill.
- **FFS providers**, on the other hand, have no agreement to limit what they will bill you. When you use a FFS provider, you will pay your coinsurance -- **plus** any difference between our allowance and charges on the bill. Here is an example: You see a FFS physician who charges $50 and our allowance is again $45. You are responsible for your coinsurance, so you pay 50% of our $45 allowance ($22.50). Plus, because there is no agreement between the FFS physician and us, the physician can bill you for the $5 difference between our allowance and the 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 example uses our example of a service for which the physician charges $50 and our allowance is $45. The example shows the amount you pay.

EXAMPLE

POS physician

Physician's charge: $50

Our allowance: We set it at: $45

We pay: Allowance less copay: $40

You owe: Coinsurance: copayment: $5

+Difference up to charge?: no: $0

TOTAL YOU PAY: $5

FFS physician

Physician's charge: $50

Our allowance: We set it at: $45

We pay: 50% of our allowance: $22.50

You owe: Coinsurance: 50% of our allowance: $22.50

+Difference up to charge?: yes: $5

TOTAL YOU PAY: $27.50

You should also see section Important Notice About Surprise Billing – Know Your Rights below that describes your protections against surprise billing under the No Surprises Act.

Your catastrophic protection out-of-pocket maximum for coinsurance

The out-of-pocket limit, or catastrophic maximum, is the most you could pay during the year for your share of the cost of services for essential health benefits covered under the Plan. We pay 100% of our allowable amount for the remainder of the calendar year after out-of-pocket expenses for deductibles and coinsurance exceed:

The out-of-pocket maximum is $8,200 for Self Only enrollment, and $12,000 for Self Plus One and Self and Family enrollments for all essential health benefits. An individual under Self Plus One and Self and Family enrollments will never have to satisfy more than what is required for the out-of-pocket maximum under Self Only enrollment.

Only out-of-pocket expenses from in-network providers count toward those limits.

The following do not count towards the out-of-pocket, or catastrophic out-of-pocket maximum:
• Expenses in excess of the Plan allowances and maximum benefit limitations;
• Expenses in excess of plan limits for dental services;
• The cost for non-approved medications and drugs that are excluded;
• Expenses the member pays for non-covered services;
• Professional charges of physicians or other healthcare professional;
• Any amounts the member pays because benefits have been reduced for non-compliance with the Plan's cost containment requirements; and
• The $100 copayment per person per admission for hospital room and board under the FFS benefit.

Carryover

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

If we overpay you

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

We will generally first seek recovery from the provider if we paid the provider directly, or from the person (covered family member, guardian, custodial parent, etc.) to whom we sent our payment. You are obligated to notify us if you receive an overpayment from us.

When Government facilities bill us

Facilities of the Department of Veteran Affairs, the Department of Defense, and the Indian Health Service are entitled to seek reimbursement from us for certain services and supplies they provide to you or a family member. They may not seek more than their governing laws allow. You may be responsible to pay for certain services and charges. Contact the government facility directly for more information.

Important Notice About Surprise Billing – Know Your Rights in the US

The No Surprises Act (NSA) is a federal law that provides you with protections against "surprise billing" and "balance billing" for out-of-network emergency services; out-of-network non-emergency services provided with respect to a visit to a participating health care facility; and out-of-network air ambulance services.

A surprise bill is an unexpected bill you receive for

- emergency care – when you have little or no say in the facility or provider from whom you receive care, or for

- non-emergency services furnished by nonparticipating providers with respect to patient visits to participating health care facilities, or for
- air ambulance services furnished by nonparticipating providers of air ambulance services.

Balance billing happens when you receive a bill from the nonparticipating provider, facility, or air ambulance service for the difference between the nonparticipating provider's charge and the amount payable by your health plan.

Your health plan must comply with the NSA protections that hold you harmless from surprise bills for claims in the United States. Please refer to Balance Billing Protection, under Section 3, for information on how the Plan protects you from balance billing from an in-network (participating) provider, including for claims in Panama.

For specific information on surprise billing, the rights and protections you have, and your responsibilities go to www.pcabp.com.pa or contact the health plan at 507-366-1400 in Panama, and 800-424-8196 or 312-935-3671 in the United States.

- **The Federal Flexible Spending Account Program – *FSAFEDS***

  - **Healthcare FSA (HCFSA)** – Reimburses you for eligible out-of-pocket healthcare expenses (such as copayments, deductibles, **physician prescribed** over-the-counter drugs and medications, vision and dental expenses, and much more) for you, your tax dependents, and your adult children (through the end of the calendar year in which they turn 26).
  - FSAFEDS offers paperless reimbursement for your HCFSA through a number of FEHB and FEDVIP plans. This means that when you or your provider files claims with your FEHB or FEDVIP plan, FSAFEDS will automatically reimburse your eligible out-of-pocket expenses based on the claim information it receives from your plan.

Section 5. Benefits

See page 14 for how our benefits changed this year and page 86 for a benefits summary. Make sure that you review the benefits that are available under the option in which you are enrolled.

Section 5(a). Medical Services and Supplies Provided by Physicians and Other Healthcare Professionals

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- The FFS benefits are the standard benefits of this Plan. **POS benefits apply only when you use a POS provider.** When no POS provider is available, FFS benefits apply. Under the FFS benefits, you owe all charges that exceed our allowable charges.
- Be sure to read Section 4, *Your Costs for Covered Services*, for valuable information about how cost-sharing works. Also read Section 9 for information about how we pay if you have other coverage, or if you are age 65 or older.
- The coverage and cost-sharing listed below are for services provided by physicians and other health care professionals for your medical care. See Section 5(c) for cost-sharing associated with the facility (i.e., hospital, surgical center, etc.).
- If you are enrolled in the POS Option in Panama, you must obtain a referral from your primary care provider before seeing a specialist. When you are referred to a specialist, the specialist must request and receive authorization from AXA prior to additional consultations and/or treatment.

Benefit Description	You Pay
Diagnostic and treatment services	
Professional services of physicians: • In physician's office • Office medical consultations • Physician home visits	POS: $5 copayment FFS Panama: 50% of the Panama POS Fee schedule amount and any difference between the POS fee schedule and the billed amount FFS US: 50% of the US FFS Plan allowance (see page 83 describing how we derive our US FFS allowance) and any difference between our allowance and the billed amount
Professional services of physicians: • In an urgent care center • Initial examination of a newborn child covered under a family enrollment • Second surgical opinion • In a skilled nursing facility	POS: Nothing FFS Panama: 50% of the Panama POS Fee schedule amount and any difference between the POS Fee schedule and the billed amount FFS US: 50% of the US FFS Plan allowance and any difference between our allowance and the billed amount
Inpatient Physician Hospital Visit	POS: Nothing FFS Panama: Nothing up to $35 per doctor per day and all charges thereafter FFS US: Nothing up to $35 per doctor per day and all charges thereafter

Benefit Description	You Pay
TeleHealth Services	
None	All charges
Lab, X-ray and other diagnostic tests	
Tests, such as: • Blood tests • Urinalysis • Non-routine pap test • Pathology • X-ray • Double contrast barium enema • Non-routine Mammogram • CT/CAT Scan • MRI • Ultrasound • Electrocardiogram and EEG Note: CAT Scans/MRIs and X-Rays, require preauthorization. See How to request precertification for an admission or get prior authorization for Other services on page 18.	POS: Nothing FFS Panama: 50% of the Panama POS Fee schedule amount and any difference between the POS Fee schedule and the billed amount FFS US: 50% of the US FFS Plan allowance and any difference between our allowance and the billed amount Note: If your POS provider uses a FFS lab or radiologist, we will pay FFS benefits for those lab and X-ray charges.
Preventive care, adult	
Routine medical check-up by your Primary Care Provider (two check ups-per calendar year). Note: These routines check-ups include: • Toe nail clipping for diabetics, • Annual digital prostate exam (rectal exam) for men age 40 and over, and • Visit to a nutritionist or licensed dietician with a referral from your Primary Care Provider	POS: Nothing FFS Panama: All charges FFS US: Nothing
A comprehensive range of A and B rated preventive care screenings as recommended by the United States Preventive Services Task Force (USPSTF), such as: • Total Blood Cholesterol-once every three years or fasting lipoprotein profile, once every five years. • Abdominal Aortic Aneurysm Screening-ultrasonography, one between the age of 65 and 75, for men with history of smoking • Colorectal Cancer Screening, including. - Fecal occult blood test, once annually - Sigmoidoscopy screening – every five years starting at age 50 - Colonoscopy screening - every ten years starting at age 50 • Lung cancer screening - annual low dose computed tomography in adults age 55 to 80 who have a 30 pack-year smoking history and currently smoke or have quit within the last 15 years • Hepatitis B virus infection screening	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: Nothing up to the US FFS Plan allowance and any difference between our allowance and the billed amount

Preventive care, adult - continued on next page

Benefit Description	You Pay
Preventive care, adult (cont.)	
• Screening for hepatitis C virus (HCV) infection in persons at high risk for infection. • Annual screening for sexually transmitted infections • Biometric Screening Services, such as body mass index (BMI), waist circumference, blood pressure, glucose, cholesterol and Hemoglobin A1c for adults over age 18 every three years. • Medical Nutrition Therapy and Intensive Behavioral Therapy for the prevention of obesity related comorbidities • Individual counseling on prevention and reducing health risks • Latent tuberculosis infection screening in populations at increased risk. Screening tests include the tuberculin skin test or the interferon-gama release. Note: For patients with diabetes, we cover Hemoglobin A1c every 6 months when results are within accepted standards and every 3 months when results are abnormal under the Diabetes Management Program. Please refer to page 40. For a complete list of screenings go to the U.S. Preventive Services Task Force (USPSTF) website at https://www.uspreventiveservicestaskforce.org/uspstf/recommendation-topics/uspstf-a-and-b- recommendations	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: Nothing up to the US FFS Plan allowance and any difference between our allowance and the billed amount
Exercise interventions to prevent falls in community-dwelling adults 65 years or older who are at increased risk for falls	POS: Nothing FFS Panama: Nothing FFS US: Nothing
Routine Prostate Specific Antigen (PSA) test – one annually for men age 40 and older	POS: Nothing FFS Panama: 50% of the Panama POS Fee schedule amount and any difference between the POS Fee schedule and the billed amount FFS US: 50% of the US FFS Plan allowance and any difference between our allowance and the billed amount
The following preventive services are covered at the time interval recommended at the link below: Preventive care benefits for women such as Pap smears, gonorrhea prophylactic medication to protect newborns, annual counseling for sexually transmitted infections, contraceptive methods, and screening for interpersonal and domestic violence. For a complete list of Preventive care benefits for women go to the Health and Human Services (HHS) website at https://www.healthcare.gov/preventive-care-women/ Note: Aspirin, iron, vitamin D, and folic acid with physician prescription who satisfy criteria as recommended by the USPSTF are covered under Section (f) Prescription Drug Benefits.	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: Nothing up to the US FFS Plan allowance and any difference between our allowance and the billed amount

Preventive care, adult - continued on next page

Benefit Description	You Pay
Preventive care, adult (cont.)	
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 year Note: Please see section 5 (f) for coverage of breast cancer preventive medications recommended by the USPSTF. To build your personalized list of preventive services go to https://health.gov/myhealthfinder	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: Nothing up to the US FFS Plan allowance and any difference between our allowance and the billed amount
Adult immunizations endorsed by the Centers for Disease Control and Prevention (CDC) such as Pneumococcal, influenza, shingles, tetanus/TdaP, and human papillomavirus (HPV): based on the Advisory Committee on Immunization Practices (ACIP) schedule. For a complete list of immunizations go to the Centers for Disease Control (CDC) website at https://www.cdc.gov/vaccines/schedules/ Note: Any procedure, injection, diagnostic service, laboratory, or x-ray service done in conjunction with a routine examination and is not included in the preventive recommended listing of services will be subject to the applicable member copayments, coinsurance, and deductible.	POS: Nothing FFS Panama: Not a covered benefit. You pay all billed charges FFS US: Nothing up to the US FFS Plan allowance and any difference between our allowance and the billed amount
Not covered: • *Physical exams required for obtaining or continuing employment or insurance, attending schools or camp, athletic exams, or travel.* • *Immunizations, boosters, and medications for travel or work-related exposure.*	*All charges*
Preventive care, children	
• Well-child visits examinations, and other preventive services as described in the Bright Future Guidelines provided by the American Academy of Pediatrics. For a complete list of the American Academy of Pediatrics Bright Futures Guidelines go to https://brightfutures.aap.org • Immunizations such as TdaP, Polio, Measles, Mumps, and Rubella (MMR), and Varicella. For a complete list of immunizations go to the Centers for Disease Control (CDC) website at https://www.cdc.gov/vaccines/schedules/index.html You may also find a complete list of preventive care services recommended under the U.S. Preventive Services Task Force (USPSTF) online at https://www.uspreventiveservicestaskforce.org/uspstf/recommendation-topics/uspstf-a-and-b- recommendations	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: Nothing up to the US FFS Plan allowance and any difference between our allowance and the billed amount
• Examinations, limited to: - Examinations for amblyopia and strabismus – limited to one screening examination (ages 3 through 5) - Examinations done on the day of immunizations (ages 3 up to age 22)	POS: Nothing FFS Panama: 50% of the Panama POS Fee schedule amount and any difference between the POS Fee schedule and the billed amount

