Coventry Health Care of Kansas, Inc.

http://www.chckansas.com

Customer Service: 1-800-969-3343

2015

A Health Maintenance Organization (High and Standard option), and a High Deductible Health Plan

This plan's health coverage qualifies as minimum essential coverage and meets the minimum value standard for the benefits it provides. See page 4 for details.

IMPORTANT
- Rates: Back Cover
- Changes for 2015: Page 16
- Summary of benefits: Page 135

Serving: **Kansas City Metropolitan Area (Kansas and Missouri)**

Enrollment in this plan is limited. You must live or work in our geographic service area to enroll. See page 15 for requirements.

Enrollment codes:

HA1	**High Option - Self Only**
HA2	**High Option - Self and Family**
HA4	**Standard Option - Self Only**
HA5	**Standard Option - Self and Family**
9H1	**HDHP - Self Only**
9H2	**HDHP - Self and Family**

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 73-128

Important Notice from Coventry Health Care of Kansas, Inc. About Our Prescription Drug Coverage and Medicare

The Office of Personnel Management (OPM) has determined that Coventry Health Care of Kansas, Inc. 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's as least as good as Medicare's prescription drug coverage, your monthly Medicare Part D premium will go up a 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 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 1-800-772-1213 (TTY 1-800-325-0778).

You can get more information about Medicare prescription drug plans and the coverage offered in your area from these places:

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

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Introduction

This brochure describes the benefits of Coventry Health Care of Kansas, Inc., under our contract (CS 1948) with the United States Office of Personnel Management, as authorized by the Federal Employees Health Benefits law. Customer Service may be reached at 1-800-969-3343 or through our website: www.chckansas.com. The address for Coventry Health Care of Kansas, Inc., administrative office is:

Coventry Health Care of Kansas, Inc.
9401 Indian Creek Parkway
Overland Park, KS 66210

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

If you are enrolled in this Plan, you are entitled to the benefits described in this brochure. If you are enrolled in Self and Family coverage, each eligible family member is also entitled to these benefits. You do not have a right to benefits that were available before January 1, 2015, unless those benefits are also shown in this brochure.

OPM negotiates benefits and rates with each Plan annually. Benefit changes are effective January 1, 2015 and changes are summarized on page 16. Rates are shown at the end of this brochure.

Coverage under this plan qualifies as minimum essential coverage (MEC) and satisfies the Patient Protection and Affordable Care Act's (ACA) individual shared responsibility requirements. 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.

The ACA establishes a minimum value for the standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). The health coverage of this plan does meet the minimum value standard for the benefits the plan provides.

Plain Language

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

- Except for necessary technical terms, we use common words. For instance, “you” means the enrollee or family member, “we” means Coventry Health Care of Kansas, Inc.
- 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 Health Care Fraud!

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

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

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

- Do not give your Plan identification (ID) number over the telephone or to people you do not know, except to your health care providers, authorized health benefits plan or OPM representative.
- Let only the appropriate medical professionals review your medical record or recommend services.
- Avoid using health care providers who say that an item or service is not usually covered, but they know how to bill us to get it paid.

- Carefully review explanations of benefits (EOBs) statements that you receive from us.
- Periodically review your claims 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 us at 1-800-969-3343 and explain the situation.
  - If we do not resolve the issue:

CALL - THE HEALTH CARE FRAUD HOTLINE
877-499-7295

OR go to www.opm.gov/oig

You can also write to:

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

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

Preventing Medical Mistakes

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

1. **Ask questions if you have doubts or concerns.**
   - Ask questions and make sure you understand the answers.
   - Choose a doctor with whom you feel comfortable talking.
   - Take a relative or friend with you to help you ask questions and understand answers.

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

- Bring the actual medicines or give your doctor and pharmacist a list of all the medicines and dosage that you take, including non-prescription (over-the-counter) medicines and nutritional supplements.
- Tell your doctor and pharmacist about any drug, food, and other allergies you have, such as to 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 medicine is what the doctor ordered. Ask the pharmacist about your medicine if it looks different than you expected.
- Read the label and patient package insert when you get your medicine, including all warnings and instructions
- Know how to use your medicine. Especially note the times and conditions when your medicine should and should not be taken.
- Contact your doctor or pharmacist if you have any questions.

3. **Get the results of any test or procedure.**

- Ask when and how you will get the results of test or procedures.
- Don't assume the results are fine if you do not get them when expected, be it in person, by phone, or by mail.
- Call your doctor and ask for your results.
- Ask what the results mean for your care.

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

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

5. **Make sure you understand what will happen if you need surgery.**

- Make sure you, your doctor, and your surgeon all agree on exactly what will be done during the operation.
- Ask your doctor, "Who will manage my care when I am in the hospital?"
- Ask your surgeon:
  - "Exactly what will you be doing?"
  - "About how long will it take?"
  - "What will happen after surgery?"
  - "How can I expect to feel during recovery?"
- Tell the surgeon, anesthesiologist, and nurses about any allergies, bad reactions to anesthesia, and any medications or nutritional supplements you are taking.

Patient Safety Links

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

Never Events

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

We have a benefit payment policy that encourages hospitals to reduce the likelihood of hospital-acquired conditions such as certain infections, severe bedsores and fractures; and reduce medical errors that should never happen. These conditions and errors are called "Never Events". When a Never Event occurs, neither your FEHB plan nor you will incur cost 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 Coventry Health Care of Kansas, Inc. preferred providers. This policy helps to protect you from preventable medical errors and improve the quality of care you receive.

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 (MEC) and satisfies the Patient Protection and Affordable Care Act's (ACA) individual shared responsibility requirement. 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 costs of essential health benefits. The 60% standard is an actuarial value; your specific out-of-pocket costs are determined as explained in this brochure.

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

  See www.opm.gov/insure/health for enrollment information as well as:

  - Information on the FEHB Program and plans available to you
  - A health plan comparison tool
  - A list of agencies 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, and give you a *Guide to Federal Benefits,* brochures for other plans, and other materials you need to make an informed decision about your FEHB coverage. These materials tell you:

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

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

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

  Self Only coverage is for you alone. Self and Family coverage is for you, your spouse, and your dependent children under age 26, including any foster children 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 and Family enrollment if you marry, give birth, or add a child to your family. You may change your enrollment 31 days before to 60 days after that event.

  The Self and Family enrollment begins on the first day of the pay period in which the child is born or becomes an eligible family member. When you change to Self and Family because you marry, the change is effective on the first day of the pay period that begins after your employing office receives your enrollment form; benefits will not be available to your spouse until you marry.

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

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

If you have a qualifying life event (QLE) - such as marriage, divorce, or the birth of a child - outside of the Federal Benefits Open Season, you may be eligible to enroll in the FEHB program, change your enrollment, or cancel coverage. For a complete list of QLEs, visit the FEHB website at www.opm.gov/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 a valid common law marriage) and children as described in the chart below.

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

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

- **Children's Equity Act**

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

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

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

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

- **When benefits and premiums start**

The benefits in this brochure are effective January 1. If you joined this Plan during Open Season, your coverage begins on the first day of your first pay period that starts on or after January 1. **If you changed plans or plan options during Open Season and you receive care between January 1 and the effective date of coverage under your new plan or option, your claims will be paid according to the 2015 benefits of your old plan or option.** However, if your old plan left the FEHB Program at the end of the year, you are covered under that plan's 2014 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 benefits under the Plan during the continuance of the confinement but not beyond the 60th day after the end of the 31 day temporary extension.

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

- **Upon divorce**

If you are divorced from a Federal employee or annuitant, you may not continue to get benefits under your former spouse's enrollment. This is the case even when the court has ordered your former spouse to provide health coverage for you. However, you may be eligible for your own FEHB coverage under either the spouse equity law or Temporary Continuation of Coverage (TCC). If you are recently divorced or are anticipating a divorce, contact your ex-spouse's employing or retirement office to get RI 70-5, the *Guide to Federal Benefits for Temporary Continuation of Coverage and Former Spouse Enrollees,* or other information about your coverage choices. You can also download the guide from OPM's website, www.opm.gov/healthcare-insurance/healthcare/plan-information/guides.

- **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). The Affordable Care Act (ACA) did not eliminate TCC or change the TCC rules. For example, you can receive TCC if you are not able to continue your FEHB enrollment after you retire, if you lose your Federal job, if you are a covered dependent child and you turn age 26, regardless of marital status, etc.

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

Enrolling in TCC. Get the RI 79-27, which describes TCC, and the RI 70-5, the Guide to Federal Benefits for Temporary Continuation of Coverage and Former Spouse Enrollees, from your employing or retirement office or from www.opm.gov/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 new kind of tax credit that lowers your monthly premiums. Visit www.HealthCare.gov to compare plans and see what your premium, deductible, and out-of-pocket costs would be before you make a decision to enroll. Finally, if you qualify for 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 FEHBP coverage.

- **Converting to individual coverage**

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

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

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

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

- **Health Insurance Marketplace**

If you would like to purchase health insurance through the Affordable Care Act'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 health maintenance organization (HMO). We require you to see specific physicians, hospitals, and other providers that contract with us. These Plan providers coordinate your health care services. The Plan is solely responsible for the selection of these providers in your area. Contact the Plan for a copy of their most recent provider directory. We give you a choice of enrollment in a High Option, a Standard Option, or a High Deductible Health Plan (HDHP).

HMOs emphasize preventive care such as routine office visits, physical exams, well-baby care, and immunizations, in addition to treatment for illness and injury. Our providers follow generally accepted medical practice when prescribing any course of treatment.

When you receive services from Plan providers, you will not have to submit claim forms or pay bills. You pay only the copayments, coinsurance, and deductibles described in this brochure. When you receive emergency services from non-Plan providers, you may have to submit claim forms.

You should join an HMO because you prefer the Plan's benefits, not because a particular provider is available. You cannot change Plans because a provider leaves our Plan. We cannot guarantee that any one physician, hospital, or other provider will be available and/or remain under contract with us.

General features of both our High and Standard Options

Features of our High Option

- A calendar year deductible of $1,000 Self Only and limited to $3,000 Self and Family.
- The catastrophic protection per calendar year is limited to $5,000 for Self Only and $10,000 for Self and Family.

Features of our Standard Option

- A calendar year deductible of $2,000 Self Only and limited to $6,000 Self and Family.
- The catastrophic protection per calendar year is limited to $5,000 for Self Only and $10,000 for Self and Family.

We have Open Access Benefits

- You are **not** required to select a primary care physician.
- These Plans allow you direct access to Plan providers, no referrals are necessary. Please be sure the provider you select – or the provider or facility you are referred to – is part of the Coventry Network. It is ultimately your responsibility to verify this information. By doing so, you get the most from your health Plan and protect yourself from paying more than you have to for covered benefits.
- These Plans include annual wellness/preventive care exams to you at no cost.
- These Plans provide diabetic and nutritional counseling if you are diagnosed with high cholesterol, high blood pressure, diabetes, and obesity.
- Routine eye exams are available to all members. Please select from one of our Coventry Network Optometrists.
- These Plans include preventive dental diagnostic services using the Coventry Dental Network.

