The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. **This is only a summary.** Please read the FEHB Plan brochure ([RI 72-004]) that contains the complete terms of this plan. **All benefits are subject to the definitions, limitations, and exclusions set forth in the FEHB Plan brochure**. Benefits may vary if you have other coverage, such as Medicare. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can get the FEHB Plan brochure at www.pcabp.com.pa and view the Glossary at www.pcabp.com.pa. You can call 507-366-1400 in Panama, or 1-800-424-8196 in the US to request a copy of either document.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$0	See the Common Medical Events chart below for your costs for services this plan covers.
Are there services covered before you meet your deductible?	No	This plan does not have any deductible.
Are there other deductibles for specific services?	No	You don´t have to meet any deductible for specific services.
What is the out-of-pocket limit for this plan?	$2,500 FFS Inpatient Hospital per person $5,000 Prescription Drugs per person.	The out-of-pocket limit is the most you could pay in a year for covered services.
What is not included in the out-of-pocket limit?	Copayments, premiums, balance-billing charges, penalties for failure to obtain preauthorization for services, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out–of–pocket limit.
Will you pay less if you use a network provider?	Yes. See www.pcabp.com.pa or call 507-366-1400 in Panama for a list of network providers in Panama.	This plan uses a provider network in Panama. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	Yes. You need a referral under Point-of-Service in the Republic of Panama.	This plan will pay some or all of the costs to see a specialist for covered services but only if you have a referral before you see the specialist.

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most, plus you may be balance billed)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	POS: $5 copay/visit	FFS: 50% coinsurance	
	Specialist visit	POS: $5 copay/visit	FFS: 50% coinsurance	Referral required under POS
	Preventive care/screening/ immunization	POS • PC: no charge • Screening: no charge • Immunization: no charge	FFS • PC: no charge for those recommended by USPSTF • Screening: no charge for those recommended by USPSTF • Immunization: no charge for those recommended by USPSTF	Adult routine checkups limited to two per calendar year. You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	POS: no charge	FFS: 50% coinsurance	Pre-authorization required for X-Ray.
	Imaging (CT/PET scans, MRIs)	POS: no charge	FFS: 50% coinsurance	Pre-authorizations required for PET & CAT Scans/ MRIs.
If you need drugs to treat your illness or condition For more information about **prescription drug coverage**, you can call 507-366-1400 in Panama, or 1-800-424-8196 in the US.	Generic drugs and Brand Name drugs	POS: 20% coinsurance	FFS: 20% coinsurance	$5,000 annual prescription out-of-pocket maximum. FDA approved medications only.
	Plan approved medication to treat diabetes, cancer, aplastic anemia, sickle cell anemia, asthma, COPD, and myelodysplasia syndrome	POS: No charge	FFS: No coinsurance	$5,000 annual prescription out-of-pocket limit. All medication must be approved by the Plan or be listed on the diabetes formulary.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	POS: $25 copay	FFS: 50% coinsurance	Pre-authorization required.
	Physician/surgeon fees	POS: No charge	FFS: 50% coinsurance	Pre-authorization required.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most, plus you may be balance billed)	
If you need immediate medical attention	Emergency room care	POS: $5 copay/ visit	FFS: 50% coinsurance	Must receive care within 72 hours for an accidental injury to be covered at 100% for POS option.
	Emergency medical transportation	POS: No charge up to $100	FFS: No charge up to $100	$ 100 allowance per occurrence. $ 200.00 allowance for inter-province ambulance use under POS option. Must be admitted to a hospital for coverage to apply.
	Urgent care	POS: no charge for Professional services of physicians only.	FFS: 50% coinsurance	For all other services, outpatient service benefits apply.
If you have a hospital stay	Facility fee (e.g., hospital room)	POS: $25 copay/admission	FFS: $100 copay/ admission and 50% coinsurance	$2,500 FFS Inpatient Hospital limit applies. Preauthorization required.
	Physician/surgeon fees	POS: no charge	FFS: 50% coinsurance	Preauthorization required.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Mental/ Behavioral/ POS: $5 copay/ visit and no charge for outpatient services at hospital, facility. Substance Abuse : POS: $5 copay visit	Mental/ Behavioral/ FFS: 50% coinsurance Substance Abuse : FFS: 50% coinsurance	Pre-authorization required. Referrals required from primary care physician for POS option.
	Inpatient services	Mental/ Behavioral/ POS: No charge. Substance Abuse : POS: No charge visit for hospital visits and $25 copay per hospitalization.	Mental/ Behavioral/ FFS: No charge up to $35/day/ doctor and all charges thereafter Substance Abuse: No charge up to $35/day/ doctor for inpatient hospital visits and 50% coinsurance for hospital or physician inpatient services.	Pre- authorization required. Not to exceed an allowance of $ 35 per day for FFS option.
If you are pregnant	Office visits	POS: No charge	FFS: No charge	
	Childbirth/delivery professional services	POS: No charge	FFS: No charge	Referrals required from primary care physician for POS option.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most, plus you may be balance billed)	
	Childbirth/delivery facility services	POS: $25 copay/ admission	FFS: $100 copay/ admission and 50% coinsurance	Pre- authorization required for extended stays for you or your baby.
If you need help recovering or have other special health needs	Home health care	POS: no charge	FFS: 50% coinsurance	Pre-authorization required. Up to 40 visits per calendar year.
	Rehabilitation services	POS: no charge	FFS: 50% coinsurance	Limited to 40 visits combined per person per year. Pre- authorization is required.
	Habilitation services	POS: no charge	FFS: 50% coinsurance	Limited to 40 visits combined per person per year. Pre-authorization is required.
	Skilled nursing care	POS: no charge	FFS: 50% of the Plan allowance	Pre- authorization required.
	Durable medical equipment	POS: 30% of the Plan allowance and any amount that exceeds our allowance	FFS: 30% of the Plan allowance and any amount that exceeds our allowance	Pre-authorization required for all DME
	Hospice services	POS: no charge	FFS: 50% of the Plan allowance	Must have a life expectancy of six months or less. $5,000 lifetime maximum. Pre-authorization required.
If your child needs dental or eye care	Children's eye exam	Not covered for eye refractions	Not covered for eye refractions	One screening examinations for amblyopia and strabismus for (ages 3 through 6).
	Children's glasses	Not covered	Not covered	
	Children's dental check-up	POS: No charge up to $20/visit	FFS: No charge up to $20/ visit	Oral prophylaxis or periodontal maintenance limited to two visits per calendar year.