Preventive care, children - continued on next page

Benefit Description	You Pay
Preventive care, children (cont.)	
• To build your personalized list of preventive services go to https://health.gov/myhealthfinder Note: Any procedure, injection, diagnostic service, laboratory, or x-ray service done in conjunction with a routine examination and is not included in the preventive recommended listing of services will be subject to the applicable member copayments, coinsurance, and deductible.	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: Nothing up to the US FFS Plan allowance and any difference between our allowance and the billed amount
Maternity care	
Complete maternity (obstetrical) care, such as: • Prenatal and Postpartum care • Delivery Note: Here are some things to keep in mind: • You do not need to precertify your vaginal delivery; however you must obtain precertification for other circumstances, such as extended stays for you or your baby. • You may remain in the hospital up to 48 hours after a vaginal delivery and 96 hours after a cesarean delivery. We will cover an extended stay if medically necessary. • We cover routine nursery care of the newborn child during the covered portion of the mother's maternity stay. We will cover other care of an infant who requires non-routine treatment if we cover the infant under a Self Plus One or Self and Family Enrollment. Surgical benefits, not maternity benefits, apply to circumcision. • Circumcision is covered under Surgery Benefits. (Section 5 (b)). • We pay hospitalization and surgeon services for non-maternity care the same as for illness and injury. • Hospital services are covered under Section 5(c) and Surgical benefits Section 5(b). Note: When a newborn requires definitive treatment during or after the mother´s confinement, the newborn is considered a patient in their own right. If the newborn is elegible for coverage, regular medical or surgical benefits apply rather than maternity benefits.	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: Nothing up to the US FFS Plan allowance and any difference between our allowance and the billed amount
• Anemia screening for iron deficiency anemia in asymptomatic pregnant woman • Preeclampsia screening • Screening for gestational diabetes • Screening and counseling for prenatal and postpartum depression • Bacteriuria screening for asymptomatic bacteriuria with urine culture in pregnant woman at 12 to 16 weeks gestation or at the first prenatal visit if later • Breastfeeding support, supplies and counseling for each birth Note: Refer to Section 5 (a) under Durable Medical Equipment (DME) for obtaining breast pumps and supplies.	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: Nothing up to the US FFS Plan allowance and any difference between our allowance and the billed amount

Benefit Description	You Pay
Family Planning	
A range of voluntary family planning services, limited to: • Contraceptive counseling • Voluntary sterilization • 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)). Refer to Surgical procedures in Section 5 (b) for information on vasectomy.	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: Nothing up to the US FFS Plan allowance and any difference between our allowance and the billed amount
Not covered: • *Reversal of voluntary surgical sterilization* • *Genetic testing and counseling that are not shown as covered*	*All charges*
Infertility services	
The Plan covers the following Assisted reproductive technology (ART) procedures, including the cost of oral and injectable drugs associated with artificial insemination procedures: • Intravaginal insemination (IVI) • Intracervical insemination (ICI) • Intrauterine insemination (IUI) For In vitro fertilization (IVF), only oral and injectable drugs are covered (See Section 5f). The procedures are not covered under the Plan. Note: The Plan covers up to three (3) cycles of drug treatments for ART per member, per year, when deemed necessary. Please refer to Section 10 for definition of Infertility.	POS: $5 copayment per consultation FFS Panama: 50% of the Panama POS Fee schedule amount and any difference between the POS Fee schedule and the billed amount FFS US: 50% of the US FFS Plan allowance and any difference between our allowance and the billed amount
Not covered: • *Infertility services after voluntary sterilization* • *Embryo transfer and gamete intra-fallopian transfer (GIFT) and zygote intra-fallopian transfer (ZIFT)* • *In vitro fertilization (IVF) procedures* • *Cost of donor sperm* • *Cost of donor egg*	*All charges*
Allergy care	
Allergy consultations	POS: $5 copayment for the consultation FFS Panama: 50% of the Panama POS Fee schedule amount and any difference between the POS Fee schedule and the billed amount FFS US: 50% of the US FFS Plan allowance and any difference between our allowance and the billed amount

Allergy care - continued on next page

Benefit Description	You Pay
Allergy care (cont.)	
Testing and treatment, including materials (such as allergy serum) and allergy injections	POS: Nothing FFS Panama: 50% of the Panama POS Fee schedule amount and any difference between the POS Fee schedule and the billed amount FFS US: 50% of the US FFS Plan allowance and any difference between our allowance and the billed amount
Not covered: • *Provocative food testing* • *Sublingual allergy desensitization*	*All charges*
Treatment therapies	
• Chemotherapy and radiation therapy including medications used directly with the chemotherapy and radiation treatment Note: High dose chemotherapy in association with autologous bone marrow transplants is limited to those transplants listed on pages 47 and 48. • Dialysis – Hemodialysis and peritoneal dialysis including medications used directly with the dialysis treatment • Intravenous (IV)/Infusion Therapy – Home IV and antibiotic therapy • Inhaler based medications to treat asthma and chronic obstructive pulmonary disease (COPD) • Growth hormone therapy (GHT) Note: Growth hormone is covered under the prescription drug benefit. Note: We only cover GHT, chemotherapy, radiation, dialysis, intravenous (IV) infusion, home (IV) and antibiotic therapies when we preauthorize the treatments. Call 507-366-1400 in Panama, and 800-424-8196 or 312-935-3671 in the United States for preauthorization. We will ask you to submit information that establishes that the GHT is medically necessary. We will only cover GHT services and related services and supplies that we determine are medically necessary. Ask us for preauthorization before you begin treatment because we will only cover GHT services that are rendered after the date we authorize treatment.	POS: Nothing FFS Panama: 50% of the Panama POS Fee schedule amount and any difference between the POS Fee schedule and the billed amount FFS US: 50% of the US FFS Plan allowance and any difference between our allowance and the billed amount
• Respiratory and inhalation therapies including oxygen; supplies and the rental of equipment to administer the oxygen, require preauthorization.	POS: Nothing FFS Panama: Nothing FFS US: Nothing

Benefit Description	You Pay
Physical, occupational, and speech therapies	
Rehabilitative physical therapy and occupational therapy are provided on an inpatient or outpatient basis. 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: Cardiac rehabilitation services are part of physical therapy and rehabilitation services Note: Rehabilitation therapies are subject to a combined visit limitation per condition of up to 40 visits per person, per calendar year (on outpatient context / office visit. This limit is not applicable on inpatients), as authorized by the Plan's Medical Director. Note: We only cover therapy when a physician: 1) Orders the care; 2) Identifies the specific professional skills the patient requires and the medical necessity for skilled services; and 3) Indicates the length of time the services are needed	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
Hearing services (testing, treatment, and supplies)	
• Hearing Exam-annual audiologic screening test • Routine Screening, testing, diagnostic evaluations and treatment for adults once every five years. For children under 21 years of age, frequency and technique can vary depending on age and risk. For more information refers to American Academy of Pediatrics (AAP) Bright Futures Guideline	POS: $10 copayment FFS Panama: 50% of the Plan Allowance and any difference between our allowance and the billed amount FFS US: 50% of the Plan Allowance and any difference between our allowance and the billed amount
• External hearing aid for children up to age 10 once every five years • External hearing aids for adults up to $1000 ($500 per ear) every three years	POS: $10 copayment FFS Panama: 50% of the Plan Allowance and any difference between our allowance and the billed amount FFS US: 50% of the Plan Allowance and any difference between our allowance and the billed amount
Not covered: • *Hearing services that are not shown as covered*	*All charges*
Vision services (testing, treatment, and supplies)	
• One pair of eyeglasses or contact lenses to correct an impairment directly caused by accidental ocular injury or intraocular surgery (such as for cataracts) Note: Eyeglasses or contact lenses are only covered within one year after intraocular surgery (such as cataracts) or after suffering an ocular injury, if the intraocular lens inserted during the surgery does not correct your vision.	POS: Nothing FFS Panama: 50% of the Panama POS Fee schedule amount and any difference between the POS Fee schedule and the billed amount FFS US: 50% of the US FFS Plan allowance and any difference between our allowance and the billed amount

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

Benefit Description	You Pay
Vision services (testing, treatment, and supplies) (cont.)	
Not covered: • *Eyeglasses or contact lenses and examinations for them, except as shown above* • *Eye exercises and orthoptics* • *Radial keratotomy and other refractive surgery*	*All charges*
Foot care	
Routine foot care when you are under active treatment for a metabolic or peripheral vascular disease, such as diabetes	POS: $5 copayment FFS Panama: 50% of the Panama POS Fee schedule amount and any difference between the POS Fee schedule and the billed amount FFS US: 50% of the US FFS Plan allowance and any difference between our allowance and the billed amount
Not covered: • *Cutting, trimming or removal of corns, calluses, or the free edge of toenails, and similar routine treatment of conditions of the foot, except as stated above* • *Treatment of weak, strained or flat feet or bunions or spurs; and of any instability, imbalance or subluxation of the foot (unless the treatment is by open cutting surgery)*	*All charges*
Orthopedic and prosthetic devices	
• Externally worn breast prostheses and surgical bras, including necessary replacements following a mastectomy Note: Externally worn breast prostheses are limited to one per year. • Internal prosthetic devices, such as artificial joints, pacemakers, cochlear implants, and surgically implanted breast implant following mastectomy Note: Penile prosthesis should be medically necessary on male patients with prostate cancer and following a radical prostatectomy with secondary erectile dysfunction, who followed an ineffective non-invasive treatments (drugs, injections and/or vacuum devices), and the dysfunction is the result of an organic rather than psychogenic cause. Note: See 5(b) for coverage of the surgery to insert the device. • External hearing aids for adults up to $1000 ($500 per ear) every three years • External hearing aid for children up to age 10 once every five years Note: Preauthorization of prostheses required.	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
• Artificial limbs and eyes • Prosthetic sleeve or sock	30% of the allowable charge and any amount that exceeds our allowance

Orthopedic and prosthetic devices - continued on next page

Benefit Description	You Pay
Orthopedic and prosthetic devices (cont.)	
Note: Refer to Section 5(a) under Durable medical equipment (DME) for a Plan definition of Durable Medical Equipment. Contact us for prior authorization. We will only pay for the cost of the standard item. You are responsible for all charges that exceed our allowance up to the billed charge.	30% of the allowable charge and any amount that exceeds our allowance
Not covered: • *Orthopedic and corrective shoes, arch supports, foot orthotics, heel pads and heel cups* • *Lumbosacral supports* • *Corsets, trusses, elastic stockings, support hose, and other supportive devices*	*All charges*
Durable medical equipment (DME)	
Durable medical equipment (DME) is equipment and supplies that: • are prescribed by your attending physician (i.e., the physician who is treating your illness or injury); • are medically necessary; • are primarily and customarily used only for a medical purpose; • are generally useful only to a person with an illness or injury; • are designed for prolonged use; and • serve a specific therapeutic purpose in the treatment of an illness or injury We will cover rental or purchase of basic durable medical equipment, at our option, including repair and adjustment. Covered items include: • Hospital beds • Crutches • Walkers • Walking canes • Glucose monitors for all diabetic patients • Blood pressure monitors for all hypertensive patients • C-PAP • Bi- PAP • Nebulizer • Artificial larynx • Insulin pumps Note: Your must obtain our prior authorization for all DMEs. Please contact us at 800-424-8196/507-366-1400. Not all equipment will be available. We will only pay for the cost of the standard item. These services are not available under the POS network. You are responsible for all charges that exceed our allowance up to the billed charge.	30% of the allowable charge and any amount that exceeds our allowance

Durable medical equipment (DME) - continued on next page

Benefit Description	You Pay
Durable medical equipment (DME) (cont.)	
Oxygen; supplies and the rental of equipment to administer the oxygen require preauthorization.	POS: Nothing FFS Panama: Nothing FFS US: Nothing up to the US FFS Plan allowance and any difference between our allowance and the billed amount
Rental of breast pumps and supplies in conjuction with each birth for breast- feeding patients.	POS: Nothing. FFS Panama: All charges. FFS US: Nothing up to the US FFS Plan allowance and any difference between our allowance and the billed amount
Not covered: • *Air conditioners, purifiers, dehumidifiers, or humidifiers* • *Exercise equipment* • *Lifts (chairs, seat, or van)* • *Bathroom equipment* • *Communication equipment and aids, such as story boards or other aids to assist in communication* • *Equipment for cosmetic purposes* • *Durable Medical Equipment we do not approve*	*All charges*
Home health services	
40 visits per calendar year when: • A registered nurse (R.N.), licensed practical nurse (L.P.N.), licensed vocational nurse (L.V.N.) or physiotherapist provides the services; • The attending physician orders the care; • The physician identifies the specific professional skills required by the patient and the medical necessity for skilled services; and • The physician indicates the length of time the services are needed. Note: Up to 4 hours of skilled services equal one visit. All home health services require preauthorization.	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*