How we pay providers

We contract with individual physicians, medical groups, and hospitals to provide the benefits in this brochure. These Plan providers accept a negotiated payment from us, and you will only be responsible for your copayments, coinsurance and applicable deductible(s).

General features of our High Deductible Health Plan (HDHP)

HDHPs have higher annual deductibles and annual out-of-pocket maximum limits than other types of FEHB plans. FEHB Program HDHPs also offer health savings accounts or health reimbursement arrangements. Please see below for more information about these savings features.

An HDHP is a health plan product that provides traditional health care coverage and a tax advantaged way to help you build savings for future medical needs. An HDHP with an HSA or HRA is designed to give greater flexibility and discretion over how you use your health care benefits. As an informed consumer, you decide how to utilize your Plan coverage with a high deductible and out-of-pocket expenses limited by catastrophic protection. And you decide how to spend the dollars in your HSA or HRA. You may consider:

- Using the most cost effective provider.
- Actively pursuing a healthier lifestyle and utilizing your preventive care benefit.
- Becoming an informed health care consumer so you can be more involved in the treatment of any medical conditions or chronic illness.

The type and extent of covered services, and the amount we allow, may be different from other plans. Read our brochure carefully to understand the benefits and features of this HDHP. Internal Revenue Service (IRS) rules govern the administration of all HDHPs. The IRS Website at http://www.ustreas.gov/offices/public-affairs/hsa/faq1.html has additional information about HDHPs.

Preventive care services

Preventive care services generally covered with no cost-sharing and are not subject to copayments, deductibles, or annual limits when received from a network provider.

Annual deductible

The annual deductible must be met before Plan benefits are paid for care other than preventive services.

Health Savings Account (HSA)

You are eligible for a Health Savings Account (HSA) if you are enrolled in an HDHP, not covered by any other health plan that is not an HDHP (including a spouses's health plan, but does not include specific injury insurance and accident, disability, dental care, vision care, or long-term care coverage), not enrolled in Medicare, not received VA or Indian Health Services (IHS) benefits within the last three (3) months, not covered by your own or your spouse's flexible spending account (FSA), and are not claimed as a dependent on someone else's tax return.

- You may use the money in your HSA to pay all or a portion of the annual deductible, copayments, coinsurance, or other out-of-pocket costs that meet the IRS definition of a qualified medical expense.
- Distributions from your HSA are tax-free for qualified medical expenses for you, your spouse, and your dependents, even if they are not covered by a HDHP.
- You may withdraw money from your HSA for items other than qualified medical expenses, but will be subject to income tax and, if you are under 65 years old, an additional 20% penalty tax on the amount withdrawn.
- For each month that you are enrolled in an HDHP and eligible for an HSA, the HDHP will pass through (contribute) a portion of the health plan premium to your HSA. You (the account holder) may contribute your own money to your HSA up to an allowable amount determined by IRS rules. Your HSA dollars earn tax-free interest.
- You may allow the contributions in your HSA to grow over time, like a savings account. The HSA is portable – you may take the HSA with you if you leave the Federal government or switch to another plan.

Health Reimbursement Arrangement (HRA)

If you are not eligible for an HSA or become ineligible to continue an HSA, you are eligible for a Health Reimbursement Arrangement (HRA). Although and HRA is similar to an HSA, there are major differences.

- An HRA does not earn interest.
- An HRA is not portable if you leave the Federal government or switch to another plan.

Catastrophic protection

We protect you against catastrophic out-of-pocket expenses for covered services. Your annual out-of-pocket expenses for covered services, including deductibles and copayments, cannot exceed $6,450 for Self Only enrollment, or $12,900 for Self and Family coverage.

Smart Payment From Coventry Consumer Choice

You now have a choice to direct payments individually with Smart Payment. This new functionality gives you more control of your health care finances. This capability will help you control your health care costs and manage the funds to pay for them. You have complete control with C3 Smart Payment. Through My Online Services, www.chckansas.com, you can change the default on your accounts.

Spend: When your payment choice is in the Spend mode, your cost-sharing eligible expenses (deductible, copay and coinsurance) aligned with the medical and pharmacy plan are automatically processed and available funds are paid to the member or provider as follows:

Copays: Pay to member

Deductible: Pay to provider

Coinsurance: Pay to provider

Pharmacy and other manual claims will always pay the member.

Save Review: In the Save Review mode you have a choice to review your claims and actively release each claim to a provider or yourself. With this option, you can also decide not to pay a claim from your HSA or HRA. When your payment choice is in this mode, you will be expected to manage your claims individually. For example:

Claim #1: Save – don't pay

Claim #2: Pay to provider

Claim #3: Reimburse you

Save: In Save mode, the only way to access your funds is to submit a manual claim.

Who provides my healthcare

Coventry Health Care of Kansas, Inc., provides you with a comprehensive benefit package that covers many kinds of health services for a fixed payroll deduction and minimal copayments. As a participant of Coventry Health Care of Kansas, Inc. you are no longer required to select a primary care physician and may access any participating provider for your care. You may choose to continue your current physician relationship however you will no longer need to obtain specialist referrals. This will enable you to self-refer within the Coventry network as necessary. Please visit our website at www.chckansas.com for up to date provider information. It is your responsibility to verify your treating physician continues to be a part of Coventry's network by calling Customer Service Department at 1-800-969-3343.

The Plan's provider directory lists primary care doctors (generally family practitioners, pediatricians, and internists) and specialists with their locations and phone numbers, and notes whether or not the doctor is accepting new patients. Directories are updated on a regular basis and are available at the time of enrollment or upon request by calling the Customer Service Department at 1-800-969-3343. You can also find out if your doctor participates by calling this number. The list is also on our website. Visit www.chckansas.com to utilize our doctor search option. Our doctor search on the web is updated monthly.

If you are interested in receiving care from a specific provider who is listed in the directory, call the provider to verify that he or she still participates with the Plan and is accepting new patients. Important note: When you enroll in the Plan, services (except for emergency benefits) are provided through the Plan's delivery system; the continued availability and/or participation of any one doctor, hospital, or other provider, cannot be guaranteed.

Health education resources and accounts management tools

Your Rights

OPM requires that all FEHB Plans provide certain information to their FEHB members. You may get information about us, our networks, and our providers. OPM's FEHB website (www.opm.gov/healthcare-insurance) lists the specific types of information that we must make available to you. Some of the required information is listed below.

Coventry Health Care of Kansas, Inc., is a for profit domiciled Kansas health maintenance organization (HMO) with certificates of authority to operate in both Kansas and Missouri. Coventry Health Care of Kansas, Inc., has been in existence since 1961, and a total membership of approximately 140,000. We are dedicated to providing quality health care at an affordable price, and we provide our members the security of knowing they are being offered a health care delivery system supported by a long tradition of quality and service.

If you want more information about us, call 1-800-969-3343, or write to Coventry Health Care of Kansas, Inc. 9401 Indian Creek Parkway, Overland Park, KS 66210. You may also contact us by visiting our website at www.chckansas.com.

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.

Service Area

To enroll in this Plan, you must live in or work in our service area. This is where our providers practice.

Our Kansas City Metropolitan service area is:

Kansas – Anderson, Allen, Atchison, Bourbon, Brown, Cherokee, Crawford, Doniphan, Douglas, Franklin, Jackson, Jefferson, Johnson, Labette, Leavenworth, Linn, Marshall, Miami, Montgomery, Neosho, Osage, Pottawatomie, Shawnee, Wabaunsee, and Wyandotte Counties

Missouri – Andrew, Barton, Benton, Buchanan, Caldwell, Carroll, Cass, Christian, Clay, Clinton, Dade, Dallas, Daviess, DeKalb, Gentry, Greene, Grundy, Henry, Jackson, Jasper, Johnson, Lafayette, Lawrence, Livingston, Newton, Pettis, Polk, Platte, Ray, Vernon and Webster Counties

Ordinarily, you must get your care from providers who contract with us. If you receive care outside our service area, we will pay only for emergency care benefits. We will not pay for any other health care services out of our service area unless the services have prior Plan approval.

If you or a covered family member move outside of our service area, you can enroll in another Plan. If your dependents live out of the area (for example, if your child goes to college in another state), you should consider enrolling in a fee-for-service plan or an HMO that has agreements with affiliates in other areas. If you or a family member move, you do not have to wait until Open Season to change plans. Contact your employing or retirement office.

Section 2. Changes for 2015

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 the Plan (All Options)

- No benefit changes for 2015.

Changes to High Option Only

- Your share of the non-postal premium will increase for Self-Only and increase for Self and Family. (See the Back Cover)

Changes to Standard Option Only

- Your share of the non-postal premium will increase for Self-Only and increase for Self and Family. (See the Back Cover)

Changes to High Deductible Health Plan (HDHP) Only

- Your share of the non-postal premium will increase for Self-Only and increase for Self and Family. (See the Back Cover)

Section 3. How you get care

Identification cards

We will send you a medical/prescription drug and dental 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 medical replacement cards, call us at 1-800-969-3343 or write to us at Coventry Health Care of Kansas, Inc., 9401 Indian Creek Parkway, Overland Park, KS 66210. You may also request replacement cards through our website at www.chckansas.com. If you need dental replacement cards, call Coventry Dental at 1-866-690-4910 or write to us at Coventry Dental, 111 Rockville Pike, Suite 950; P.O. Box 10949; Rockville, MD 20849. You may also request replacement cards through the website at www.chckansas.com.

Where you get covered care

You get care from "Plan providers" and "Plan facilities." You will only pay copayments, deductibles, and/or coinsurance.

- **Plan providers**

Plan providers are physicians and other health care professionals in our service area that we contract with to provide covered services to our members. We credential Plan providers according to national standards.

We list Plan providers in the provider directory, which we update periodically. The list is also on our website. Visit www.chckansas.com to utilize our doctor search option. Our doctor search on the web is updated monthly.

- **Plan facilities**

Plan facilities are hospitals and other facilities in our service area that we contract with to provide covered services to our members. We list these in the provider directory, which we update periodically. The list is also on our website www.chckansas.com.

What you must do to get covered care

You are no longer required to select a Primary Care Physician or obtain a referral to a participating specialist. You now have direct access to any HMO participating or Plan provider. You may choose to continue your current physician relationship however you will no longer need to obtain specialist referrals. This will enable you to self-refer within the Coventry network as necessary. Please visit our website at www.chckansas.com for up to date provider information. It is your responsibility to verify your treating physician continues to be apart of Coventry's network by calling Customer Service Department at 1-800-969-3343.

The Plan's provider directory lists primary care doctors (generally family practitioners, pediatricians, and internists) and specialists with their locations and phone numbers, and notes whether or not the doctor is accepting new patients. Directories are updated on a regular basis and are available at the time of enrollment or upon request by calling the Customer Service Department at 1-800-969-3343. You can also find out if your doctor participates by calling this number. The list is also on our website. Visit www.chckansas.comto utilize our doctor search option. Our doctor search on the web is updated monthly.

If you are interested in receiving care from a specific provider who is listed in the directory, call the provider to verify that he or she still participates with the Plan and is accepting new patients. Important note: When you enroll in the Plan, services (except for emergency benefits) are provided through the Plan's delivery system; the continued availability and/or participation of any one doctor, hospital, or other provider, cannot be guaranteed.