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your plan's FEHB brochure for more information and a list of any other excluded services.)

- Cosmetic surgery.
- Long- Term care
- Naturopathic services
- Nonprescription medicines and non FDA
- Penalty due to failure obtain preauthorization for services
- Private-duty nursing
- Routine eye care (Adult)
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan's FEHB brochure.)

- Acupuncture (only for anesthesia or pain relief)
- Chiropractic care
- Bariatric Surgery
- Hearing aids
- Infertility treatment (only diagnosis and treatment of infertility including fertility drugs)
- Limited Dental care (Adult)
- Routine foot care (only if you are under active treatment for a metabolic or peripheral vascular disease, such as diabetes)
- Non-emergency care when travelling outside U.S.

Your Rights to Continue Coverage: You can get help if you want to continue your coverage after it ends. See the FEHB Plan brochure, contact your HR office/retirement system, contact your plan at 507-366-1400 in Panama or 1-800-424-8196 in the US, or visit www.opm.gov.insure/health. Generally, if you lose coverage under the plan, then, depending on the circumstances, you may be eligible for a 31-day free extension of coverage, a conversion policy (a non-FEHB individual policy), spouse equity coverage, or receive temporary continuation of coverage (TCC). Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: If you are dissatisfied with a denial of coverage for claims under your plan, you may be able to appeal. For information about your appeal rights please see Section 3, "How you get care," and Section 8 "The disputed claims process," in your plan's FEHB brochure. If you need assistance, you can contact: 507-366-1400 in Panama, or 1-800-424-8196 in the U.S.

Language Access Services:
[Spanish (Español): Para obtener asistencia en español, llame al 1-800-424-8196

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network (POS) pre-natal care and a hospital delivery)

- **The plan's overall deductible** **$0**
- **Specialist *[cost sharing]*** **$0**
- **Hospital (facility) *[cost sharing]*** **$25**
- **Other *[cost sharing]*** **0%**

This EXAMPLE event includes services like:
Specialist office visits (*prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$0
Copayments	$25
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Peg would pay is	$25

Managing Joe's type 2 Diabetes
(a year of routine in-network (POS) care of a well-controlled condition)

- **The plan's overall deductible** **$0**
- **Specialist *[cost sharing]*** **$0**
- **Hospital (facility) *[cost sharing]*** **0%**
- **Other *[cost sharing]*** **0%**

This EXAMPLE event includes services like:
Primary care physician office visits (*including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$0
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	$0

Note: These numbers assume the patient is participating in our diabetes management program under POS option and have not met his or her two check-ups per calendar year. If you have diabetes and do not participate in the program, your costs may be higher. For more information, please call us at 507- 366-1400 in Panama.

Mia's Simple Fracture
(in-network (POS) emergency room visit and follow up care)

- **The plan's overall deductible** $0
- **Specialist *[cost sharing]*** **$0**
- **Hospital (facility) *[cost sharing]*** **0%**
- **Other *[cost sharing]*** **0%**

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$1,900**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$0
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$0**

The **plan** would be responsible for the other costs of these EXAMPLE covered services.