Benefit Description	You Pay
Chiropractic	
Chiropractic Services – By a physician or licensed doctor of chiropractic medicine for pain management, asthma and arthritis up to 10 treatment sessions per calendar year. • Manipulation of the spine and extremities • Adjunctive procedures such as ultrasound, electrical muscle stimulation, vibratory therapy, and cold pack application	POS: $10 copayment for first visit in an authorized series and all charges in excess of 10 treatment sessions FFS Panama: 50% of the Panama POS Fee schedule amount and any difference between the POS Fee schedule and the billed amount and all charges in excess of 10 treatment sessions FFS US: 50% of the US FFS Plan allowance and any difference between our allowance and the billed amount and all charges in excess of 10 treatment sessions
Alternative treatments	
Acupuncture – by a doctor of medicine or osteopathy, or licensed or certified acupuncture practitioner up to the benefit maximum of $250 per calendar year	POS: $10 copayment for first visit in an authorized series and all charges over the $250 annual benefit maximum FFS Panama: 50% of the Panama POS Fee schedule amount and any difference between the POS Fee schedule and the billed amount and all charges over the $250 annual benefit maximum FFS US: 50% of the US FFS Plan allowance and any difference between our allowance and the billed amount and all charges over the $250 annual benefit maximum
Not covered: • *Naturopathic services*	*All charges*
Tobacco Cessation Program	
• Tobacco counseling sessions (includes proactive phone counseling, group counseling and individual counseling) • Physician prescribed over-the-counter (OTC) and prescription drugs approved by the FDA to treat tobacco dependence	POS: Nothing for counseling and nothing for OTC and prescription drugs approved by the FDA to treat tobacco dependence FFS Panama: Nothing for counseling and nothing for OTC and prescription drugs approved by the FDA to treat tobacco dependence FFS US: Nothing for counseling and nothing for OTC and prescription drugs approved by the FDA to treat tobacco dependence

Benefit Description	You Pay
Diabetes Management program	
The Diabetes Management Program is available for POS members in the Republic of Panama only Eligibility Requirements for the Diabetes Management Program: • Diabetes diagnosis established through the diabetes diagnosis protocol. • Preauthorization is required to proceed with any treatment. Available Benefits through the Diabetes Management Program: • HbA1c at no cost to the patient; every 6 months for patients with results within accepted standards and every 3 months for patients with abnormal results • Annual determination of fasting lipid profile, including: total cholesterol, HDL, triglycerides and LDL • Annual microalbuminuria test • Medication to treat diabetes and its complications as specifically approved by the Plan (See note below) • Counseling and education sessions provided by a physician as approved by the Plan including a multicomponent, family centered program focused on childhood obesity that are part of intensive behavioral interventions (behavior change counseling for healthy diet and physical activity) • Toe nail clipping included with routine medical check-up every 6 months by the PCP • Glucometer, lancets and strips as approved by the Plan Note: Only those medications **listed on the Plan's formulary for diabetes** are covered under this program. All other eligible medications are covered under the normal prescription drug benefits of the Plan. See Section 5(f). Note: Although the Diabetes Management Program is only for POS members, the Plan will cover diabetes medications listed on the Plan's formulary at 100% of the allowable charge for FFS members in the U. S. and FFS members in the Republic of Panama.	POS: Nothing FFS Panama: Nothing for medication to treat diabetes listed on the Plan's formulary for diabetes. 100% of all other charges FFS US: Nothing for medication to treat diabetes listed on the Plan's formulary for diabetes. 100% of all other charges
Osteoporosis Management program	
The Osteoporosis Management Program is available for POS members in the Republic of Panama only. Eligibility Requirements for the Osteoporosis Management Program: • Women (65 years old or older) diagnosed with osteoporosis through a bone density study • Women between 60 and 64 years old with predisposing factors • Patients with chronic back pain with a documented history of this problem and a referral by their PCP Available Benefits through the Osteoporosis Management Program: • Annual bone density study for women 65 and older	POS: Nothing FFS Panama: All charges FFS US: All charges

Osteoporosis Management program - continued on next page

Benefit Description	You Pay
Osteoporosis Management program (cont.)	
• Annual bone density study beginning at age 60 for members who are at increased risk for osteoporosis • Counseling and education sessions provided by a physician as approved by the Plan Note: The Osteoporosis Management Program is not available to FFS members in the U.S. or FFS members in the Republic of Panama. Note: Eligible medications are covered under the prescription drug benefits and subject to coinsurance. See Section 5(f). Please refer to your plan for details on specific benefits covered under the osteoporosis management program.	POS: Nothing FFS Panama: All charges FFS US: All charges
Wellness program	
The Wellness Program is benefit for all members of the Plan that reside in the Republic of Panama only. The Wellness program includes: • Education on preventive care, • Participation in the Prevention of Caregiver's Burnout Program. • Indoor and outdoor physical activities for a health lifestyle. • Health Risk Assessment (HRA) Note: All members that participate in activities of the wellness program should consult their Primary Care Provider for recommendations on type and intensity of physical activities you can perform.	POS: Nothing FFS Panama: Nothing FFS US: Service is not available outside of Panama except for access to the web page which costs nothing

Section 5(b). Surgical and Anesthesia Services Provided by Physicians and Other Healthcare Professionals

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- This Plan has no calendar year deductible. However, in most cases, both POS and FFS members will be asked to share the costs of the procedures in the form of a copayment or coinsurance.
- The FFS benefits are the standard benefits of this Plan. POS benefits apply only when you use a POS provider. When no POS provider is available, FFS benefits apply. Under the FFS benefits, you owe all charges that exceed our allowable charges.
- Be sure to read Section 4, *Your Costs for Covered Services*, for valuable information about how cost-sharing works. Also read Section 9 for information about how we pay if you have other coverage or if you are age 65 or older.
- The services listed below are for the charges billed by a physician or other healthcare professional for your surgical care. See Section 5(c) for charges associated with a facility (i.e. hospital, surgical center, etc.).
- **YOU MUST GET PRECERTIFICATION FOR SURGICAL PROCEDURES. Please refer to the precertification information shown in Section 3 to be sure which services require precertification.**
- **Certain surgical procedures have been designated as outpatient procedures.** Please refer to page 44 for a list of the procedures.

Benefit Description	You Pay
Surgical procedures	
A comprehensive range of services, such as: • Operative procedures • Treatment of fractures, including casting • Normal pre- and post-operative care by the surgeon • Correction of amblyopia and strabismus • Endoscopy procedures • Biopsy procedures	POS: Nothing FFS Panama: 50% of the Panama POS Fee schedule amount and any difference between the POS fee schedule and the billed amount FFS US: 50% of the US FFS Plan allowance and any difference between our allowance and the billed amount Note: For Plan allowances please see page 83.
• Removal of tumors and cysts (non-cosmetic) • Correction of congenital anomalies (see Reconstructive surgery) • Insertion of internal prosthetic devices. See 5(a) – Orthopedic and prosthetic devices for device coverage information • Vasectomy • Eye surgery • Treatment of burns • Surgical treatment of severe obesity (bariatric surgery) -- a condition in which an individual weighs 100 pounds or 100% over their normal weight according to current underwriting standards; eligible members must be age 18 or over and satisfy the following criteria:	POS: Nothing FFS Panama: 50% of the Panama POS Fee schedule amount and any difference between the POS Fee schedule and the billed amount FFS US: 50% of the US FFS Plan allowance any difference between our allowance and the billed amount

Surgical procedures - continued on next page

Benefit Description	You Pay
Surgical procedures (cont.)	
- Have a pathological obesity with a body mass index (BMI) of at least 35kg/m^2 with one or more co-morbidities or a BMI of 40 kg/m^2 or greater with no co-morbidities; - Have had a psychiatric evaluation; - Understand the risks and the postoperative care involved; - Not have any serious concomitant illness; and - Receive approval by a peer review consultant Note: You must precertify all surgical procedures. In addition, we may require you to obtain a second surgical opinion for certain procedures. If you are planning to have a surgery, please call our medical department at 507-366-1400 in Panama, and 800-424-8196 or 312-935-3671 in the United States to precertify and determine whether or not we require a second opinion for your specific procedure. If you do not precertify or obtain a required second opinion for your procedure, you will be responsible for 50%. You pay nothing for the second surgical opinion if we require you to obtain it. If you are a Panama POS member, you must obtain prior authorization for a second opinion or surgical procedure to be rendered outside of Panama prior to leaving Panama by contacting the Medical Department at 507-366-1400. Note: For information on surgically implanted contraceptives, voluntary sterilization, or IUD insertion, see Section 5(a) Family planning on page 33.	POS: Nothing FFS Panama: 50% of the Panama POS Fee schedule amount and any difference between the POS Fee schedule and the billed amount FFS US: 50% of the US FFS Plan allowance any difference between our allowance and the billed amount
When multiple or bilateral surgical procedures performed during the same operative session add time or complexity to patient care, our benefits are: • For the primary procedure: - POS: 100% of the POS fee schedule amount or - FFS: 50% of the Plan allowance • For the secondary procedure(s): - POS: 100% of one-half of the POS fee schedule amount or - FFS: 50% of one-half of the Plan allowance Note: Multiple or bilateral surgical procedures performed through the same incision are incidental to the primary surgery. That is, the procedure would not add time or complexity to patient care. We do not pay extra for incidental procedures.	POS: Nothing FFS Panama: 50% of the Panama POS Fee schedule amount for the primary procedure and 50% of one-half of the Plan allowance for the secondary procedure(s); and any difference between our payment and the billed amount FFS US: 50% of the US FFS Plan allowance for the primary procedure and 50% of one-half of the Plan allowance for the secondary procedure(s); and any difference between our payment and the billed amount
Not covered: • *Reversal of voluntary sterilization* • *Services of a standby surgeon, except during angioplastry or other high risk procedures when we determine standbys are medically necessary* • *Routine treatment of conditions of the foot (see Foot care)*	*All charges*

Surgical procedures - continued on next page

Benefit Description	You Pay
Surgical procedures (cont.)	
We have designated the following as outpatient surgical procedures. If you undergo one of the following procedures inpatient without explicit approval from us, we will apply a $500 penalty and limit our payment to 50% of our plan allowance: • Arthroscopy (internal exam of a joint) • Breast Biopsy • Bronchoscopy (internal exam of lung), adult, with or without biopsy • Cataract removal • Cystourethroscopy • Digestive tract endoscopy (internal exam of esophagus, stomach, colon or rectum) • Dilation and curettage of uterus (D&C) • Excision of pilonidal cyst, simple • Laparoscopy (internal exam of abdomen) with or without tubal ligation (female sterilization) • Laryngoscopy and tracheoscopy (internal exam of larynx and windpipe) • Myringotomy (incision of the membrane in ear) • Prostate biopsy • Reduction of nasal fracture, open or closed • Voluntary sterilization (Tubal ligation, Vasectomy) Note: All surgeries, both inpatient and outpatient, must be certified. See page 18.	POS: Nothing when the procedure is performed outpatient FFS Panama: 50% of the Panama POS Fee schedule amount and any difference between the POS Fee schedule and the billed amount when performed outpatient FFS US: 50% of the US FFS Plan allowance and any difference between our allowance and the billed amount when performed outpatient Note: If any of the designated procedures are performed on an inpatient basis without our explicit approval, we will apply a $500 penalty and limit our payment to 50% of the Plan allowance under POS or FFS.
Coverage for up to two assistant surgeons when it is medically necessary for complex surgical procedures	POS: Nothing FFS Panama: 50% of the Panama POS fee schedule amount and any difference between the POS fee schedule and the billed amount FFS US: 50% of the US FFS Plan allowance and any difference between our allowance and the billed amount
Reconstructive surgery	
• Surgery to correct a functional defect • Surgery to correct a condition caused by injury or illness if: - the condition produced a major effect on the member's appearance and - the condition can reasonably be expected to be corrected by such surgery • Surgery to correct a condition that existed at or from birth and is a significant deviation from the common form or norm. Examples of congenital anomalies are: protruding ear deformities; cleft lip; cleft palate; birth marks; and webbed fingers and toes. • All stages of breast reconstruction surgery following a mastectomy, such as:	POS: Nothing FFS Panama: 50% of the Panama POS Fee schedule amount and any difference between the POS Fee schedule and the billed amount FFS US: 50% of the US FFS Plan allowance and any difference between our allowance and the billed amount