- **Primary care** — A primary care physician will generally be a family practitioner, internist, general practitioner, and pediatricians. A primary care physician may provide most of your health care, or offer guidance in selecting a specialist.

- **Specialty care** — You can go directly to a specialist for care without obtaining a referral from your primary care physician, however, it is your responsibility to make sure the referred provider is participating. Your primary care physician may assist you in selecting a specialist for needed care.

  Here are some other things you should know about specialty care:

  - If you need to see a specialist frequently because of a chronic, complex, or serious medical condition, a primary care physician may work with the specialist to develop a treatment plan. Your physician will use our criteria when creating your treatment plan (the physician may have to get an authorization or approval beforehand).
  - If you are seeing a specialist when you enroll in our Plan, please verify with the Plan whether your current physician is a participating provider. If your current specialist does not participate with us, you must receive treatment from a specialist who does. Generally, we will not pay for you to see a specialist who does not participate with our Plan. Please be sure the provider you select – or the provider or facility you are referred to – is part of the Coventry Network. It is ultimately your responsibility to verify this information. By doing so, you get the most from your health Plan and protect yourself from paying more than you have to for covered benefits.
  - If you are seeing a specialist and your specialist leaves the Plan, the Plan will assist you in finding another participating specialist. You may receive services from your current specialist until we can make arrangements for you to see someone else.
  - If you have a chronic and disabling condition and lose access to your specialist because we:
    - terminate our contract with your specialist for other than cause;
    - drop out of the Federal Employees Health Benefits (FEHB) Program and you enroll in another FEHB program plan; or
    - reduce our service area and you enroll in another FEHB plan;

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

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

- **Hospital care** — Your Plan primary care physician will make necessary hospital arrangements. Please be sure the provider you select – or the provider or facility you are referred to – is part of the Coventry Network. It is ultimately your responsibility to verify this information. By doing so, you get the most from your health plan and protect yourself from paying more than you have to for covered benefits.

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 1-800-969-3343. If you are new to the FEHB Program, we will arrange for you to receive care and provide benefits 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 Program in whole or in part, or if OPM orders an enrollment change, this continuation of coverage provision does not apply. In such case, the hospitalized family member's benefits under the new plan begin on the effective date of enrollment.

You need prior Plan approval for certain services

Since your primary care physician arranges most referrals to specialists and inpatient hospitalization, the pre-service claim approval process only applies to care show under *Other services.*

- **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.

- **Other services**

Your primary care physician has authority to refer you for the most services. For certain services, however, your physician must obtain prior approval from us. Before giving approval, we consider if the services is covered, medically necessary, and follows generally accepted medical practice. You must obtain prior authoriztion for:

- Inpatient Hospital Admissions /Observation stays/ LTAC
- Skilled nursing admissions
- Chemotherapy Herceptin; Avastin
- Durable medical equipment purchase over $500 and all rental items except Oxygen – no auth required
- on Oxygen
- Experimental and Investigational services, devices, drugs
- Gamma Knife, Cyber knife
- Genetic testing / counseling
- Habilitative services for physical, occupational and speech therapy
- Home health care infusions – (see attached list)
- Home health aide
- Hospice - inpatient
- Hyperbaric services
- Imaging - PET or PET/CT fusion scans; MRI/MRA; CTA; CTTA
- Implantable pain & insulin pumps, spinal stimulators and trials, peripheral stimulators
- Injectable medications / infusions (see attached list)
- Lab tests for Specialty disease markers
- Neuropsych testing
- Nuclear cardiology in outpatient hospital setting CPT codes billed with A9500 or A9505
- Orthotics and prosthetics
- Pain management (all services beyond initial evaluation)
- Rehabilitation, full- or partial-day and inpatient; including cardiac and pulmonary rehab
- Rhinoplasty
- Septoplasty
- Sleep Studies
- Transplants

- Varicose vein surgical treatments including Sclerotherapy

Listed here are injectable medications / infusions that require pre-certification from Coventry Health Care prior to services being performed. Please call Coventry's Health Services department at 877-837-8914 with any questions.

Actimmune	Apokyn	Aranesp
Arcalyst	Arixtra	Avonex
Betaseron	Cimzia	Copaxone
Copegus	Enbrel	Epogen
Extavia	Forteo	Fragmin
Fuzeon	Growth Hormone	HCV
Humira	Ilaris	Increlex
Innohep	Intron-A	IVIG
Kineret	Leukine	Lovenox
Neulasta	Neupogen	Omnitrope
Pegasys	PegIntron	Procrit
Rebetol	Rebif	Sandostatin
Serostim	Simponi	Somavert
Stelara	Teutropin	Vivaglobin
Zorbtive		

To obtain authorization for services or to inquire about benefits for Mental Health, Alcohol and Drug Abuse Services, please contact **MH Net Behavioral Health,** PO Box 209010Austin, TX 78720, or (866) 607-5970.

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

First, your physician, your hospital, you, or your representative, must call us at 877-837-8914 (866-607-5970 for Mental Health or Substance Abuse) before admission or service 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 of requested for hospital stay.

- **Non-urgent care claims**

For non-urgent care claims, we will then 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 of an extension of time before the end of the original 15 day period. Our notice will include the circumstances underlying the request for the extension and the date when 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.

- **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 an physician with knowledge of your medical condition, would subject you to severe pain that cannot be adequately managed without this care or treatment), we will expedite our review and notify you of our decision within 72 hours. If you request that we review your claim as an urgent care claim, we will review the documentation you provide and decide whether it is an urgent care claim by applying the judgement of a prudent layperson who possesses an average knowledge of health and medicine.

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

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

  You may request that your urgent care claims 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 1-800-969-3343. You may also call OPM's Health Insurance (3) at (202) 606-0737 between 8 a.m. and 5 p.m. Eastern Time to ask for 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 1-800-969-3343. 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, then 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 telephone us within two business days following the day of the emergency admission, even if you have been discharged from the hospital.

- **Maternity services**

  Maternity-related Covered Services are treated as any other illness, including testing for lead poisoning. Hospital Coverage for the mother and her newborn child includes forty-eight (48) hours of post-natal maternity care for vaginal delivery and ninety-six (96) hours of post-natal maternity care for cesarean delivery. The Plan may authorize a shorter hospital stay if the attending provider, after consulting with the mother, approves discharging earlier than 48 hours (or 96 hours as applicable). The discharge shall be made in accordance with the most current version of the “Guidelines for Perinatal Care”, or similar guidelines.

The Plan shall provide post-discharge care consisting of two visits by a registered professional nurse, at least one of which shall be in the home. The services provided includes a physical assessment of the newborn and mother, parent education, assistance and training in breast or bottle feeding, education and services for complete childhood immunizations, the performance of any necessary and appropriate clinical tests, and submission of a metabolic specimen satisfactory to the state laboratory. The location and schedule of the post-discharge visits shall be determined by the attending physician who has approved the early discharge. Inpatient Hospital services may be subject to Your Responsibility as defined in the Schedule of Benefits.

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

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

What happens when you do not follow the precertification rules when using non-network facilities

You are responsible for verifying precertification has been obtained whenever you seek covered services from a non-participating provider. Failure to obtain precertification could result in a reduction of benefits.

Circumstances beyond our control

Under certain extraordinary circumstances, such as natural disasters, we may have to delay your services or we may be unable to provide them. In that case, we will make all reasonable efforts to provide you with the necessary care.

If you disagree with our pre-service claim decision

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

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

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

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

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

1. Precertify your hospital stay or, if applicable, arrange for the health care provider to give you the care or grant your request for prior approval for a service, drug, or supply; or
2. Ask you or your provider for more information.

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

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

3. Write to you and maintain our denial.

- **To reconsider an urgent care claim**

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

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

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

Section 4. Your cost 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.

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: In our Plan, you pay 50% of our allowance for infertility services and for covered durable medical equipment.

Copayments

A copayment is a fixed amount of money you pay to the provider, facility, pharmacy, etc., when you receive certain services. You are responsible for paying copayments to providers at the time of service.

Example: When you see your primary care physician, you pay a copayment of $30 per office visit, and when you go in the hospital, you pay $100 per admission.

Deductible

A deductible is a fixed expense you must incur for certain covered services and supplies before we start paying benefits for them. Copayments do not count toward any deductible.

High Option Plan:

The calendar year deductible is $1,000 Self Only and $3,000 Self and Family.

Standard Option Plan:

The calendar year deductible is $2,000 Self Only and $6,000 Self and Family.

High Deductible Health Plan: The calendar year deductible is $2,500 for Self Only and $5,000 for Self and Family. The individual deductible applies to members enrolled in Self Only. The family deductible applies collectively to all members enrolled in Self and Family. After you have paid your Single Only or Self and Family calendar year deductible amount, we pay 80% of our allowable for covered Traditional services for the remainder of the calendar year.

Note: If you change plans during Open Season, you do not have to start a new deductible under your old plan between January 1 and the effective date of your new Plan. If you change plans at another time during the year, you must begin a new deductible under your new Plan.

If you change options in this Plan during the year, we will credit the amount of covered expenses already applied toward the deductible of your old option to the deductible of your new option.

Your catastrophic protection out-of-pocket maximum

After your copayments, any applicable deductible, and coinsurance total the amounts listed below, you do not have to pay any more for covered services. Be sure to keep accurate records of your copayments, applicable deductible and coinsurance since you are responsible for informing us when you reach the maximum.

High Option Plan: After your copayments, deductible, and coinsurance total the amounts listed below in the calendar year, you do not have to pay any more for covered services. However, copayments or coinsurance for the following services do not count toward your catastrophic protection out-of-pocket maximum, and you must continue to pay copayments or coinsurance for: Dental benefits.

Under our **High Option Plan** the out-of-pocket maximum for Self Only is $5,000 and $10,000 for Self and Family.

Standard Option Plan: After your copayments, deductible, and coinsurance total the amounts listed below in the calendar year, you do not have to pay any more for covered services. However, copayments, deductible, or coinsurance for the following services do not count toward your catastrophic protection out-of-pocket maximum, and you must continue to pay copayments or coinsurance for: Dental benefits.

Under our **Standard Option Plan** the out-of-pocket maximum for Self Only is $5,000 and $10,000 for Self and Family.

High Deductible Health Plan: After your copayments, coinsurance and deductible total the amounts listed below in the calendar year, you do not have to pay any more for covered services. However, copayments or coinsurance for the following services do not count toward your catastrophic protection out-of-pocket maximum, and you must continue to pay copayments or coinsurance for: Dental benefits. The individual out-of-pocket maximum applies to members enrolled in Self Only. The family out-of-pocket maximum applies collectively to all members enrolled in Self and Family.

Under our **High Deductible Health Plan** the out-of-pocket maximum for Self Only is $4,000 and $8,000 for Self and Family. Deductible, coinsurance and copayments are included in your out-of-pocket maximum.

When Government facilities bill us

Facilities of the Department of Veterans Affairs, the Department of Defense, and the Indian Health Services 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.

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.

Section 5. High and Standard Option Benefits

See page 16 for how our benefits changed this year. On page 135 and page 136 is a benefit summary of each option. Make sure that you review the benefits that are available under the option which you are enrolled.