Reconstructive surgery - continued on next page

Benefit Description	You Pay
Reconstructive surgery (cont.)	
- surgery to produce a symmetrical appearance of breasts; - treatment of any physical complications, such as lymphedemas; - breast prostheses; and surgical bras and replacements (see Prosthetic devices for coverage) Note: We pay for internal breast prostheses as hospital benefits. Note: If you need a mastectomy, you may choose to have the procedure performed on an inpatient basis and remain in the hospital for up to 48 hours after the procedure. Note: Reconstructive surgery requires preauthorization.	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
• Gender Affirming Surgery (subject to medical necessity): All procedures must be pre-authorized. - Feminizing surgery (for members born with masculine sex), includes: • Surgical removal of the testicles (orchiectomy) alone • Vaginoplasty, a procedure that can also includes the following: Penectomy, orchiectomy, vaginoplasty , clitoroplasty, labioplasty) • Breast augmentation • Facial feminization surgery - Masculinizing surgery (for members born with feminine sex) • Breast reduction (surgical removal of breast tissue). • Thoracoplasty - Chest reconstruction (“Top Surgery”) • Total or partial hysterectomy, and/or salpingo-oophorectomy. • Vaginectomy (total or partial vagina removal), scrotoplasty (scrotum creation) with or without testicular prostheses. • Metoidioplasty (increment of length of clitoris) or phalloplasty (creation of a penis). • Facial masculinization surgery Eligibility Criteria for gender affirming surgeries: • Age: 18 years and older • Persistent, well documented gender dysphoria, including ALL of the following: - 1. The individual has demonstrated the desire to live and be accepted as different gender, in addition to a desire to make one’s body as consistent as possible with the preferred gender utilizing surgery and hormone replacement, and - 2. Gender dysphoria has been present continuously for at least two years, and - 3. The individual has lived fulltime in the identified gender for 1 year prior to reassignment surgery, and	POS: Not available FFS Panamá: 50% of the Panama POS Fee schedule amount and any difference between the POS fee schedule and the billed amount. FFS US: 50% of the US FFS Plan allowance and any difference between our allowance and the billed amount

Reconstructive surgery - continued on next page

Benefit Description	You Pay
Reconstructive surgery (cont.)	
- 4. Gender non-conformity causes clinically significant distress or impairment in social, occupational, or other important areas of functioning. • Written consent document signed by the member, as evidence of a fully informed decision. • One (1) previous calendar year of continuous hormonal therapy as appropriate to the member´s gender goals. • Referral for Primary Care Provider to gender affirming care multidisciplinary team. • No medical contraindications for surgery • Genital surgeries require complete and documented evaluations from the gender affirming care multidisciplinary team, which is composed by 01 mental health providers (psychiatrist), 01 endocrinologist, 01 gynecologist/urologist (depending upon final gender chosen by the member) and 01 plastic/reconstructive surgeon. All members of the multidisciplinary team must recommend unanimously the proposed surgery. Note: The plan follows the World Professional Association for Transgender Health - WPATH standards and guidelines, version 8, for medical necessity evaluation and coverage. No lifetime or singly procedure (one step/"one and done") limitations apply. Note: For more information on the types of Gender Reassignment Surgery covered please contact our Customer Service Department at 507-366-1400 in Panama, and 800-424-8196 or 312-935-3671 in the United States.	POS: Not available FFS Panamá: 50% of the Panama POS Fee schedule amount and any difference between the POS fee schedule and the billed amount. FFS US: 50% of the US FFS Plan allowance and any difference between our allowance and the billed amount
Not covered: • *Cosmetic surgery - any surgical procedure (or any portion of a procedure), except for gender affirming care services recommended for WPATH version 8 guidelines, performed primarily to improve physical appearance through change in bodily form, except repair of accidental injury.* • Gender affirming procedures and services defined as cosmetic including, but not limited to: abdominoplasty, blepharoplasty, brow lift, calf implants, cheek/malar implants. Forehead lift, hair removal, hair transplantation, lip reduction, liposuction, mastopexy, neck tightening, pectoral implants or prosthesis, removal of redundant skin, rhinoplasty. • Reversal of gender affirming surgeries.	*All charges*

Benefit Description	You Pay
Oral and maxillofacial surgery	
Oral surgical procedures, limited to: • Reduction of fractures of the jaws or facial bones • Surgical correction of cleft lip, cleft palate or severe functional malocclusion • Removal of stones from salivary ducts • Excision of leukoplakia or malignancies • Excision of cysts and incision of abscesses when done as independent procedures • Other surgical procedures that do not involve the teeth or their supporting structures	POS: Nothing FFS Panama: 50% of the Panama POS Fee schedule amount and any difference between the POS fee schedule and the billed amount FFS US: 50% of the US FFS Plan allowance and any difference between our allowance and the billed amount
Not covered: • *Oral implants and transplants* • *Procedures that involve the teeth or their supporting structures (such as the periodontal membrane, gingiva, and alveolar bone)*	*All charges*
Organ/tissue transplants	
Solid organ transplants are limited to: • Autologous pancreas islet cell transplant (as an adjunct to total or near total pancreatectomy) only for patients with chronic pancreatitis • Cornea • Heart • Heart/lung • Intestinal transplants - Isolated Small intestine - Small intestine with the liver - Small intestine with multiple organs, such as the liver, stomach, and pancreas • Kidney • Kidney-Pancreas • Liver • Lung single/bilateral/lobar • Pancreas	POS: Nothing FFS Panama: 50% of the Panama POS Fee schedule amount and any difference between the POS fee schedule and the billed amount FFS US: 50% of the US FFS Plan allowance and any difference between our allowance and the billed amount
Blood or marrow stem cell transplants The Plan extends coverage for the diagnoses as indicated below. Allogeneic transplants for • Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia • Myeloproliferative Disorders (MPDs) • Acute myeloid leukemia • Advanced neuroblastoma • Chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL)	POS: Nothing FFS Panama: 50% of the Panama POS Fee schedule amount and any difference between the POS fee schedule and the billed amount FFS US: 50% of the US FFS Plan allowance and any difference between our allowance and the billed amount

Organ/tissue transplants - continued on next page

Benefit Description	You Pay
Organ/tissue transplants (cont.)	
• Hemoglobinopathy • Hodgkin's lymphoma with recurrence (relapsed) • Marrow failure and related disorders (i.e. Fanconi's, Paroxysmal Nocturnal Hemoglobinuria, Pure Red Cell Aplasia) • Myelodysplasia/Myelodysplastic syndromes • Non-Hodgkin's lymphoma with recurrence (relapsed) • Paroxysmal Nocturnal Hemoglobinuria • Phagocytic/Hemophagocytic deficiency diseases (e.g., Wiskott-Aldrich syndrome) • Immune deficiency diseases other than SCID (e.g., Wiskott-Aldrich syndrome, Kostmann's Syndrome, Leukocyte) • Adhesion Deficiencies) not amenable to more conservative treatments • Severe combined immunodeficiency • Severe or very severe aplastic anemia • Sickle cell anemia • X-linked lymphoproliferative syndrome Autologous transplants for • Amyloidosis • Hodgkin's lymphoma with recurrence (relapsed) • Multiple myeloma • Testicular, Mediastinal, Retroperitoneal, and ovarian germ cell tumors • Neuroblastoma • Non-Hodgkin's lymphoma with recurrence (relapsed) • Medulloblastoma • Pineoblastoma • Waldenstrom's Macroglobulinemia	POS: Nothing FFS Panama: 50% of the Panama POS Fee schedule amount and any difference between the POS fee schedule and the billed amount FFS US: 50% of the US FFS Plan allowance and any difference between our allowance and the billed amount
Blood or Marrow Stem Cell Transplants limited to Clinical Trials: Autologous transplants for: • High-risk Ewing sarcoma • High-risk Childhood kidney cancers • Aggressive non Hodgkin´s lymphoma (adult T- cell leukemia/ Lymphoma, peripheral T-cell Lymphomas and aggressive Dendritic Cell neoplasms) • Breast cancer • Childhood rhabdomyosarcoma • Epithelial ovarian cancer • Mantle Cell (Non-Hodgkin lymphoma)	POS: Nothing FFS Panama: 50% of the Panama POS fee schedule amount any difference between the POS fee schedule and the billed amount FFS US: 50% of the US FFS Plan allowance and any difference between our allowance and the billed amount

Organ/tissue transplants - continued on next page

Benefit Description	You Pay
Organ/tissue transplants (cont.)	
Mini-transplants performed in a Clinical Trial Setting (non-myeloblative, reduced intensity conditioning or RIC) for members with a diagnosis listed below), subject to medical necessity: Refer to Other services in Section 3 for prior authorization procedures: Allogeneic transplants for • Acute lymphocytic (i.e. myelogenous) leukemia • Acute myeloid leukemia • Advanced Hodgkin´s lymphoma-relapsed • Advance non- Hodgkin´s lymphoma- relapsed • Advanced Myeloproliferative Disorders (MPDs) • Amyloidosis • Chronic lymphocytic leukemia/small lymphocitic leukemia (CLL/SLL) • Hemoglobinopathy • Marrow Failure and Related Disorders (i.e. Fanconi´s, PNH, Pure Red Cell Aplasia) • Myelodysplasia/Myelodysplastic Syndromes • Paroxysmal Nocturnal Hemoglobinuria • Severe combined immunodeficiency • Severe or very severe aplastic anemia Autologous transplants for: • Acute lymphocytic or nonlymphocytic (i.e., myelogenous) leukemia • Advanced Hodgkin´s lymphoma- relapsed. • Advanced non- Hodgkin´s lymphoma- relapsed • Amyloidosis • Neuroblastoma	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
These tandem blood or marrow stem cell for covered transplants are subject to medical necessity review by the Plan Refer to Other Services in Section 3 prior authorization procedures. Autologous Tandem transplant for. • AL Amyloidosis • Multiple Myeloma (de novo and treated) • Recurrent germ cell tumors (including testicular cancer) Note: We cover related medical and hospital expenses of the donor when we cover the recipient. If you are a Panama POS member, you must obtain prior authorization for a second opinion or surgical procedure to be rendered outside of Panama prior to leaving Panama by contacting the Medical Department at 507-366-1400.	POS: Nothing FFS Panama: 50% of the Panama POS Fee schedule amount and any difference between the POS fee schedule and the billed amount FFS US: 50% of the US FFS Plan allowance and any difference between our allowance and the billed amount

Organ/tissue transplants - continued on next page

Benefit Description	You Pay
Organ/tissue transplants (cont.)	
Not covered: • *Donor screening tests and donor search expenses, except as shown above* • *Implants of artificial organs* • *Transplants not listed as covered*	*All charges*
Anesthesia	
Professional services provided in: • Hospital (inpatient) • Hospital outpatient department • Skilled nursing facility • Ambulatory surgical center • Office	POS: Nothing FFS Panama: 50% of the Panama POS Fee schedule amount and any difference between the POS Fee schedule and the billed amount FFS US: 50% of the US FFS Plan allowance and any difference between our allowance and the billed amount Note: If your POS provider uses a nonparticipating anesthesiologist, we will pay FFS benefits for those anesthesia charges.
Not covered: • *Anesthesia performed on an inpatient or outpatient basis in conjunction with a non-covered surgery or procedure*	*All charges*

Section 5(c). Services Provided by a Hospital or Other Facility, and Ambulance Services

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- In this section a $25 per admission copayment for POS members and a $100 per admission copayment for FFS members applies to only a few benefits.
- The FFS benefits are the standard benefits of this Plan. POS benefits apply only when you use a POS provider. When no POS provider is available, FFS benefits apply. Under the FFS benefits, you owe all charges that exceed our allowable charges.
- Be sure to read Section 4, *Your Costs for Covered Services*, for valuable information about how cost-sharing works. Also read Section 9 for information about how we pay if you have other coverage, or if you are age 65 or older.
- The amounts listed below are for the charges billed by the facility (i.e. hospital or surgical center) or ambulance service for your surgery or care. Any costs associated with the professional charge (i. e. physicians, etc.) are in Sections 5(a) or (b).
- See page 83 for a definition of plan allowances.
- **YOU MUST GET PRECERTIFICATION FOR HOSPITAL STAYS; FAILURE TO DO SO WILL RESULT IN A MINIMUM $500 PENALTY.** Please refer to the precertification information shown in Section 3 to be sure which services require precertification.

Benefit Description	You Pay
Inpatient hospital	
Room and board, such as: • Ward, semiprivate, or intensive care accommodations • General nursing care • Meals and special diets Note: We only cover a private room when you must be isolated to prevent contagion. Otherwise, we will pay the hospital's average charge for semiprivate accommodations. If the hospital only has private rooms, we base our payment on the average semiprivate rate of the most comparable hospital in the area. Note: When the FFS hospital bills a flat rate, we prorate the charges to determine how to pay them, as follows: 30% room and board and 70% other charges.	POS: Nothing after the $25 per admission copayment FFS Panama: $100 per admission, then 50% of the Panama POS fee schedule amount and any difference between the POS Fee schedule and the billed amount FFS US: $100 per admission and 50% of the covered charges Note: When you select the POS option and are readmitted to a participating hospital with the same diagnosis within 30 days of being discharged, we will waive the $25 copayment for the readmission
Other hospital services and supplies, such as: • Operating, recovery, maternity, and other treatment rooms • Prescribed drugs and medications • Diagnostic laboratory tests and X-rays • Blood or blood plasma, if not donated or replaced Blood test, supplies and procedures for screening to ensure biosafety of donated blood components, including donor´s test. Those include, but not limited to, bloodtype, crossmatch, and infectious diseases testing. • Dressings, splints, casts, and sterile tray services	POS: Nothing after the $25 per admission copayment FFS Panama: $100 per admission, then 50% of the Panama POS fee schedule amount and any difference between the POS Fee schedule and the billed amount FFS US: $100 per admission and 50% of the covered charges

Inpatient hospital - continued on next page

Benefit Description	You Pay
Inpatient hospital (cont.)	
• 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 healthcare professional bills for the services or supplies. For example, when the hospital bills for its nurse anesthetists' services, we pay Hospital benefits and when the anesthesiologist bills, we pay Surgery benefits. Note: When you select the POS option and are readmitted to a participating hospital with the same diagnosis within 30 days of being discharged, we will waive the $25 copayment for the readmission. Note: Any medicine, drug, vitamin or dietary supplement that an inpatient receives while admitted into a medical facility and it is medically necessary for treatment of underlying clinical condition(s) will be covered under medical benefit, even if it is considered for a different coverage under prescribed drugs benefit for outpatient, ambulatory or homecare setting.	POS: Nothing after the $25 per admission copayment FFS Panama: $100 per admission, then 50% of the Panama POS fee schedule amount and any difference between the POS Fee schedule and the billed amount FFS US: $100 per admission and 50% of the covered charges
Not covered: • *Any part of a hospital admission that is not medically necessary (see definition), such as when you do not need acute hospital inpatient (overnight) care, but could receive care in some other setting without adversely affecting your condition or the quality of your medical care. Note: In this event, we pay benefits for services and supplies other than room and board and in-hospital physician care at the level they would have been covered if provided in an alternative setting* • *Custodial care; see definition* • *Non-covered facilities, such as nursing homes, schools* • *Personal comfort items, such as phone, television, barber services, guest meals and beds* • *Private nursing care* • *Inpatient hospital charges related to a non- covered surgery or procedure*	*All charges*
Outpatient hospital or ambulatory surgical center	
• Operating, recovery, and other treatment rooms • Prescribed drugs and medications • Diagnostic laboratory tests, X-rays, and pathology services • Administration of blood, blood plasma, and other biologicals • Blood and blood plasma, if not donated or replaced • Pre-surgical testing • Dressings, casts, and sterile tray services • Medical supplies, including oxygen • Anesthetics and anesthesia service	POS: $25 copayment to facility for surgeries in operating room and nothing for other services FFS Panama: 50% of the Panama POS Fee schedule amount and any difference between the POS Fee schedule and the billed amount FFS US: 50% of the US FFS Plan allowance and any difference between our allowance and the billed amount

Outpatient hospital or ambulatory surgical center - continued on next page

Benefit Description	You Pay
Outpatient hospital or ambulatory surgical center (cont.)	
Note: – We cover hospital services and supplies related to dental procedures when necessitated by a non-dental physical impairment. We do not cover the dental procedures.	POS: $25 copayment to facility for surgeries in operating room and nothing for other services FFS Panama: 50% of the Panama POS Fee schedule amount and any difference between the POS Fee schedule and the billed amount FFS US: 50% of the US FFS Plan allowance and any difference between our allowance and the billed amount
Not covered: • *Outpatient hospital or ambulatory surgical center charges related to a non-covered surgery or procedure*	*All charges*
Extended care benefits/Skilled nursing care facility benefits	
Skilled nursing facility (SNF) - We cover semiprivate room, board, services and supplies in a SNF for up to 60 days per confinement when: 1) You are admitted directly from a pre-certified hospital stay of at least 3 consecutive days; and 2) You are admitted for the same condition as the hospital stay; and 3) Your skilled nursing care is supervised by a physician and provided by an R.N., L.P.N., or L.V.N.; and 4) SNF care is medically appropriate	POS: Nothing FFS Panama: 50% of the Panama POS Fee schedule amount and any difference between the POS fee schedule and the billed amount FFS US: 50% of the US FFS Plan allowance and any difference between our allowance and the billed amount
Extended care benefit: Sub-Acute Care: We cover room, board (i.e., meals) and general nursing services, in a hospital or sub-acute care facility, when we determine that you are eligible for this less acute hospital care.	POS: Nothing FFS: Not an eligible benefit outside of the POS network
Not Covered: Custodial care	*All charges*
Hospice care	
Hospice is a coordinated program of maintenance and supportive care for the terminally ill provided by a medically supervised team under the direction of a Plan-approved independent hospice administration as approved by the Plan's Medical Director	POS: Nothing FFS Panama: 50% of the Panama POS Fee schedule amount and any difference between the POS Fee schedule and the billed amount. FFS US: 50% of the US FFS Plan allowance and any difference between our allowance and the billed amount
Not covered: • *Independent nursing* • *homemaker services*	*All charges*

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

Section 5(d). Emergency Services/Accidents

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Please remember, we require both FFS and POS Plan members to precertify all admissions to evaluate th*e medical necessity of your proposed admissions and the number of hospital days you will need.*
- The FFS benefits are the standard benefits of this Plan. POS benefits apply only when you use a POS provider. When no POS provider is available, FFS benefits apply. Under the FFS benefits, you owe all charges that exceed our allowable charges.
- If you have an emergency admission due to a condition that you reasonably believe puts your life in danger or could cause serious damage to bodily function, you, your representative, the doctor, or the hospital must phone us within two business days following the day of the emergency admission, even if you have been discharged from the hospital.
- Be sure to read Section 4, *Your Costs for Covered Services*, for valuable information about how cost-sharing works. Also read Section 9 for information about how we pay if you have other coverage, or if you are age 65 or older.

What is an accidental injury?

An accidental injury is a bodily injury sustained solely through violent, external, and accidental means, such as broken bones, animal bites, and poisonings. We cover dental care for accidental injury at 80% of Plan allowance.

What is a medical emergency?

A medical emergency is the sudden and unexpected onset of a condition or an injury that you believe endangers your life or could result in serious injury or disability, and requires immediate medical care. The severity of the condition as revealed by the doctor's diagnosis must be such as would normally require emergency care. Examples of medical emergencies include heart attacks, cardiovascular accidents, poisoning, and loss of consciousness or respiration, convulsions, etc. It is your responsibility to notify the Panama Canal Area Benefit Plan within 48 hours of onset of the emergency room visit at 507-366-1400 in Panama, and 800-424-8196 or 312-935-3671 in the United States.

What is non-emergent care?

Examples of non emergent care are refilling of medications, rash, common cold, sore throat, cough, physical exam, hemorrhoids, diarrhea and runny nose. Note: These conditions should be treated by a Primary Care Provider or at an Urgent Care Facility. See Section 5(a) under Diagnostic and treatment services.

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

Accidental injury - continued on next page

Benefit Description	You pay
Accidental injury (cont.)	
If you receive care for your accidental injury after 72 hours, we cover: • Physician services and supplies • Surgical care Note: We pay Hospital benefits if you are admitted.	POS: $5 copayment for office visit or emergency room visit FFS Panama: 50% of the Panama POS Fee schedule amount and any difference between the POS Fee schedule and the billed amount FFS US: 50% of the US FFS Plan allowance and any difference between our allowance and the billed amount
Medical emergency	
Outpatient medical or surgical services and supplies Note: If you are under the Point of Service option, traveling outside of Panama, and require medical emergency care, you will be covered at the POS benefit level. Medical services received while traveling outside of Panama for conditions not serious enough to be classified as emergencies, will be reimbursed under the FFS benefit provisions. You will usually have to pay directly for care for medical services provided to you outside of Panama and then we will reimburse you according to the benefits described in this brochure. However, if the provider agrees to file the claim directly to the Plan, he/she should send a completed Claim Form and the itemized bills to the Panama Canal Area Benefit Plan at AXA assistance, PO Box 31-0940, Miami, FL. 33231-0940. Medical services received while traveling outside of the service area for conditions not serious enough to be classified as emergencies, will be reimbursed under the FFS benefit provisions.	POS: $5 facility copayment for emergency room visit or office visit FFS Panama: 50% of the Panama POS Fee schedule amount and any difference between the POS fee schedule and the billed amount FFS US: 50% of the US FFS Plan allowance and any difference between our allowance and the billed amount
Urgent Care Facility	
Professional services of physicians	POS: Nothing at an Urgent Care Center 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 See Section 5(a) under Diagnosis and treatment services.
Ambulance	
We pay reasonable and customary charges up to $100 per incident for intra-province ambulance use and $200 for inter-province ambulance use that results in admission to a hospital or transfer between medical facilities, when Preauthorization is obtained and services are provided by a Plan participating ambulance service provider.	POS: Nothing. All charges after $100 allowance for intra-province ambulance use and $200 for inter-province ambulance use FFS Panama: 50% of the Panama POS Fee schedule amount and any difference between the POS fee schedule and the billed amount. All charges after $100 allowance

Ambulance - continued on next page

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

Section 5(e). Mental Health and Substance Use Disorder Benefits

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Your cost-sharing responsibilities are no greater than for any other illnesses or conditions.
- The outpatient and inpatient copayments apply to almost all benefits in this Section.
- The FFS benefits are the standard benefits of this Plan. POS benefits apply only when you use a POS provider. When no POS provider is available, FFS benefits apply. Under the FFS benefits, you owe all charges that exceed our allowable charges.
- Be sure to read Section 4, *Your Costs for Covered Services*, for valuable information about how cost-sharing works. Also read Section 9 for information about how we pay if you have other coverage or if you are age 65 or over.
- See page 83 for a definition of plan allowances.
- Our case management nurses and medical director will work with your mental health provider to develop a treatment plan for you.
- If you are enrolled in the POS Option in Panama, you must obtain a referral from your primary care provider before seeing a specialist. When you are referred to a specialist, the specialist must request and receive authorization from AXA prior to additional consultations and/or treatment.
- 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. **FAILURE TO DO SO WILL RESULT IN A MINIMUM $500 PENALTY.** Please refer to the precertification information shown in Section 3 to be sure which services require precertification.

Benefit Description	You pay
Professional Services	
We cover professional services by licensed professional mental health and substance use disorder treatment practitioners when acting within the scope of their license, such as psychiatrists, psychologists, clinical social workers. Diagnosis and treatment of psychiatric conditions, mental illness, or mental disorders. Services include: • Diagnostic evaluation • Crisis Intervention and stabilization for acute episodes • Medication evaluation and management (pharmacotherapy) • Psychological and neuropsychological testing necessary to determine the appropriate psychiatric treatment • Treatment and counseling (including individual or group therapy visits) • Diagnosis and treatment of substance use disorders, including detoxification, treatment and counseling • Professional charges for intensive outpatient treatment in a provider's office or other professional setting • Electroconvulsive therapy	POS: $5 copayment per visit FFS Panama: 50% of the Panama POS Fee schedule amount and any difference between the POS Fee schedule and the billed amount FFS US: 50% of the US FFS Plan allowance and any difference between our allowance and the billed amount

Professional Services - continued on next page

Benefit Description	You pay
Professional Services (cont.)	
• Inpatient physician hospital visit	POS: Nothing FFS Panama: Nothing up to $35 per doctor per day and all charges thereafter FFS US: Nothing up to $35 per doctor per day and all charges thereafter
• Alcohol misuse: screening and counseling	POS: Nothing FFS Panama: Panama 50% of the Panama POS fee schedule amount and any difference between the POS fee schedule and the billed amount FFS US: Nothing up to the difference between the plan allowance and the billed charge
Diagnostics	
• Outpatient diagnostic tests provided and billed by a licensed mental health and substance use disorder treatment practitioner • Outpatient diagnostic tests provided and billed by a laboratory, hospital or other covered facility • Inpatient diagnostic tests provided and billed by a hospital or other covered facility	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 Hospital or other covered facility	
Inpatient services provided and billed by a hospital or other covered facility • Room and board, such as semiprivate or intensive accommodations, general nursing care, meals and special diets, and other hospital services	POS: $25 per hospitalization FFS Panama: 50% of the Panama POS fee schedule amount and any difference between the POS Fee schedule and the billed amount FFS US: 50% of the covered charges
Outpatient hospital or other covered facility	
Outpatient services provided and billed by a hospital or other covered facility • Services such as partial hospitalization, half-way house, residential treatment, full-day hospitalization, or facility-based intensive outpatient treatment	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: • *Services that are not medically necessary or clinically appropriate*	All charges

Section 5(f). Prescription Drug Benefits

Important things you should keep in mind about these benefits:

- We cover FDA approved prescribed drugs and medications (and their equivalents), as described in the chart below.
- Please remember that all benefits are subject to the definitions, limitations and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Your prescribers must obtain prior approval/authorizations for certain prescription drugs and supplies before coverage applies. Prior approval/authorization must be renewed periodically.
- Federal law prevents the pharmacy from accepting unused medications.
- Prior approval is required for certain medications (for example, oncology drugs, opioid drugs, and specialty drugs). Opioids are medications used to treat moderate or severe pain. They diminish the effects of a painful stimulus (i.e., Codeine, Morphine, Methadone, Oxycodone)
- Be sure to read Section 4, *Your Costs for Covered Services*, for valuable information about how cost-sharing works. Also read Section 9 for information about how we pay if you have other coverage or if you are age 65 or older.
- NOTE: Coinsurance for prescription drugs accumulates to the out-of-pocket maximum of $8,200 for Self Only enrollment, and $12,000 for Self Plus One and Self and Family enrollments per year.