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Section 5. High and Standard Option Benefits Overview

This Plan offers both a High and Standard Option. Both benefit packages are described in Section 5. Make sure that you review the benefits that are available under the option in which you are enrolled.

The High and Standard Option Section 5 is divided into subsections. Please read *Important things you should keep in mind* at the beginning of the subsections. Also read the general exclusions in Section 6; they apply to the benefits in the following subsections. To obtain claim forms, claims filing advice, or more information about High and Standard Option benefits, contact us at 1-800-969-3343 or on our website at www.chckansas.com.

Each option offers unique features.

- You are not required to select a primary care physician. Please be sure the provider you select – or the provider or facility you are referred to – is part of the Coventry Network. It is ultimately your responsibility to verify this information. By doing so, you get the most from your health Plan and protect yourself from paying more than you have to for covered benefits.
- You do not need a referral from a primary care physician to see a specialist.
- These Plans include annual wellness/preventive care exams to You at no cost.
- These Plans provide diabetic and nutritional counseling when You are diagnosed with high cholesterol, high blood pressure, diabetes, and obesity.
- Routine eye exams are available to all members. Please select from one of our Coventry Network Optometrists.
- These Plans include preventive dental diagnostic services using the Coventry Dental Network.

Features of our High Option

- A calendar year deductible of $1,000 Self Only and limited to $3,000 Self and Family.
- Catastrophic protection per calendar year is limited to $5,000 for Self Only and $10,000 for Self and Family.

Features of our Standard Option

- A calendar year deductible of $2,000 Self Only and limited to $6,000 Self and Family.
- Catastrophic protection per calendar year is limited to $5,000 for Self Only and $10,000 for Self and Family.

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

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan physicians must provide or arrange your care.
- A facility copay applies to services that appear in this section but are performed in an ambulatory surgical center or the outpatient department of a hospital.
- High Option: The calendar year deductible is $1,000 Self Only and $3,000 Self and Family. The calendar year deductible applies to almost all benefits in this Section. We added ("No Deductible") to show when the calendar year deductible does not apply.
- Standard Option: The calendar year deductible is $2,000 Self Only and $6,000 Self and Family. The calendar year deductible applies to almost all benefits in this Section. We added ("No Deductible") to show when the calendar year deductible does not apply.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

Benefit Descripion	You pay After the calendar year deductible. . .	
Diagnostic and treatment services	**High Option**	**Standard Option**
Professional services of physicians • In physician's office, not including minor surgery	$30 per visit to a primary care physician or OB/GYN, No Deductible $60 per visit to a specialist, No Deductible	$30 per visit to a primary care physicann or OB/GYN, No Deductible $60 per visit to a specialist, No Deductible
Professional services of physicians • In an urgent care center	Nothing	Nothing
During a hospital stay	25% of our allowance	30% of our allowance
In a skilled nursing facility	25% of our allowance	30% of our allowance
• Office medical consultations • Second Surgical opinion • At home	$30 per visit to a primary care physician or OB/GYN, No Deductible $60 per visit to a specialist, No Deductible	$30 per visit to a primary care physcian or OB/GYN, No Deductible $60 per visit to a specialist, No Deductible
Lab, X-ray and other diagnostic tests	**High Option**	**Standard Option**
Tests, such as: • Blood tests • Urinalysis • Non-routine Pap tests • Pathology	Nothing, No Deductible if services received in your Physician's Office or at a Quest Diagnostics facility.	Nothing, No Deductible if services received in your Physician's Office or at a Quest Diagnostics facility.

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

Benefit Descripion	You pay After the calendar year deductible. . .	
Lab, X-ray and other diagnostic tests (cont.)	**High Option**	**Standard Option**
• X-ray	Nothing, No Deductible if services received in your Physician's Office or at a diagnostic imaging facility.	Nothing, No Deductible if services received in your Physician's Office or at a diagnostic imaging facility.
Hi Tech Diagnostics • MRI • MRA • CAT and PET Scans • Cardiac Catheterization • Thallium Scans	$250 per visit, No Deductible	$250 per visit, No Deductible
• Non-routine Mammograms	Nothing	Nothing
Preventive care, adult	**High Option**	**Standard Option**
Routine physical, which includes: • Blood test • Urinalysis • Total Blood Cholesterol Routine screenings, such as: • Total Blood Cholesterol • Colorectal Cancer Screening - Fecal occult blood test - Sigmoidoscopy screening - every five years starting at age 50 - Colonoscopy screening - every ten years starting at age 50	Nothing, No Deductible	Nothing, No Deductible
Routine Prostate Specific Antigen (PSA) test	Nothing, No Deductible	Nothing, No Deductible
Well woman care; including, but not limited to: • Routine Pap test • Human papillomavirus testing for women age 30 and up once every three years • Annual counseling for sexually transmitted infections • Annual counseling and screening for human immune-deficiency virus • Contraceptive methods and counseling • Screening and counseling for interpersonal and domestic violence	Nothing, No Deductible	Nothing, No Deductible
Routine mammogram - covered for women age 35 and older, as follows: • From age 35 through 39, one during this five year period	Nothing, No Deductible	Nothing, No Deductible

Preventive care, adult - continued on next page

Benefit Descripion	You pay After the calendar year deductible. . .	
Preventive care, adult (cont.)	**High Option**	**Standard Option**
• From age 40 through 64, one every calendar year • At age 65 and older, one every two consecutive calendar years	Nothing, No Deductible	Nothing, No Deductible
• 1 routine eye exam every 12 months • 1 routine hearing exam every 24 months	Nothing, No Deductible	Nothing, No Deductible
Adult routine immunizations endorsed by the Centers for Disease Control and Prevention (CDC):	Nothing, No Deductible	Nothing, No Deductible
Note: A complete list of preventive care services recommended under the U.S. Preventive Services Task Force is available (USPSTF) online at http://www.uspreventiveservicestaskforce.org/uspstf/uspsabrecs.htm and HHS at www.healthcare.gov/prevention.		
Not covered: Physical exams and immunizations required for obtaining or continuing employment or insurance, attending schools or camp, or travel.	*All charges*	*All charges*
Preventive care, children	**High Option**	**Standard Option**
• Childhood immunizations recommended by the American Academy of Pediatrics	Nothing, No Deductible	Nothing, No Deductible
• Well-child care charges for routine examinations, immunizations and care (up to age 22) • Examinations, such as: - Eye exams through age 17 - Ear exams through age 17 - Examinations done on the day of immunizations (up to age 22)	Nothing, No Deductible	Nothing, No Deductible
Note: A complete list of preventive care services recommended under the U.S. Preventive Services Task Force (USPSTF) is available online at http://www.uspreventiveservicestaskforce.org/uspstf/uspsabrecs.htm and HHS at www.healthcare.gov/prevention.		
Not covered: Physical exams and immunizations required for obtaining or continuing employment or insurance, attending schools or camp, or travel.	*All charges*	*All charges*
Maternity care	**High Option**	**Standard Option**
Complete maternity (obstetrical) care, such as: • Prenatal care • Screening for gestational diabetes for pregnant women between 24-28 weeks gestation or first prenatal visit for women at a high risk. No cost sharing. • Delivery	$30 for initial office visit confirm pregnancy, No Deductible	$30 for initial office visit to confirm pregnancy, No Deductible

Maternity care - continued on next page

Benefit Descripion	You pay After the calendar year deductible. . .	
Maternity care (cont.)	**High Option**	**Standard Option**
• Postnatal care	$30 for initial office visit confirm pregnancy, No Deductible All other copayments for prenatal visits during the course of pregnancy are waived. See Section 5(c) for Maternity Care received at an Inpatient Hospital.	$30 for initial office visit to confirm pregnancy, No Deductible All other copayments for prenatal visits during the course of pregnancy are waived. See Section 5(c) for Maternity Care received at an Inpatient Hospital.
Breastfeeding support, supplies and counseling for each birth	Nothing	Nothing
Note: Here are some things to keep in mind: • You do not need to precertify your normal delivery; see page 21 for other circumstances, such as extended stays for you or your baby. • You may remain in the hospital up to 48 hours after a regular delivery and 96 hours after a cesarean delivery. We will extend your inpatient 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 only if we cover the infant under a Self and Family enrollment. • We pay hospitalization and surgeon services for non-maternity care the same as for illness and injury.		
Family planning	**High Option**	**Standard Option**
A range of voluntary family planning services, limited to: • Voluntary sterilization (See Surgical procedures Section 5 (b))	Nothing	Nothing
• Surgically implanted contraceptives • Injectable contraceptive drugs (such as Depo provera) • Intrauterine devices (IUDs) • Diaphragms Note: We cover oral contraceptives under the prescription drug benefit.	Nothing	Nothing
Contraceptive counseling on an annual basis	Nothing	Nothing
Not covered: • *Reversal of voluntary surgical sterilization* • *Genetic counseling*	*All charges*	*All charges*

Benefit Descripion	You pay After the calendar year deductible. . .	
Infertility services	**High Option**	**Standard Option**
Diagnosis and treatment of infertility such as: • Artificial insemination: - Intravaginal insemination (IVI) - Intracervical insemination (ICI) - Intrauterine insemination (IUI)	50% of our allowance	50% of our allowance
Not covered: • *Assisted reproductive technology (ART) procedures, such as:* - *In Vitro fertilization* - *embryo transfer, gamete intra-fallopian transfer (GIFT) and zygote intra-fallopian transfer (ZIFT)* - *Zygote transfer* • *Services and supplies related to ART procedures* • *Cost of donor sperm* • *Cost of donor egg* • *Fertility drugs*	*All charges*	*All charges*
Allergy care	**High Option**	**Standard Option**
• Testing and treatment	25% of our allowance	30% of our allowance
• Allergy injections	$5 Copayment	$5 Copayment
• Allergy serum	Nothing	Nothing
Not covered: Provocative food testing and sublingual allergy desensitization	*All charges*	*All charges*
Treatment therapies	**High Option**	**Standard Option**
• Chemotherapy and radiation therapy Note: High dose chemotherapy in association with autologous bone marrow transplants is limited to those transplants listed under Organ/Tissue Transplants *(see Section 5b Surgical and anesthesia services provided by physicians and other health care).* • Respiratory and inhalation therapy - outpatient rehabilitation limited to 60 visits per condition • Dialysis - hemodialysis and peritoneal dialysis • Intraveneous (IV)/Infusion Therapy - Home IV and antibiotic therapy • Applied Behavior Analysis (ABA) Therapy for Autism Spectrum Disorder • Grownth hormone therapy (GHT)	25% of our allowance	30% of our allowance