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

- **Who can write your prescription.** A licensed physician or dentist, and in states allowing it, licensed/certified providers with prescriptive authority prescribing within their scope of practice must prescribe your medication.
- **Where you can obtain them.** You may fill the prescription at any pharmacy.
- **How to submit your claims for prescription drugs.** Claims for prescription drugs and medications must include receipts that include the patient's name, prescription number, name of drug, prescribing doctor's name, date and charge.
- **Why use generic drugs?** Generic drugs offer a safe and economic way to meet your prescription drug needs. A generic drug, is a drug which active ingredient is comparable to the brand product in dosage form, strenght, quality, performance characteristics, and intended use. However, are marketed under the chemical name of the brand, but without advertising. Under federal law, generic and name brand drugs must meet the same standards for safety, purity, strength, and effectiveness. A generic prescription costs you less than a name brand prescription.

Benefits Description	You Pay
Covered medications and supplies	
You may purchase the following medications and supplies prescribed by a physician from a pharmacy: • Drugs and medications (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* • Opioid Drugs • Insulin • Diabetic supplies limited to: - Disposable needles and syringes for the administration of covered medications • Drugs to treat gender dysphoria	Generic drugs: POS: 20% of charges plus any non-covered expenses FFS Panama: 20% of charges plus any non-covered expenses FFS US: 20% of charges plus any non-covered expenses Brand name drugs: POS: 30% of charges plus any non-covered expenses

Covered medications and supplies - continued on next page

Benefits Description	You Pay
Covered medications and supplies (cont.)	
Note: We cover diabetes medications that are part of the Diabetes Disease Management Program formulary at 100%. For other Diabetes medications regular benefits apply. Note: A medical food is a specially formulated and processed food for the enteral feeding of a patient; is intended for the dietary management for patients' therapeutic or chronic medical needs; provides nutritional support specifically modified for the dietary management of a specific disease or condition determined by a physician; and is used for a patient receiving active and ongoing medical supervision. Medical Foods are exclusively for the treatment of inborn errors of metabolism (IEM). Such IEM can include, but are not limited, to: • Phenylketonuria (PKU) • Maple syrup urine disease (MSUD) • Homocystonuria • Disorder of leucine metabolism • Tyroosinemia I and II Pre-authorization will be required.	Generic drugs: POS: 20% of charges plus any non-covered expenses FFS Panama: 20% of charges plus any non-covered expenses FFS US: 20% of charges plus any non-covered expenses Brand name drugs: POS: 30% of charges plus any non-covered expenses FFS Panama: 30% of charges plus any non-covered expenses FFS US: 30% of charges plus any non-covered expenses
Obesity Drugs: The following FDA approved prescription drugs for obesity for members with a body mass index (BMI) of 30 or higher. A pre-authorization is required. Prescriptions must be requested by the patient's treating physician and requires a second opinion review by an endocrinologist and a nutritionist. • Liraglutide • Semaglutide • Naltrexone-bupropion • Orlistat • Phentermine-topiramate	Generic drugs: POS: 20% of charges plus any non-covered expenses FFS Panama: 20% of charges plus any non-covered expenses FFS US: 20% of charges plus any non-covered expenses Brand name drugs: POS: 30% of charges plus any non-covered expenses FFS Panama: 30% of charges plus any non-covered expenses FFS US: 30% of charges plus any non-covered expenses
Contraceptive drugs and devices as listed in the ACA/HRSAsite. Contraceptive coverage is available at no cost to FEHB members, under the POS option, and under the FFS US option. The contraceptive benefit includes at least one option in all FDA-approved methods of contraception (as well as the screening, education, counseling, and follow-up care). Any contraceptive that is not already available without cost sharing on the formulary can be accessed through the contraceptive exceptions process described below. **Exception Process Steps:**	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: Nothing up to the US FFS Plan allowance and any difference between our allowance and the billed amount

Covered medications and supplies - continued on next page

Benefits Description	You Pay
Covered medications and supplies (cont.)	
1. You can obtain a copy of our exception process form by visiting our website at pcabp.com.pa or by calling us at 507-366-1400 in Panama, and 800-424-8196 or 312-935-3671 in the United States. 2. The member or medical provider must send the exception process form, along with a completed preauthorization form and/or a medical prescription order, properly filled and signed detailing the drug brand name, generic, dose and instructions to preautorizaciones@axa-assistance.com.pa. Please indicate in the subject of the e-mail: "urgent – contraception". If information is not complete or any document is missing, the member and/or provider will be contacted to request additional information. We will make our decision within 24 hours. Reimbursement for over-the-counter contraceptives can be submitted by completing the same exception process as described above. If you have any concerns about the Plan's compliance with contraceptive coverage you can contact OPM at contraceptive@opm.gov or visit their contraceptive webpage at Consumer Protections (opm.gov).	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: Nothing up to the US FFS Plan allowance and any difference between our allowance and the billed amount
FDA and Plan approved medications for prevention and treatment of cancers, aplastic anemia, sickle -cell anemia, inhaler based medications for asthma and chronic obstructive pulmonary disease (COPD), and myelodysplasia syndrome NOTE: Preauthorization is required for medications that treat cancer, aplastic anemia, sickle -cell anemia, and myelodysplasia syndrome at 100%.	Nothing
Infertility drugs Oral and injectable drugs associated with artificial insemination procedures listed in Section 5(a), under Infertility services. Note: The Plan covers up to three (3) cycles of drug treatments for ART per member, per year, when deemed necessary.	Generic drugs: POS: 20% of charges plus any non-covered expenses FFS Panama: 20% of charges plus any non-covered expenses FFS US: 20% of charges plus any non-covered expenses Brand name drugs: POS: 30% of charges plus any non-covered expenses FFS Panama: 30% of charges plus any non-covered expenses FFS US: 30% of charges plus any non-covered expenses

Benefits Description	You Pay
Preventive care medications	
We cover the following preventive care medications which have A & B ratings as recommended by the USPSTF with a written prescription from your physician: • aspirin for preeclampsia prevention or to prevent cardiovascular disease in men ages 45 to 79 and women ages 55-79 when the potential benefits outweigh the potential harm • tamoxifen and raloxifen for women who are at increased risk for breast cancer and at low risk for adverse medication effects • fluoride supplementation for infants starting at 6 months and children up to age 5 • vitamin D supplementation in community-dwelling adults age 65 years and older who are at increased risk for falls • folic acid supplementation for women planning or capable of pregnancy • iron supplementation in children ages 6 months to 12 months who are at increased risk for iron deficiency anemia • prophylactic ocular topical medication for all newborns for prevention of gonococcal ophthalmia neonatorum	POS: Nothing FFS Panama: Generic drugs: 20% of charges plus any non-covered expenses / Brand name drugs: 30% of charges plus any non-covered expenses FFS US: Nothing up to the FFS US allowance and any difference between our allowance and the billed amount
• Statin medications with atorvastatin and rosuvastatin as cardiovascular disease preventive medication for adults 40-75 years of age with no history of cardiovascular disease (CVD). Note: You must have a risk assessment questionnaire with your PCP. PCP must notify the Plan of the patient´s risk of CVD being 10% or higher within 10 years. Note: Preventive Medications with a USPSTF recommendation of A or B are covered without cost-share when prescribed by a healthcare professional and filled by a network pharmacy. These may include some over-the-counter vitamins, nicotine replacement medications, and low dose aspirin for certain patients. For current recommendations go to www.uspreventiveservicestaskforce.org/BrowseRec/Index/browse-recommendations	POS: Nothing for atorvastatin and rosuvastatin to prevent CVD FFS Panama: Generic drugs: 20% of charges plus any non-covered expenses / Brand name drugs: 30% of charges plus any non-covered expenses FFS US: Nothing for atorvastatin and rosuvastatin to prevent CVD
Not covered: • *Drugs and supplies for cosmetic purposes* • *Vitamins, nutrients and food supplements not listed as a covered benefit even if a physician prescribes or administers them unless shown as covered* • *Nonprescription medications unless specifically indicated elsewhere* • *Medical supplies such as dressings and antiseptics* • *Medication not FDA approved or not FDA equivalent* *Note: Physician prescribed over-the-counter and prescription drugs approved by the FDA to treat tobacco dependence are covered under the Tobacco Cessation program benefit. (See page 39).*	All Charges

Section 5(g). Dental Benefits

Important things you should keep in mind about these benefits:

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

Accidental injury benefit	You Pay
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 for covered dental work required as a result of accidental injury that you incur within 52 weeks after the accident.

Dental Benefits	Service	
Office visits	**We Pay**	**You Pay**
Dental caries prevention by the application of fluoride varnish to the primary teeth of all infants and children starting at the age of primary tooth eruption in primary care practices	All charges	Nothing
Office visits for preventive care. Oral prophylaxis or periodontal maintenance limited to two visits per calendar year	$20 per visit	All charges in excess of our fee schedule payment
Dental Surgery	**We Pay**	**You Pay**
Extraction of impacted teeth, including X-rays	$100	All charges in excess of our fee schedule payment
Apicoectomy	$85	All charges in excess of our fee schedule payment
Lancing of erupting tooth	$70	All charges in excess of our fee schedule payment
Periodontics	**We Pay**	**You Pay**
Periodontal scaling and root planing Note: Prior to treatment, you must submit a competed dental Pre-Treatment Estimate form to obtain approval of benefits for the work to be performed. If approval is not obtained, we will limit benefits to 50% of the fee schedule.	$60 per quadrant	All charges in excess of our fee schedule payment

Dental Benefits	Service	
Endodontics	**We Pay**	**You Pay**
Root canal treatment, including • intra-oral drainage of abscess • devitalization • removal of pulp • root canal filing (limited to 4 canals) Note: Prior to treatment, you must submit a competed dental Pre-Treatment Estimate form to obtain approval of benefits for the work to be performed. If approval is not obtained, we will limit benefits to 50% of the fee schedule. Note: The Endodontics fee schedule allowance includes X-rays and there is no additional allowance for X-rays.	$120 for one canal $150 for two canals $180 for three canals $210 for four canals	All charges in excess of our fee schedule payment
What is not covered	**We Pay**	**You Pay**
• *Realignment of teeth (orthodontia) or treatment for cosmetic purposes* • *Repair of cavities* • *Repair or replacement of teeth except as shown above* • *Masticating (chewing) incidents* • *Tooth extractions not specified as covered above* • *X-rays (fee schedule includes the X-ray)* • *Dental surgery other than those specifically described above* • *Dental surgery, appliances, and adjustments of occlusion for temporomandibular joint syndrome (TMJ)*	*Nothing*	*All charges*

Section 5(h). Wellness and Other Special Features

Special feature	Description
Health support programs	The Panama Canal Area Benefit Plan offers patient education and health support programs for post-hospitalization and health maintenance in Panama. Examples of these services may include hospital discharge planning, coordination with community support, local social work services and coordination of home care services. Call the Customer Service team in Panama at 507-366-1400 to find out what programs are available.
Flexible benefits option	Under the flexible benefits option, we determine the most effective way to provide services. • We may identify medically appropriate alternatives to regular contract benefits as a less costly alternative. If we identify a less costly, we will ask you to sign an alternative benefits agreement that will include all of the following terms in addition to other terms as necessary. Until you sign and return the agreement, regular contract benefits will continue. • Alternative benefits will be made available for a limited time period and are subject to our ongoing review. You must cooperate with the review process. • By approving an alternative benefit, we do not guarantee you will get it in the future. • The decision to offer an alternative benefit is solely ours, and except as expressly provided in the agreement, we may withdraw it at any time and resume regular contract benefits. • If you sign the agreement, we will provide the agreed-upon alternative benefits for the stated time period (unless circumstances change). You may request an extension of the time period, but regular contract benefits will resume if we do not approve your request. • Our decision to offer or withdraw alternative benefits is not subject to OPM review under the disputed claims process. However, if at the time we make a decision regarding alternative benefits, we also decide that regular contract benefits are not payable, then you may dispute our regular contract benefits decision under the OPM disputed claim process (see Section 8).
Centers of excellence	In the United States we have designated certain specialty hospitals as centers of excellence. We strongly encourage Plan members to use them for highly specialized procedures. If you are planning to undergo a highly specialized surgical procedure such as open heart surgery, or would like additional information on these facilities, please call our case management department in Panama at 507-366-1400, and 800-424-8196 or 312-935-3671 in the United States. As stated on Section 1 For these cases fee-for-services (FFS) benefits will be applied.