Treatment therapies - continued on next page

Benefit Descripion	You pay After the calendar year deductible. . .	
Treatment therapies (cont.)	**High Option**	**Standard Option**
Note: Growth hormone is covered under the prescription drug benefit. Note: We only cover GHT when we preauthorize the treatment. Call 1-800-969-3343 for preauthorization. We will ask you to submit information that establishes that the GHT is medically necessary. Ask us to authorize GHT before you begin treatment. We will only cover GHT services and related services and supplies that we determine are medically necessary. See *Other services* under *You need prior Plan approval for certain services* in Section 3.	25% of our allowance	30% of our allowance
Physical and occupational therapies	**High Option**	**Standard Option**
60 visits per condition for the each of the following services: • Qualified physical therapists • Occupational therapists (Chiropractors coverage included in the visit limit, See Chiropractic) Note: We only cover therapy when a provider: • orders the care; • identifies the specific professional skills the patient requires and the medical necessity for skilled services; and • indicates the length of time the services are needed. Cardiac rehabilitation following a heart transplant, bypass surgery or a myocardial infarction is provided for up to 60 sessions. Habilitative Services – 60 visits per condition for the following services: physical, occupational and speech therapies. Habilitative services will be subject to the same copay and visits as rehabilitative services.	25% of our allowance	30% of our allowance
Not covered • *Long-term rehabilitative therapy* • *Exercise programs*	*All charges*	*All charges*

Benefit Descripion	You pay After the calendar year deductible. . .	
Speech therapy	**High Option**	**Standard Option**
60 visits per condition Habilitative Services – 60 visits per condition for the following services: physical, occupational and speech therapies. Habilitative services will be subject to the same copay and visits as rehabilitative services.	25% of our allowance	30% of our allowance
Hearing services (testing, treatment, and supplies)	**High Option**	**Standard Option**
• For treatment related to illness or injury, including evaluation and diagnostic hearing tests performed by an M.D., D.O., or audiologist	25% of our allowance Note: For routine hearing screening performed during a child's preventive care visit, see Section 5(a) *Preventive care, children.*	30% of our allowance Note: For routine hearing screening performed during a child's preventive care visit, see Section 5(a) *Preventive care, children.*
• External hearing aids • Implanted hearing-related devices, such as bone anchored hearing aids (BAHA) and cochlear implants	25% of our allowance Note: For benefits for the devices, see Section 5(a) *Orthopedic and prosthetic devices*	30% of our allowance Note: For benefits for the devices, see Section 5(a) *Orthopedic and prosthetic devices*
Not covered: • *Hearing services that are not show as covered*	*All charges*	*All charges*
Vision services (testing, treatment, and supplies)	**High Option**	**Standard Option**
• One pair of eyeglasses or contact lenses to correct an impairment directly caused by accidental ocular injury or intraocular surgery (such as for cataracts) • Eye exam to determine the need for vision correction for children through age 17 (see Preventive care, children)	$30 per visit to a primary care physician, No Deductible $60 per visit to a specialist, No Deductible	$30 per visit to a primary care physician, No Deductible $60 per visit to a specialist, No Deductible
• Annual eye refraction exam for all members	$30 per visit to a primary care physician, No Deductible $60 per visit to a specialist, No Deductible	$30 per visit to a primary care physician, No Deductible $60 per visit to a specialist, No Deductible
Not covered • *Eyeglasses or contact lenses; or contact lense exam* • *Exams of fitting fees for contact lenses* • *Eye exercises and orthoptics* • *Radial keratotomy and other refractive surgery*	*All charges*	*All charges*

Benefit Descripion	You pay After the calendar year deductible. . .	
Foot care	**High Option**	**Standard Option**
Routine foot care when you are under active treatment for a metabolic or peripheral vascular disease, such as diabetes. Note: See Orthopedic and prosthetic devices for information on podiatric shoe inserts.	$30 per visit to a primary care physician, No Deductible $60 per visit to a specialist, No Deductible	$30 per visit to a primary care physician, No Deductible $60 per visit to a specialist, No Deductible
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*	*All charges*
Orthopedic and prosthetic devices	**High Option**	**Standard Option**
• Artificial limbs and eyes • Stump hose • Externally worn breast prostheses and surgical bras, including necessary replacements following a mastectomy. External prosthetic devices, except those associated with reconstructive surgery after a mastectomy are limited to two per member per calendar year. • Corrective orthopedic appliances for non-dental treatment of temporomandibular joint (TMJ) pain dysfunction syndrome. • Internal prosthetic devices, such as artificial joints, pacemakers, and surgically implanted breast implant following mastectomy. • Foot Orthotics and Ankle Foot Orthotics are covered for members who have diabetes with demonstrated peripheral neuropathy or the insert is needed for a shoe that is part of a covered brace.	50% of our allowance, No Deductible	50% of our allowance, No Deductible
• External hearing aids • Implanted hearing-related devices, such as bone anchored hearing aids (BAHA) and cochlear implants We limit coverage to one (1) device per ear per every 24 months. Note: For information onteh professional charges for surgery to insert an implant, see Section 5(b) Surgical procedures. For information on the hospital and.or ambulatory surgery center benefits, see Section 5(c) Services provided by a hospital or other facility, and ambulance services.	$500 copayment per eligible device, No Deductible	$500 copayment per eligible device, No Deductible

Orthopedic and prosthetic devices - continued on next page

Benefit Descripion	You pay After the calendar year deductible. . .	
Orthopedic and prosthetic devices (cont.)	**High Option**	**Standard Option**
Not covered: • *Orthopedic and corrective shoes, arch supports, foot orthotics, heel pads and heel cups* • *Dental braces, devices, and appliances* • *Braces for aid in sports activities* • *Internally implanted devices, equipment and prosthetics related to treatment of sexual dysfunction* • *DOC Bands (Dynamic Orthotic Cranial Bands)* • *Lumbosacral supports* • *Corsets, trusses, elastic stockings, support hose, and other supportive devices* • *Orthotics (regular or custom, including but not limited to ankle foot orthotics or podiatric orthotics)* • *Repair and replacement of orthopedic and prosthetic devices, unless necessiated by normal growth* • *Hearing aid batteries* • *Replacement hearing aid devices within the same 24 month period* • *Hearing devices that are not specifically listed in the covered services section*	*All charges*	*All charges*
Durable medical equipment (DME)	**High Option**	**Standard Option**
• Rental or purchase, at our option, including repair and adjustment, of durable medical equipment prescribed by your Plan physician, such as oxygen and dialysis equipment. Under this benefit, we also cover: • Hospital beds • Wheelchairs • Crutches • Walkers • Audible prescription reading devices • Speech generating devices • Enteral feeding pumps • Insulin pumps, and syringes for insulin pumps • Apnea monitor • Cane • Ostomy and urological supplies • Prosthetic and orthotic supplies • Replacement due to anatomical growth	50% of our allowance, No Deductible	50% of our allowance, No Deductible

Durable medical equipment (DME) - continued on next page

Benefit Descripion	You pay After the calendar year deductible. . .	
Durable medical equipment (DME) (cont.)	**High Option**	**Standard Option**
• Repair and replacement of DME determined to be medically necessary.	50% of our allowance, No Deductible	50% of our allowance, No Deductible
• Blood glucose monitors for members with diabetes Note: Prior authorization is required for non-preferred blood glucose monitors and supplies.	Nothing, if you obtain our preferred brand. You pay 50% of our allowance if you receive a non-preferred brand or replacement device, No Deductible	Nothing, if you obtain our preferred brand. You pay 50% of our allowance if you receive a non-preferred brand or replacement device, No Deductible
Note: Call us at 1-800-969-3343 as soon as your Plan physician prescribes this equipment. We will arrange with a health care provider to rent or sell you durable medical equipment at discounted rates and will tell you more about this service when you call.		
Not covered: • *Motorized wheelchairs* • *Oral supplements and/or enteral feeding, either by mouth or by tube* • *Comfort, convenience, or luxury items or features, including breast pumps, air conditioners, humidifiers and dehumidifiers* • *Electric monitors of bodily functions, except for apnea monitors* • *Devices to perform medical testing of bodily fluids, excretions or substances* • *Disposable supplies* • *Electronically controlled cooling or heating compression therapy devices (such polar ice packs, Ice Man Cool Therapy, or Cryo-cuff)* • *Home traction units* • *Replacement of lost equipment* • *Repair, adjustment, or replacement necessitated by wear, tear or misuse* • *More than one piece of durable medical equipment serving essentially the same function, except for replacement due to anatomical growth; spare equipment or alternate use equipment is not provided*	*All charges*	*All charges*

Benefit Descripion	You pay After the calendar year deductible. . .	
Home health services	**High Option**	**Standard Option**
• Home health care ordered by a Plan physician and provided by a registered nurse (R.N.), licensed practical nurse (L.P.N.), licensed vocational nurse (L.V.N.), physical therapist, speech therapist, occupational therapist or home health aide. • Services include intravenous therapy and medications (oxygen is covered under DME).	25% of our allowance	30% of our allowance
Not covered: • *Home care requested by, or the convenience of, the patient or the patient's family;* • *Services primarily for hygiene, feeding, exercising, moving the patient, homemaking, companionship or giving oral medication;* • *Home care that could appropriately be rendered in a Plan medical office, affiliated hospital, or skilled nursing facility;* • *Home care that can be performed safely and effectively by people whom, in order to provide the care do not require medical licenses or certificates, or the presence of a supervising licensed nurse* • *Home care primarily for personal assistance that does not include a medical component and is not diagnostic, therapeutic, or rehabilitative.*	*All charges*	*All charges*
Chiropractic	**High Option**	**Standard Option**
• Coverage limited to subluxation and manipulation • 60 visits per condition (visit limit includes physical and occupational therapies. See Physical and Occupational therapies) Note: We only cover therapy to restore bodily function when there has been a total or partial loss of bodily function due to illness or injury.	25% of our allowance	30% of our allowance
Alternative treatments	**High Option**	**Standard Option**
No benefit	*All charges*	*All charges*
Educational classes and programs	**High Option**	**Standard Option**
Coverage is available for up to six (6) nutritional counseling visits with a registered dietician for any covered condition, but especially: • High cholesterol • Obesity • High blood pressure • Diabetes	Nothing	Nothing

Educational classes and programs - continued on next page

Benefit Descripion	You pay After the calendar year deductible. . .	
Educational classes and programs (cont.)	**High Option**	**Standard Option**
Tobacco cessation program including individual/group/telephone counseling, and for **physician prescribed** over-the-counter (OTC) and prescription drugs approved by the FDA to treat tobacco dependence. Enroll online at www.quitnet.com/coventrywellbeing or call 1-866-577-8210. A representative will ask you for your Authentication code which is your 11 digit Coventry ID number - and will then assist you in the completion of the registration process.	Nothing for the counseling for up to two quit attempts per year. Nothing for **physician prescribed** OTC and prescription drugs approved by the FDA to treat tobacco dependence.	Nothing for the counseling for up to two quit attempts per year. Nothing for **physician prescribed** OTC and prescription drugs approved by the FDA to treat tobacco dependence.