Section 6. General Exclusions – Services, Drugs and Supplies We Do Not Cover

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

We do not cover and will not pay for the following:

- Services, drugs, or supplies you receive while you are not enrolled in this Plan.
- Services, drugs, or supplies not medically necessary.
- Services, drugs, or supplies not required according to accepted standards of medical, dental, or psychiatric practice.
- Experimental or investigational procedures, treatments, drugs or devices (see specifics regarding transplants).
- Services, drugs, or supplies related to abortions, except when the life of the mother would be endangered if the fetus were carried to term, or when the pregnancy is the result of an act of rape or incest.
- Services, drugs, or supplies you receive from a provider or facility barred from the FEHB Program.
- Services, drugs, or supplies you receive without charge while in active military service.
- Services or supplies for which no charge would be made if the covered individual had no health insurance coverage.
- Services or supplies we are prohibited from covering under the Federal Law.
- Services or supplies furnished by yourself, immediate relatives or household members, such as spouse, parents, children, brothers or sisters by blood, marriage or adoption.
- Services or supplies furnished or billed by a non-covered facility, except that medically necessary prescription drugs and physical, speech and occupational therapy rendered by a qualified professional therapist on an outpatient basis are covered subject to plan limits.
- Charges which the enrollee or Plan has no legal obligation to pay, such as excess charges for an annuitant age 65 or older who is not covered by Medicare Parts A and/or B (see page 78), doctor's charges exceeding the amount specified by the Department of Health & Human Services when benefits are payable under Medicare (limiting charge, see page 79, or State premium taxes however applied).
- Any portion of a provider's fee or charge that is ordinarily due from the enrollee but has been waived. If a provider routinely waives (does not require the enrollee to pay) a deductible or coinsurance, the Plan will calculate the actual provider fee or charge by reducing the fee or charge of the waived amount.
- Private duty nursing care services, in or out of hospital.
- Expenses to the extent they exceed the Plan allowance for the service or supply.
- Applied behavior analysis (ABA) or ABA therapy
- 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.
- Research costs related to conducting the clinical trial such as research physician and nurse time, analysis of results, and clinical tests performed only for research purposes.
- Extra care costs related to taking part in a clinical trial such as additional tests that a patient may need as part of the trial, but not as part of the patient's routine care.

Section 7. Filing a Claim for Covered Services

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

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

How to claim benefits

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

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

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

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

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

In addition:

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

Post-service claims procedures

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

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

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

Records

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

Deadline for filing your claim

Send us all the documents for your claim as soon as possible. You must submit the claim by December 31 of the year after the year you received the service. If you could not file on time because of Government administrative operations or legal incapacity, you must submit your claim as soon as reasonably possible. Once we pay benefits, there is a three-year limitation on the re-issuance of uncashed checks.

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

Overseas claims

For covered services you receive by providers and hospitals outside the United States, Panama and Puerto Rico send a completed Claim Form and the itemized bills to the Panama Canal Area Benefit Plan at AXA Assistance, PO Box 31-0940, Miami, FL. 33231- 0940. You may also obtain Claim Forms from the same address. If you have questions about the processing of overseas claims, contact us at 800-424-8196 or 312-935-3671 in the United States.

When we need more information

Please reply promptly when we ask for additional information. We may delay processing or deny benefits for your claim if you do not respond. Our deadline for responding to your claim is stayed while we await all of the additional information needed to process your claim.

Authorized Representative

You may designate an authorized representative to act on your behalf for filing a claim or to appeal claims decisions to us. For urgent care claims, a healthcare professional with knowledge of your medical condition will be permitted to act as your authorized representative without your express consent. For the purposes of this section, we are also referring to your authorized representative when we refer to you.

Notice Requirements

The Secretary of Health and Human Services has identified counties where at least 10% of the population is literate only in certain non-English languages. The non-English languages meeting this threshold in certain counties are Spanish, Chinese, Navajo and Tagalog. If you live in one of these counties, we will provide language assistance in the applicable non-English language. You can request a copy of your Explanation of Benefits (EOB) statement, related correspondence, oral language services (such as phone customer assistance), and help with filing claims and appeals (including external reviews) in the applicable non-English language. The English versions of your EOBs and related correspondence will include information in the non-English language about how to access language services in that non-English language.

Any notice of an adverse benefit determination or correspondence from us confirming an adverse benefit determination will include information sufficient to identify the claim involved (including the date of service, the healthcare provider, and the claim amount, if applicable), and a statement describing the availability, upon request, of the diagnosis and procedure codes and its corresponding meaning, and the treatment code and its corresponding meaning).

Section 8. The Disputed Claims Process

You may appeal directly to the Office of Personnel Management (OPM) if we do not follow required claims processes. For more information or to make an inquiry about situations in which you are entitled to immediately appeal to OPM, including additional requirements not listed in Sections 3, 7 and 8 of this brochure, please call your plan's customer service representative at the phone number found on your enrollment card, plan brochure, or plan website.

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

To help you prepare your appeal, you may arrange with us to review and copy, free of charge, all relevant materials and Plan documents under our control relating to your claim, including those that involve any expert review(s) of your claim. To make your request, please contact our Customer Service Department by writing to AXA Assistance, PO Box 31-0940, Miami Florida 33231-0940 (if services were provided anywhere outside of Panama) or to AXA Assistance, Torre BICSA Financial Center, 48th Floor, Avenida Balboa y Alquilino de la Guardias. Panama City, Republic of Panama (if services were provided in Panama), or by calling 507-366-1400 in Panama, and 800-424-8196 or 312-935-3671 in the United States.

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

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

Our reconsideration will not take into account the initial decision. The review will not be conducted by the same person, or their subordinate, who made the initial decision.

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

Step	Description
1	Ask us in writing to reconsider our initial decision. You must: (a) Write to us within 6 months from the date of our decision; and (b) Send your request to us to the Panama Canal Area Benefit Plan at AXA Assistance, PO Box 31-0940, Miami, FL. 33231- 0940. If you reside in the Republic of Panama, please submit your disputed claim to the Panama Canal Area Benefit Plan at AXA Assistance, Torre BICSA Financial Center, 48th Floor, Avenida Balboa y Alquilino de la Guardias. Panama City, Republic of Panama. We also have customer service offices at Clínica Hospital San Fernando, Centro Médico Paitilla and Centro Médico Caribe (Colon). (c) Include a statement about why you believe our initial decision was wrong, based on specific benefit provisions in this brochure; and (d) Include copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms. (e) Include your email address (optional for member), if you would like to receive our decision via email. Please note that by giving us your email, we may be able to provide our decision more quickly.

We will provide you, free of charge and in a timely manner, with any new or additional evidence considered, relied upon, or generated by us or at our direction in connection with your claim and any new rationale for our claim decision. We will provide you with this information sufficiently in advance of the date that we are required to provide you with our reconsideration decision to allow you a reasonable opportunity to respond to us before that date. However, our failure to provide you with new evidence or rationale in sufficient time to allow you to timely respond shall not invalidate our decision on reconsideration. You may respond to that new evidence or rationale at the OPM review stage described in step 4.

2 In the case of a post-service claim, we have 30 days from the date we receive your request to:

a) Pay the claim

b) Write to you and maintain our denial or

c) Ask you or your provider for more information

You or your provider must send the information so that we receive it within 60 days of our request. We will then decide within 30 more days.

If we do not receive the information within 60 days we will decide within 30 days of the date the information was due. We will base our decision on the information we already have. We will write to you with our decision.

3 If you do not agree with our decision, you may ask OPM to review it.

You must write to OPM within:

- 90 days after the date of our letter upholding our initial decision; or
- 120 days after you first wrote to us -- if we did not answer that request in some way within 30 days; or
- 120 days after we asked for additional information.

Write to OPM at: United States Office of Personnel Management, Healthcare and Insurance, Federal Employee Insurance Operations, FEHB 2, 1900 E Street, NW, Washington, DC 20415-3620.

Send OPM the following information:

- A statement about why you believe our decision was wrong, based on specific benefit provisions in this brochure;
- Copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms;
- Copies of all letters you sent to us about the claim;
- Copies of all letters we sent to you about the claim; and
- Your daytime phone number and the best time to call.
- Your email address, if you would like to receive OPM’s decision via email. Please note that by providing your email address, you may receive OPM’s decision more quickly.

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

Note: You are the only person who has a right to file a disputed claim with OPM. Parties acting as your representative, such as medical providers, must include a copy of your specific written consent with the review request. However, for urgent care claims, a healthcare professional with knowledge of your medical condition may act as your authorized representative without your express consent.

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

Step	Description
4	OPM will review your disputed claim request and will use the information it collects from you and us to decide whether our decision is correct. OPM will send you a final decision or notify you of the status of OPM's review within 60 days. There are no other administrative appeals. If you do not agree with OPM's decision, your only recourse is to file a lawsuit. If you decide to sue, you must file the suit against OPM in Federal court by December 31 of the third year after the year in which you received the disputed services, drugs, or supplies or from the year in which you were denied precertification or prior approval. This is the only deadline that may not be extended. OPM may disclose the information it collects during the review process to support their disputed claim decision. This information will become part of the court record. You may not file a lawsuit until you have completed the disputed claims process. Further, Federal law governs your lawsuit, benefits, and payment of benefits. The Federal court will base its review on the record that was before OPM when OPM decided to uphold or overturn our decision. You may recover only the amount of benefits in dispute.

Note: **If you have a serious or life threatening condition** (one that may cause permanent loss of bodily functions or death if not treated as soon as possible), and you did not indicate that your claim was a claim for urgent care, then call us at 507-366-1400 in Panama, and 800-424-8196 or 312-935-3671 in the United States. We will expedite our review (if we have not yet responded to your claim); or we will inform OPM so they can quickly review your claim on appeal. You may call OPM's FEHB 2 at (202) 606-3818 between 8 a.m. and 5 p.m. Eastern Time.

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

Section 9. Coordinating Benefits with Medicare and Other Coverage

When you have other health coverage

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

When you have double coverage, one plan normally pays its benefits in full as the primary payor and the other plan pays a reduced benefit as the secondary payor. We, like other insurers, determine which coverage is primary according to the National Association of Insurance Commissioners' (NAIC) guidelines. For more information on NAIC rules regarding the coordinating of benefits, visit our website at https://www.pcabp.com.pa/members/services-1/summary-of-benefits-and-coverage.aspx.

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

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

Please see Section 4, Your Costs for Covered Services, for more information about how we pay claims.

- **TRICARE and CHAMPVA**

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

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

- **Workers' Compensation**

Every job-related injury or illness should be reported as soon as possible to your supervisor. Injury also means any illness or disease that is caused or aggravated by the employment as well as damage to medical braces, artificial limbs and other prosthetic devices. If you are a federal or postal employee, ask your supervisor to authorize medical treatment by use of form CA-16 before you obtain treatment. If your medical treatment is accepted by the Dept. of Labor Office of Workers' Compensation (OWCP), the provider will be compensated by OWCP. If your treatment is determined not job-related, we will process your benefit according to the terms of this plan, including use of in-network providers. Take form CA-16 and form OWCP-1500/HCFA-1500 to your provider, or send it to your provider as soon as possible after treatment, to avoid complications about whether your treatment is covered by this plan or by OWCP.