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

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan physicians must provide or arrange your care.
- The calendar year deductible is: High Option: $1,000 Self Only and $3,000 Self and Family. The calendar year deductible applies to almost all benefits in this Section. We added "(No deductible)" to show when the calendar year deductible does not apply.
- The calendar year deductible is: Standard Option: $2,000 Self Only and $6,000 Self and Family. The calendar year deductible applies to almost all benefits in this Section. We added "(No deductible)" to show when the calendar year deductible does not apply.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost-sharing works. Also, read Section 9 about coordinating benefits with other coverage, including with Medicare.
- The services listed below are for the charges billed by a physician or other health care professional for your surgical care. See Section 5(c) for charges associated with the facility (i.e. hospital, surgical center, etc.).
- **YOUR PHYSICIAN MUST GET PRECERTIFICATION FOR SOME SURGICAL PROCEDURES. Please refer to the precertification information shown in Section 3 to be sure which services require precertification and identify which surgeries require precertification.**

Benefit Description	You pay After the calendar year deductible. . .	
Surgical procedures	**High Option**	**Standard Option**
A comprehensive range of services, such as: • Operative procedures • Circumcision of a newborn • Treatment of fractures, including casting • Normal pre- and post-operative care by the surgeon • Correction of amblyopia and strabismus • Endoscopy procedures • Biopsy procedures • Removal of tumors and cysts • Correction of congenital anomalies (see Reconstructive surgery)	25% of our allowance	30% of our allowance
• Minor surgery in physician office	$30 per visit to a primary care physician or OB/GYN, No Deductible $60 per visit to a specialist, No Deductible	30% of our allowance
• Surgical treatment of morbid obesity (bariatric surgery) Roux-en-Y Gastric Bypass, Laparoscopic Gastric Banding, and Vertical Banded Gastroplasty.	25% of our allowance	30% of our allowance

Surgical procedures - continued on next page

Benefit Description	You pay After the calendar year deductible. . .	
Surgical procedures (cont.)	**High Option**	**Standard Option**
- a condition in which an individual weighs 100 pounds or 100% over his or her normal weight according to current underwriting standards; eligible members must be age 18 or over - the patient is an adult (≥ 18 years of age) with morbid obesity that has persisted for at least 3 years, and for which there is no treatable metabolic cause for the obesity; - there is presence of morbid obesity, defined as a body mass index (BMI) exceeding 40, or greater than 35 with documented co-morbid conditions (cardiopulmonary problems e.g., severe apnea, Pickwickian Syndrome, and obesity-related cardiomyopathy, severe diabetes mellitus, hypertension, or arthritis). (BMI is calculated by dividing a patient's weight (in kilograms) by height (in meters) squared. To convert pounds to kilograms, multiply pounds by 0.45. To convert inches to meters, multiply inches by .0254); - The patient has failed to lose weight (approximately 10% from baseline) or has regained weight despite participation in a three month physician-supervised multidisciplinary program within the past six months that included dietary therapy, physical activity and behavior therapy and support; - The patient has been evaluated for restrictive lung disease and received surgical clearance by a pulmonologist, if clinically indicated; has received cardiac clearance by a cardiologist if there is a history of prior phen-fen or redux use, and the patient has agreed, following surgery, to participate in a multidisciplinary program that will provide guidance on diet, physical activity and social support; and, - The patient has completed a psychological evaluation and has been recommended for bariatric surgery by a licensed mental health professional (this must be documented in the patient's medical record) and the patient's medical record reflects documentation by the treating psychotherapist that all psychosocial issues have been identified and addressed; and the psychotherapist indicates that the patient is likely to be compliant with the post-operative diet restrictions; • Insertion of internal prosthetic devices. See 5(a) – Orthopedic and prosthetic devices for device coverage information • Treatment of burns	25% of our allowance	30% of our allowance

Surgical procedures - continued on next page

Benefit Description	You pay After the calendar year deductible. . .	
Surgical procedures (cont.)	**High Option**	**Standard Option**
Note: Generally, we pay for internal prostheses (devices) according to where the procedure is done. For example, we pay Hospital benefits for a pacemaker and Surgery benefits for insertion of the pacemaker.		
Voluntary sterilization (e.g., Tubal ligation, Vasectomy)	25% of our allowance	30% of our allowance
Not covered: • *Surgical treatment of morbid obesity (bariatric surgery) Jujunoileal Bypass, Gastric Stapling, Duodenal Switch, and Bilopancreatic Diversion.* • *Reversal of voluntary sterilization* • *Routine treatment of conditions of the foot; see Foot care*	*All charges*	*All charges*
Reconstructive surgery	**High Option**	**Standard Option**
• 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; webbed fingers; and webbed toes. • All stages of breast reconstruction surgery following a mastectomy, such as: - surgery to produce a symmetrical appearance of breasts; - treatment of any physical complications, such as lymphedemas; - breast prostheses and surgical bras and replacements (see Prosthetic devices) Note: If you need a mastectomy, you may choose to have the procedure performed on an inpatient basis and remain in the hospital up to 48 hours after the procedure.	25% of our allowance	30% of our allowance
Not covered: • *Cosmetic surgery – any surgical procedure (or any portion of a procedure) performed primarily to improve physical appearance through change in bodily form, except repair of accidental injury*	*All charges*	*All charges*

Reconstructive surgery - continued on next page

Benefit Description	You pay After the calendar year deductible. . .	
Reconstructive surgery (cont.)	**High Option**	**Standard Option**
• *Surgeries related to sex transformation* • *Hair pieces*	*All charges*	*All charges*
Oral and maxillofacial surgery	**High Option**	**Standard Option**
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; and • Treatment of TMJ (non-dental).	25% of our allowance	30% of our allowance
Not covered: • *Oral implants and transplants* • *Procedures that involve the teeth or their supporting structures (such as the periodontal membrane, gingiva, and alveolar bone)* • *TMJ related dental work*	*All charges*	*All charges*
Organ/tissue transplants	**High Option**	**Standard Option**
These **solid organ transplants** are subject to medical necessity and experimental /investigational review by the Plan. Refer to Other Services in Section 3 for prior authorization procedures. Transplant services must be performed at a participating Center of Excellence. We approve and designate where all transplants must be performed including hospitals for specific transplant procedures. If you would like to know about a specific facility, please contact Customer Service. Solid organ transplants limited to: • Cornea • Heart • Heart/lung • Kidney • Liver • Pancreas* • Kidney/Pancreas • Lung: single / bilateral / lobar • Intestinal transplants - Isolated small intestine	25% of our allowance	30% of our allowance

Organ/tissue transplants - continued on next page

Benefit Description	You pay After the calendar year deductible. . .	
Organ/tissue transplants (cont.)	**High Option**	**Standard Option**
- Small intestine with the liver - Small intestine with multiple organs such as the liver, stomach, and pancreas • Autologous pancreas islet cell transplant (as an adjunct to total or near total pancreatectomy) only for patients with chronic pancreatitis. * We limit the coverage for pancreas (only) transplants to patients who have insulin dependent (or Type 1) diabetes mellitus when we find that exogenous treatment with insulin is ineffective.	25% of our allowance	30% of our allowance
These **tandem blood or marrow stem cell transplants** for covered transplants are subject to medical necessity review by the Plan. Refer to *Other services* in Section 3 for prior authorization procedures. • Autologous tandem transplants for - AL Amyloidosis - Multiple myeloma (de novo and treated) - Recurrent germ cell tumors (including testicular cancer)	25% of our allowable	30% of our allowable
Blood or marrow stem cell transplants limited to the stages of the following diagnoses. For the diagnoses listed below, the medical necessity limitation is considered satisfied if the patient meets the staging description. Allogeneic (donor) transplants for: • Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia • Advanced Hodgkin's lymphoma with recurrence (relapsed) • Advanced non-Hodgkin's lymphoma with recurrence (relapsed) • Aggressive non-Hodgkin's lymphoma • Acute myeloid leukemia • Advanced Myeloproliferative Disorder (MPDs) • Advanced Neuroblastoma • Amyloidosis • Chronic lymphocytic lymphoma /small lymphocytic lymphoma (CLL/SLL) • Hemoglobinopathy • Infantile malignant osteopetrosis • Kostmann's syndrome • Leukocyte adhesion deficiencies	25% of our allowance	30% of our allowance

Organ/tissue transplants - continued on next page

Benefit Description	You pay After the calendar year deductible. . .	
Organ/tissue transplants (cont.)	**High Option**	**Standard Option**
• Marrow Failure and Related Disorders (i.e. Fanconi's, PNH, Pure Red Cell Aplasia) • Mucolipidosis (e.g. Gaucher's disease, metachromatic leukodystrophy, adrenoleukodystrophy) • Mucopolysaccharidosis (e.g. Hunter's Syndrome, Hurler's syndrome, Sanfillippo's syndrome, Maroteauxlamy syndrome variants) • Myelodysplasia/Myelodysplastic syndromes • Paroxysmal Nocturnal Hemoglobinuria • Phagocytic / Hemophagocytic deficiency diseases (e.g. Wiskott-Aldrich syndrome) • Severe combined immuno-deficiency disease • Severe or very severe aplastic anemia • Sickle cell anemia Autologous transplants for: • Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia • Advanced Hodgkin's lymphoma with recurrence (relapsed) • Advanced non-Hodgkin's lymphoma with recurrence (relapsed) • Amyloidosis • Advanced Neuroblastoma • Multiple Myeloma • Testicular, Mediastinal, Retroperitoneal, and ovarian germ cell tumors	25% of our allowance	30% of our allowance
Mini Transplants performed in a clinical trial setting (non-myeloblative, reduced intensity conditioning or RIC) for members with a diagnosis listed below are subject to medical necessity review by the Plan. Refer to Other Services in Section 3 for prior authorization procedures: Allogeneic transplants for: • Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia • Advanced Hodgkin's lymphoma with recurrence (relapsed) • Advanced non-Hodgkin's lymphoma with recurrence (relapsed) • Acute myeloid leukemia • Advanced Myeloproliferative Disorder (MPDs) • Amyloidosis	25% of our allowable	30% of our allowable

Organ/tissue transplants - continued on next page

Benefit Description	You pay After the calendar year deductible. . .	
Organ/tissue transplants (cont.)	**High Option**	**Standard Option**
• Chronic lymphocytic lymphoma /small lymphocytic lymphoma (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 immuno-deficiency disease • Severe or very severe aplastic anemia Autologous transplants for: • Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia • Advanced Hodgkin's lymphoma with recurrence (relapsed) • Advanced non-Hodgkin's lymphoma with recurrence (relapsed) • Amyloidosis • Neuroblastoma • Breast cancer • Epithelial ovarian cancer	25% of our allowable	30% of our allowable
These **blood or marrow stem cell transplants** are covered only in a National Cancer Institute or National Institutes of health **approved clinical trial** or a Plan-designated center of excellence and if approved by the Plan's medical director in accordance with the Plan's protocols. If you are a participant in a clinical trial, the Plan will provide benefits for related routine care that is medically necessary (such as doctor visits, lab tests, x-rays and scans, and hospitalization related to treating the patient's condition) if it is not provided by the clinical trial. Section 9 has additional information on costs related to clinical trials. We encourage you to contact the Plan to discuss specific services if you participate in a clinical trial. Allogeneic transplants for: • Advanced Hodgkin's lymphoma • Advanced non-Hodgkin's lymphoma • Chronic inflammatory demyelination polyneuropathy (CIDP) • Early stage (indolent or non-advanced) small cell lymphocytic lymphoma	25% of our allowance	30% of our allowance

Organ/tissue transplants - continued on next page

Benefit Description	You pay After the calendar year deductible. . .	
Organ/tissue transplants (cont.)	**High Option**	**Standard Option**
Mini-transplants (non-myeloblative allogeneic, reduced intensity conditioning or RIC) for • Acute lymphocytic or non-lymphocytic leukemia • Advanced Hodgkin's lymphoma • Advanced non-Hodgkin's lymphoma • Breast Cancer • Chronic lymphocytic leukemia • Chronic myelogenous leukemia • Colon cancer • Chronic lymphocytic lymphoma /small lymphocytic lymphoma (CLL/SLL) • Early stage (indolent or non-advanced) small cell lymphocytic lymphoma • Multiple Myeloma • Multiple sclerosis • Myeloproliferative Disorder (MPDs) • Myelodysplasia/Myelodysplastic syndromes • Non-small lung cancer • Ovarian cancer • Prostate cancer • Renal cell carcinoma • Sarcomas • Sickle cell anemia (pediatric only) Autologous Transplants for • Advanced Childhood kidney cancers • Advanced Ewing sarcoma • Advanced Hodgkin's lymphoma • Advanced non-Hodgkin's lymphoma • Breast Cancer • Childhood rhabdomyosarcoma • Chronic myelogenous leukemia • Chronic lymphocytic lymphoma /small lymphocytic lymphoma (CLL/SLL) • Early stage (indolent or non-advanced) small cell lymphocytic lymphoma • Epithelial Ovarian Cancer • Mantle Cell (Non-Hodgkin lymphoma) • Multiple sclerosis • Small cell lung cancer • Systemic lupus erythematosus	25% of our allowance	30% of our allowance

Organ/tissue transplants - continued on next page

Benefit Description	You pay After the calendar year deductible. . .	
Organ/tissue transplants (cont.)	**High Option**	**Standard Option**
• Systemic sclerosis	25% of our allowance	30% of our allowance
• NOTE: We cover related medical and hospital expenses of the donor when we cover the recipient. We cover donor testing for the actual solid organ or up to four bone marrow /stem cell transplant donors in addition to the testing of family members. • After referral to a transplant facility, the following will apply: - If our Medical Director or the referral facility decides you do not satisfy criteria for a transplant, we only pay for covered services you receive before that decision is made - We, and the Plan providers are not responsible for finding, furnishing, or ensuring the availability of a bone marrow or organ donor - We cover reasonable medical and hospital expenses as long as the expenses are directly related to a covered transplant of the donor or an individual identified as a potential donor, even if a member - Unless otherwise authorized by our Medical Director, we provide transplants only at approved Transplant Network facilities	25% of our allowance	30% of our allowance
Not covered: • *Donor screening tests and donor search expenses, except as shown above.* • *Any related conditions or complications for a member who is donating an organ or tissue when the recipient is not a member* • *Outpatient immunosuppressive agents* • *Any transplant procedure that is performed in a facility that has not been designated by the Medical Director as a approved transplant facility* • *Implants of non-human or artificial organs* • *Transplants not listed as covered*	*All charges*	*All charges*
Anesthesia	**High Option**	**Standard Option**
Professional services provided in – • Hospital (inpatient) • Hospital outpatient department • Skilled nursing facility • Ambulatory surgical center	25% of our allowance	30% of our allowance

Anesthesia - continued on next page

Benefit Description	You pay After the calendar year deductible. . .	
Anesthesia (cont.)	**High Option**	**Standard Option**
• Office	$30 per visit to a primary care physician or OB/GYN, No Deductible $60 per visit to a specialist, No Deductible	30% of our allowance

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.
- Plan physicians must provide or arrange your care and you must be hospitalized in a Plan facility.
- High Option: The calendar year deductible is $1,000 Self Only and $3,000 Self and Family. The calendar year deductible applies to almost all benefits in this Section. We added ("No Deductible") to show when the calendar year deductible does not apply.
- Standard Option: The calendar year deductible is $2,000 Self Only and $6,000 Self and Family. The calendar year deductible applies to almost all benefits in this Section. We added ("No Deductible") to show when the calendar year deductible does not apply.
- Be sure to read Section 4, *Your costs for covered services* for valuable information about how cost-sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- 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).
- **YOUR PHYSICIAN MUST GET PRECERTIFICATION FOR HOSPITAL STAYS**. Please refer to Section 3 to be sure which services require precertification.

Benefit Description	You pay After the calendar year deductible. . .	
Inpatient hospital	**High Option**	**Standard Option**
Room and board, such as • Ward, semiprivate, or intensive care accommodations • General nursing care • Meals and special diets • Special duty nursing Note: If you want a private room when it is not medically necessary, you pay the additional charge above the semiprivate room rate.	25% of our allowance	30% of our allowance
Other hospital services and supplies, such as: • Operating, recovery, maternity, and other treatment rooms • Prescribed drugs and medicines • Diagnostic laboratory tests and X-rays • Administration of blood and blood products • Blood or blood plasma, if not donated or replaced • Dressings, splints, casts, and sterile tray services • Medical supplies and equipment, including oxygen • Anesthetics, including nurse anesthetist services	25% of our allowance	30% of our allowance

Inpatient hospital - continued on next page

Benefit Description	You pay After the calendar year deductible. . .	
Inpatient hospital (cont.)	**High Option**	**Standard Option**
• Medical supplies, appliances, medical equipment, and any covered items billed by a hospital for use at home 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. We must authorize benefits for the administration of general anesthesia and for hospital services related to dental care, when the following members receive these services: • A dependent child age five and under; • A member who is severely disabled; or • A member who has a medical behavioral condition which requires hospitalization or general anesthesia when dental care is provided. A participating provider must administer the general anesthesia whether or not the dental services are provided in a hospital, surgical center or office.	25% of our allowance	30% of our allowance
Not covered: • *Custodial care* • *Non-covered facilities, such as nursing homes, schools* • *Personal comfort items, such as telephone, television, barber services, guest meals and beds* • *Private nursing care* • *Take home items*	*All charges*	*All charges*
Outpatient hospital or ambulatory surgical center	**High Option**	**Standard Option**
• Operating, recovery, and other treatment rooms • Prescribed drugs and medicines • Diagnostic laboratory tests, X-rays, and pathology services • Administration of blood, blood plasma, and other biologicals • Blood and blood plasma, if not donated or replaced • Pre-surgical testing • Dressings, casts, and sterile tray services • Medical supplies, including oxygen • Anesthetics and anesthesia service	25% of our allowance	30% of our allowance

Outpatient hospital or ambulatory surgical center - continued on next page

Benefit Description	You pay After the calendar year deductible. . .	
Outpatient hospital or ambulatory surgical center (cont.)	**High Option**	**Standard Option**
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. We must authorize benefits for the administration of general anesthesia and for hospital services related to dental care, when the following members receive these services: • A dependent child age five and under; • A member who is severely disabled; or • A member who has a medical behavioral condition which requires hospitalization or general anesthesia when dental care is provided. A participating provider must administer the general anesthesia whether or not the dental services are provided in a hospital, surgical center or office.	25% of our allowance	30% of our allowance
High Tech Diagnostics - CAT, PET, MRI, MRA, and EEGs	$250 per visit, No Deductible	$250 per visit, No Deductible
Not covered: Blood and blood derivatives not replaced by the member	*All charges*	*All charges*
Extended care benefits/Skilled nursing care facility benefits	**High Option**	**Standard Option**
A comprehensive range of benefits covered for 60 days per calendar year when full-time skilled nursing care is necessary and confinement in a skilled nursing facility is medically appropriate as determined by a Plan doctor and approved by the Plan. All necessary services are covered, including: • Bed, board and general nursing care • Drugs, biologicals, supplies, and equipment ordinarily provided and arranged by the skilled nursing facility when prescribed by a Plan doctor.	25% of our allowance	30% of our allowance
Not covered: Custodial care	*All charges*	*All charges*
Hospice care	**High Option**	**Standard Option**
Supportive and Palliative care for a terminally ill member is covered in the home or hospice facility. Services include inpatient and outpatient care and family counseling. These services are provided under the direction of a Plan doctor who certifies that the patient is in the terminal stages of illness, with a life expectancy of approximately six months or less.	25% of our allowance	30% of our allowance
Not covered:	*All charges*	*All charges*

Hospice care - continued on next page

Benefit Description	You pay After the calendar year deductible. . .	
Hospice care (cont.)	**High Option**	**Standard Option**
• *Service in the member's home outside of the service area* • *Any service for which the hospice does not customarily charge the member, or his or her family* • *Independent nursing, homemaker services*	*All charges*	*All charges*
Ambulance	**High Option**	**Standard Option**
• Local professional ambulance service to the nearest hospital equipped to handle your medical condition when medically appropriate. • Air ambulance when medically appropriate.	25% of our allowance	25% of our allowance

Section 5(d). Emergency services/accidents

Important things to keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- High Option: The calendar year deductible is $1,000 Self Only and $3,000 for Self and Family. The calendar year deductible applies to almost all benefits in this Section. We added ("No Deductible") to show when the calendar year deductible does not apply.
- Standard Option: The calendar year deductible is $2,000 Self Only and $6,000 for Self and Family. The calendar year deductible applies to almost all benefits in this Section. We added ("No Deductible") to show when the calendar year deductible does not apply.
- Be sure to read Section 4, *Your costs for covered services,* for valuable information about how cost-sharing works. Also read Section 9 about Coordinating benefits with other coverage, including with Medicare.

What is a medical emergency?

A medical emergency is the sudden and unexpected onset of a condition or an injury that manifests itself by symptoms of sufficient severity that would lead a prudent layperson to believe that immediate care is required. Some problems are emergencies because, if not treated promptly, they might become more serious; examples include deep cuts and broken bones. Others are emergencies because they are potentially life-threatening, such as heart attacks, strokes, poisonings, gunshot wounds, or sudden inability to breathe. There are many other acute conditions that we may determine are medical emergencies – what they all have in common is the need for quick action.

What to do in case of emergency:

In a medical emergency, call the local emergency system (e.g., the local 911 telephone system), or go to the nearest emergency facility. Be sure to tell the paramedics, or emergency room personnel that you are a Coventry Health Care of Kansas, Inc. Plan member so they can notify us. You or a family member must notify the Plan within 48 hours or as soon as reasonably possible. It is your responsibility to ensure that the Plan has been timely notified.

Emergencies within our service area:

If your symptoms are not life-threatening, contact your physician, who is on call 24 hours a day, seven days a week. During after hours or weekends, your physician my use an answering service, therefore your physician or covering physician will generally return your call within 30 minutes. We also provide **FirstHelp**, which is available to our members 24 hours a day, seven days a week by calling **1-800-622-9528**. With this service, registered nurses are available to help you to the appropriate level of care or provide medical advice.

If you need to be hospitalized and are admitted to a non-Plan facility, call Customer Service at 1-800-969-3343. You must notify us about your medical emergency within a reasonable time period as dictated by the circumstances. If you are hospitalized in a non-Plan hospital and a Plan physician believes your care can be provided in one of our Plan hospitals, we will transfer you when medically feasible with any ambulance charges covered in full.

To be covered by this Plan, any follow-up care recommended by non-Plan providers must be approved by the Plan.

We also provide access to Take Care Clinics (Walgreens), Minute Clinics (CVS Pharmacy), and several urgent care centers which are open on evenings, weekends and holidays, and are designed to give our members fast, effective quality care for non-emergent conditions such as: sprains, influenza, sore throats, ear infections, minor lacerations, and upper respiratory infections.