We do not cover services that:

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

• **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 or employing 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	Our right to pursue and receive subrogation and reimbursement recoveries is a condition of, and a limitation on, the nature of benefits or benefit payments and on the provision of benefits under our coverage. If you have received benefits or benefits payments as a result of an injury or illness and you our your representatives, heirs, administrators, successors, or assignees receive payment from any party that may be liable, a third party´s insurance policies, your own insurance policies, or a worker's compensation program or policy, you must reimburse us out of that payment. Our right of reimbursement extends to any payment received by settlement, judgment, or otherwise. We are entitled to reimbursement to the extent of the benefits we have paid or provide in connection with your injury or illness. However we will cover the cost of treatment that exceeds the amount of the payment you received. Reimbursement to us out of the payment shall take first priority (before any of the rights of any other parties are honored) and is not impacted by how the judgment, settlement, or other recovery is characterized, designated, or apportioned. Our right of reimbursement is not subject to reduction based on attorney fees or costs under the "common fund" doctrine and is fully enforceable regardless of whether you are "made whole" or fully compensated for the full amount of damages claimed. We may, at our option, choose to exercise our right of subrogation and pursue a recovery from any liable party as successor to your rights. If you do pursue a claim or case related to your injury or illness, you must promptly notify us and cooperate with our reimbursement or subrogation efforts.
When you have Federal Employees Dental and Vision Insurance Plan (FEDVIP)	Some FEHB plans already cover some dental and vision services. FEDVIP coverage pays secondary to that coverage. When you enroll in a dental and/or vision plan on BENEFEDS.com or by phone at 877-888-3337, (TTY 877-889-5680), you will be asked to provide information on your FEHB plan so that your plans can coordinate benefits. Providing your FEHB information may reduce your out-of-pocket cost.
Clinical Trials	An approved clinical trial includes a phase I, phase II, phase III, or phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition, and is either Federally-funded; conducted under an investigational new drug application reviewed by the Food and Drug Administration (FDA); or is a drug trial that is exempt from the requirement of an investigational new drug application. If you are a participant in a clinical trial, this health plan will provide related care as follows, if it is not provided by the clinical trial:

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

When you have Medicare

For more detailed information on "What is Medicare?" and "Should I Enroll in Medicare?" please contact Medicare at 1-800-MEDICARE (1-800-633-4227), (TTY 1-877-486-2048) or at www.medicare.gov.

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

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

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

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

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

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

When Original Medicare is the primary payor, Medicare processes your claim first. In most cases, your claim will be coordinated automatically and we will then provide secondary benefits for covered charges. To find out if you need to do something to file your claim, call us at 507-366-1400 in Panama, and 800-424-8196 or 312-935-3671 in the United States or visit our website at www.pcabp.com.pa.

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

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

Please review the following examples which illustrates your cost share if you are enrolled in Medicare Part B. If you purchase Medicare Part B, your provider is in our network and participates in Medicare, then we waive some costs because Medicare will be the primary payor.

Benefit Description: Deductible
You Pay without Medicare: In-Network: No deductible
You Pay without Medicare: Out-of-Network: No deductible
You Pay with Medicare Part B: In Network*: No deductible
You Pay with Medicare Part B: Out-of-Network: No deductible

Benefit Description: Catastrophic Protection Out-of-Pocket Maximum
You Pay without Medicare: In-Network: NA
You Pay without Medicare: Out-of-Network: $8,200 Self Only/$12,000 Self Plus One or Self and Family
You Pay with Medicare Part B: In Network*: NA
You Pay with Medicare Part B: Out-of-Network: NA

Benefit Description: Part B Premium Reimbursement Offered
You Pay without Medicare:In-Network: NA
You Pay without Medicare: Out-of-Network: NA
You Pay with Medicare Part B: In Network*: NA
You Pay with Medicare Part B: Out-of-Network: NA

Benefit Description: Primary Care Provider
You Pay without Medicare: In-Network*: $5
You Pay without Medicare: Out-of-Network: 50% of the FFS Plan allowance
You Pay with Medicare Part B: In Network*: NA
You Pay with Medicare Part B: Out-of-Network: WAIVED

Benefit Description: Specialist
You Pay without Medicare: In-Network*: $5
You Pay without Medicare: Out-of-Network: 50% of the FFS Plan allowance
You Pay with Medicare Part B: In Network*: NA
You Pay with Medicare Part B: Out-of-Network: WAIVED

Benefit Description: Inpatient Hospital
You Pay without Medicare: In-Network*: $25
You Pay without Medicare: Out-of-Network: $100 per admission and 50% of the covered charges
You Pay with Medicare Part B: In Network*: NA
You Pay with Medicare Part B: Out-of-Network: WAIVED**

Benefit Description: Outpatient Hospital
You Pay without Medicare:In-Network*: $25
You Pay without Medicare: Out-of-Network: 50% of the US FFS Plan allowance and any difference between our allowance and billed amount
You Pay with Medicare Part B: In Network*: NA
You Pay with Medicare Part B: Out-of-Network: WAIVED**

Benefit Description: Incentives Offered
You Pay without Medicare: In-Network: NA
You Pay without Medicare:Out-of-Network: NA
You Pay with Medicare Part B: In Network*: NA
You Pay with Medicare Part B:Out-of-Network: NA

*Reflect only provider network in the Republic of Panama.
**Cost share may differ for Medicare Part A recipients.

- **Tell us about your Medicare coverage**

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

- **Private contract with your physician**

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

- **Medicare Advantage (Part C)**

  If you are eligible for Medicare, you may choose to enroll in and get your Medicare benefits from a Medicare Advantage plan. These are private healthcare choices (like HMOs and regional PPOs) in some areas of the country. To learn more about Medicare Advantage plans, contact Medicare at 1-800-MEDICARE (1-800-633-4227), (TTY: 877-486-2048) or at www.medicare.gov.

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

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

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

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

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

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

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

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

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

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

If you:

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

Then, for your inpatient hospital care:

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

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

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

If your physician: Participates with Medicare,
Then you are responsible for: your deductibles, coinsurance or copayments, and any balances up to the Medicare approved amount.

If your physician: Does not participate with Medicare,
Then you are responsible for: your deductibles, coinsurance, copayments, and any balance up to 115% of the Medicare approved amount.

If your physician: Opts-out of Medicare via private contract
Then you are responsible for: your deductibles, coinsurance, copayments, and any balance your physician charges.

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.

Physicians Who Opt-Out of Medicare

A physician may have opted-out of Medicare and may or may-not ask you to sign a private contract agreeing that you can be billed directly for services ordinarily covered by Original Medicare. This is different than a non-participating doctor, and we recommend you ask your physician if they have opted-out of Medicare. Should you visit an opt-out physician, the physician will not be limited to 115% of the Medicare approved amount. You may be responsible for paying the difference between the billed amount and our regular in-network/out-of-network benefits.

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

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

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

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

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

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

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

Section 10. Definitions of Terms We Use in This Brochure

Assignment

An authorization by you (the enrollee or covered family member) that is approved by us (the Carrier), for us to issue payment of benefits directly to the provider.

- We reserve the right to pay you directly for all covered services. Benefits payable under the contract are not assignable by you to any person without express written approval from us, and in the absence of such approval, any assignment shall be void.
- Your specific written consent for a designated authorized representative to act on your behalf to request reconsideration of a claim decision (or, for an urgent care claim, for a representative to act on your behalf without designation) does not constitute an Assignment.
- OPM's contract with us, based on federal statute and regulation, gives you a right to seek judicial review of OPM's final action on the denial of a health benefits claim but it does not provide you with authority to assign your right to file such a lawsuit to any other person or entity. Any agreement you enter into with another person or entity (such as a provider, or other individual or entity) authorizing that person or entity to bring a lawsuit against OPM, whether or not acting on your behalf, does not constitute an Assignment, is not a valid authorization under this contract, and is void.

Calendar year

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

Clinical Trials Cost Categories

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

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

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

Coinsurance

See Section 4 page 22

Copayment

See Section 4 page 22

Cost-sharing

See Section 4 page 22

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 See Section 4 page 22

Emergency See page 55 for definition of emergency.

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

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

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

Group health coverage Healthcare 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 healthcare 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**.**

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

Infertility Infertility is the failure to achieve a successful pregnancy after regular, unprotected intercourse or artificial insemination for 12 months or more (6 months for individuals with female reproductive organs over age 35). Evaluation may be justified based on medical history and diagnostic testing. Infertility may also be established through an evaluation based on medical history and diagnostic testing.

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

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

2. Are consistent with standards of good medical practice in the United States and/or Panama;

3. Are not primarily for your personal comfort or convenience

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

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

Plan allowance

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

Panama Point-of-Service (In -network)

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

Panama Fee-for-Service

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

US Fee-for-Service

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

You should also see Important Notice About Surprise Billing – Know Your Rights in Section 4 that describes your protections against surprise billing under the No Surprises Act.

Post-service claims

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

Pre-service claims

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

Reimbursement

A carrier's pursuit of a recovery if a covered individual has suffered an illness or injury and has received, in connection with that illness or injury, a payment from any party that may be liable, any applicable insurance policy, or a workers' compensation program or insurance policy, and the terms of the carrier's health benefits plan require the covered individual, as a result of such payment, to reimburse the carrier out of the payment to the extent of the benefits initially paid or provided. The right of reimbursement is cumulative with and not exclusive of the right of subrogation

Subrogation

A carrier's pursuit of a recovery from any party that may be liable, any applicable insurance policy, or a workers' compensation program or insurance policy, as successor to the rights of a covered individual who suffered an illness or injury and has obtained benefits from that carrier's health benefits plan.

Surprise bill

An unexpected bill you receive for

- emergency care – when you have little or no say in the facility or provider from whom you receive care, or for
- non-emergency services furnished by nonparticipating providers with respect to patient visits to participating health care facilities, or for

- air ambulance services furnished by nonparticipating providers of air ambulance services.

Urgent care claims

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

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

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

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

Us/We

Us and we refer to Panama Canal Area Benefit Plan

You

You refers to the enrollee and each covered family member.

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Summary of Benefits for the Panama Canal Area Benefit Plan - 2024

Do not rely on this chart alone. This is a summary. All benefits are subject to the definitions, limitations, and exclusions in this brochure. Before making a final decision, please read this FEHB brochure. You can also obtain a copy of our Summary of Benefits and Coverage as required by the Affordable Care Act at https://pcabp.com.pa/members/services-1/summary-of-benefits-and-coverage.aspx.

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 owe any difference between our allowance and the billed amount. If you are a POS member and receive your medical care through your primary care provider 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
Services provided by physicians: Diagnostic and treatment services provided in the office	POS: $5 copayment FFS Panama: 50% of the Panama POS Fee schedule amount and any difference between the POS Fee schedule and the billed amount FFS US: 50% of the US FFS Plan allowance and any difference between our allowance and the billed amount	28
Services provided by a hospital: Inpatient	POS: Nothing after the $25 per admission copayment FFS Panama: $100 per admission, then 50% of the Panama POS fee schedule amount and any difference between the POS Fee schedule and the billed amount FFS US: $100 per admission and 50% of the covered charges	51
Services provided by a hospital: Outpatient	POS: $25 copayment to facility for surgeries and nothing for other services FFS Panama: 50% of the Panama POS Fee schedule amount and any difference between the POS Fee schedule and the billed amount FFS US: 50% of the US FFS Plan allowance and any difference between our allowance and the billed amount	52
Emergency Benefits: • Accidental injury (after 72 hours) • Medical Emergency	POS: $5 copayment FFS Panama: 50% of the Panama POS Fee schedule amount and any difference between the POS Fee schedule and the billed amount FFS US: 50% of the US FFS Plan allowance and any difference between our allowance and the billed amount	55 - 56
Mental Health and Substance Use Disorder Treatment	Regular cost-sharing	58
Prescription Drugs: FDA and Plan approved medication	Generic drugs: 20% of eligible charges Brand name drugs: 30% of eligible charges Note: Coinsurance for prescription drugs goes towards the out-of-pocket maximum of $8,200 for Self Only enrollment, and $12,000 for Self Plus One and Self and Family enrollments per year.	60

Benefits	You Pay	Page
Dental Care	All charges in excess of the fee schedule	64
Protection against catastrophic costs	All charges that exceed our allowance After the out-of-pocket maximum of $8,200 for Self Only enrollment, and $12,000 for Self Plus One and Self and Family enrollments for all essential health benefits per year, we will pay 100% of our allowable amount for the remainder of the calendar year. Note: Some costs do not count toward this out-of-pocket maximum. Please refer to Section 4. Your costs for covered services.	24

Notes

Notes

2024 Rate Information for the Panama Canal Area Benefit Plan

To compare your FEHB health plan options please go to www.opm.gov/fehbcompare.

Type of Enrollment	Enrollment Code	Premium Rate			
		Biweekly		Monthly	
		Gov't Share	Your Share	Gov't Share	Your Share
Self Only	431	$271.43	$115.76	$588.10	$250.81
Self Plus One	433	$585.01	$195.00	$1,267.52	$422.50
Self and Family	432	$611.84	$203.94	$1,325.64	$441.88