Emergencies outside our service area:

Benefits are available for any medically necessary health service that is immediately required because of injury or unforeseen illness. If you are hospitalized, the Plan must be notified within 48 hours on the first working day following your admission, unless it is not reasonably possible to notify the Plan within that time. If a Plan physician believes your care can be provided in one of our Plan hospitals, we will transfer you when medically feasible with any ambulance charges covered in full.

To be covered by this Plan, any follow-up care recommended by non-Plan providers must be approved by the Plan.

Benefit Description	You pay After the calendar year deductible. . .	
Emergency within our service area	**High Option**	**Standard Option**
• Emergency care at a doctor's office (consultation only)	$30 per visit to a primary care physician or OB/GYN, No Deductible $60 per visit to a specialist, No Deductible	$30 per visit to a primary care physician, No Deductible $60 per visit to a specialist, No Deductible
• Emergency care at an urgent care center • Take Care Clinic (Walgreens) • Minute Clinic (CVS Pharmacy)	$75 per urgent care visit, No Deductible $30 per visit, No Deductible	$75 per urgent care visit, No Deductible $30 per visit, No Deductible
• Emergency care at a hospital	$300 for facility and physician per visit, No Deductible; waived if admitted to hospital	30% Coinsurance for facility and physician per visit, No Deductible; waived if admitted to hospital
Not covered: Elective care or non-emergency care	*All charges*	*All charges*
Emergency outside our service area	**High Option**	**Standard Option**
• Emergency care at a doctor's office (consultation only)	$30 per visit to a primary care physician or OB/GYN, No Deductible $60 per visit to a specialist, No Deductible	$30 per visit to a primary care physician or OB/GYN, No Deductible $60 per visit to a specialist, No Deductible
• Emergency care at an urgent care center • Take Care Clinic (Walgreens) • Minute Clinic (CVS Pharmacy)	$75 per urgent care visit, No Deductible $30 per visit, No Deductible	$75 per urgent care visit, No Deductible $30 per visit, No Deductible
• Emergency care at a hospital	$300 for facility and physician per visit, No Deductible; waived if admitted to hospital	30% Coinsurance for facility and physician per visit, No Deductible; waived if admitted to hospital
Not covered: • *Elective care or non-emergency care* • *Emergency care provided outside the service area if the need for care could have been foreseen before leaving the service area* • *Medical and hospital costs resulting from a normal full-term delivery of a baby outside the service area*	*All charges*	*All charges*

Benefit Description	You pay After the calendar year deductible. . .	
Ambulance	**High Option**	**Standard Option**
• Local professional ambulance service to the nearest hospital equipped to handle your medical condition when medically appropriate. • Air ambulance when medically appropriate Note: See 5(c) for non-emergency service.	25% of our allowance	30% of our allowance

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

Important things to keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- High Option: The calendar year deductible is $1,000 Self Only and $3,000 Self and Family. The calendar year deductible applies to almost all benefits in this Section. We added ("No Deductible") to show when the calendar year deductible does not apply.
- Standard Option: The calendar year deductible is $2,000 Self Only and $6,000 Self and Family. The calendar year deductible applies to almost all benefits in this Section. We added ("No Deductible") to show when the calendar year deductible does not apply.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost-sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- **YOU MUST GET PREAUTHORIZATION FOR THESE SERVICES.** Benefits are payable only when we determine the care is clinically appropriate to treat your condition and only when you receive the care as part of a treatment plan that we approve. The treatment plan may include services, drugs, and supplies described elsewhere in this brochure. To be eligible to receive full benefits, you must follow the preauthorization process and get Plan approval of your treatment plan with MHNet Behavioral Health at 1-866-607-5970. They can be reached 24 hours a day, 7 days a week to answer questions and assist you in choosing appropriate services. Your mental health provider will obtain subsequent authorizations for treatment.
- We will provide medical review criteria or reasons for treatment plan denials to enrollees, patient or providers upon request or as otherwise required.
- OPM will base its review of disputes about treatment plans on the treatment plan's clinical appropriateness. OPM will generally not order us to pay or provide one clinically appropriate treatment plan in favor of another.

Benefit Description	You pay After the calendar year deductible. . .	
Professional Services	**High Option**	**Standard Option**
We cover professional services by licensed professional mental health and substance abuse practitioners when acting within the scope of their license, such as psychiatrists, psychologists, clinical social workers, licensed professional counselors, or marriage and family therapists.	Your cost-sharing responsibilities are no greater than for other illnesses or conditions.	Your cost-sharing responsibilities are no greater than for other illnesses or conditions.
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)	$0 per visit, No Deductible	$0 per visit, No Deductible

Professional Services - continued on next page

Benefit Description	You pay After the calendar year deductible. . .	
Professional Services (cont.)	**High Option**	**Standard Option**
• Diagnosis and treatment of alcoholism and drug abuse, including detoxification, treatment and counseling • Professional charges for intensive outpatient treatment in a provider's office or other professional setting • Electroconvulsive therapy	$0 per visit, No Deductible	$0 per visit, No Deductible
Diagnostics	**High Option**	**Standard Option**
• Outpatient diagnostic tests and billed by a licensed mental health and substance abuse practitioner • Outpatient diagnostic tests provided and billed by a laboratory, hospital or other covered facility • Inpatient diagnostic tests provided and billed by a hospital or other covered facility	25% of our allowance	30% of our allowance
Inpatient hospital or other covered facility	**High Option**	**Standard Option**
Inpatient services provided and billed by a hospital or other covered facility • Room and board, such as semiprivate or intensive accomodations, general nursing care, meals and special diets, and other hospital services	25% of our allowance	30% of our allowance
Outpatient hospital or other covered facility	**High Option**	**Standard Option**
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.	25% of our allowance	30% of our allowance
Not covered	**High Option**	**Standard Option**
• Services that are not part of a preauthorized approved treatment plan	All charges	All charges

Preauthorization

To be eligible to receive these benefits you must obtain a treatment plan and follow all of the following network authorization processes.

MHNet Behavioral Health, is contracted by Coventry Health Care of Kansas, Inc., to provide a network of providers who offer a variety of therapeutic services on an inpatient and outpatient basis.

All inpatient and outpatient treatment must be authorized through MHNet Behavioral Health, at 1-866-607-5970.

Limitation

We may limit your benefits if you do not obtain a treatment plan.

Section 5(f). Prescription drug benefits

Important things you should keep in mind about these benefits:

- We cover prescribed drugs and medications, as described in the chart beginning on the next page.
- 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.
- Members must make sure their physicians obtain prior approval/authorizations for certain prescription drugs and supplies before coverage applies. Prior approval/authorizations must be renewed periodically.
- We have no calendar year deductible for Prescription drugs.
- Be sure to read Section 4, *Your costs for covered services,* for valuable information about how cost-sharing works. Also, read Section 9 about coordinating benefits with other coverage, including with Medicare.

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 or certified Physician Assistant, Nurse Practitioner and Psychologist must prescribe your medication.

Where you can obtain them. You may fill the prescription at a participating pharmacy. You may obtain maintenance medication through Express Scripts, our mail order prescription drug program by calling the phone number on the back of your ID card.

We use a formulary. A formulary is a list of specific generic and brand name prescription drugs authorized by the Health Plan, and subject to periodic review and modification. Since there may be more than one brand name of a prescription drug, not all brands of the same prescription drug (e.g., different manufactures) may be included in the Formulary. If you would like information on whether a specific drug is included in our drug formulary, please call the Customer Service Department at the number on the back of your ID card. If your physician specifically prescribes a non-formulary drug because it is medically necessary, you will receive the non-formulary drug at the Plan non-formulary copayment.

These are the dispensing limitations. Prescription drugs will be dispensed in the quantity determined by the prescribing provider. The following also apply:

- One (1) applicable copayment is due each time a prescription is filled or refilled at a retail pharmacy for up to a thirty-one (31) day supply.
- Mail order drugs are obtained through Express Scripts, our mail order prescription drug program, and may be dispensed with three (3) applicable copayment(s) for a ninety-three (93) day supply. To order prescriptions or refills please contact the Customer Service number on the back of your ID card or visit the website www.express-scripts.com available 24 hours a day – 7 days a week.
- To promote appropriate utilization, or following manufacturer's recommendations, certain plan approved medications may have a quantity limit on the amount of medication dispensed and Prior Authorization must be obtained prior to dispensing.
- We reserve the right to include only one dosage or form of a drug on our Formulary when the same drug (i.e., a drug with the same active ingredient) is available in different dosages or forms (i.e., dissolvable tablets, capsules, etc) from the same or different manufacturers. The product, in the dosage or form, that is listed on the Formulary will be Covered at the applicable Member Responsibility. The drug, product or products, in different forms or dosages or from the same or different manufacturers, not listed on the Formulary will be excluded from coverage.
- Coverage of Prescription Drugs, therapeutic devices or supplies requiring a Prescription Order and prescribed by a Prescribing Provider is limited to Plan approved drugs, devices, supplies, or spacers for metered dose inhalers.

Members called to active military duty in a time of national or other emergency who need to obtain a greater-than-normal supply of prescribed medications should call us at the number on the back of your ID card.

- If a brand name prescription drug is dispensed, and an equivalent generic prescription is available, you pay an ancillary charge in addition to the brand name copayment. The ancillary charge will be due whether or not the prescribing provider indicates that the pharmacy is to "Dispense as Written." The ancillary charge is the difference between the average wholesale price of the brand name and the maximum allowable cost price of the generic prescription. Copayments and ancillary charges do not apply to the catastrophic protection out-of-pocket maximum.

Why use generic drugs? Generic drugs are lower-priced drugs that are the therapeutic equivalent to more expensive brand-name drugs. They must contain the same active ingredients and must be equivalent in strength and dosage to the original brand-name product. Generics cost less than the equivalent brand-name product. The U.S. Food and Drug Administration sets quality standards for generic drugs to ensure that these drugs meet the same standards of quality and strength as brand-name drugs. Generic drugs are indicated on the formulary listing of prescription drugs.

When you do have to file a manual claim. When you receive drugs from a Plan pharmacy and present your ID card, you do not have to file a manual claim. For a covered out-of-area emergency, you will need to file a claim when you receive drugs from a non-Plan pharmacy.

Benefit Description	You pay	
Covered medications and supplies	**High Option**	**Standard Option**
We cover the following medications and supplies prescribed by a Plan physician and obtained from a Plan pharmacy or through our mail order program: • Drugs and medicines that by Federal law of the United States require a physician's prescription for their purchase, except those listed as *Not covered.* • Insulin • Diabetic supplies, including insulin syringes, needles, glucose test tablets and test tape* • Disposable needles and syringes for the administration of covered medications. • Drugs for sexual dysfunction • Injectable contraceptive drugs (such as Depo Provera) • Immunosuppressant drugs required after a covered transplant* • Growth hormones and other self-administered injectables* • Vitamin D for adults 65 and older *Note: Non-formulary Diabetic supplies, etc., Immunosuppressants, and GHT require prior authorization. To find Your Prescription Drug, its applicable Tier and any Prior Authorization requirements, visit Our searchable Formulary on Our website www.chckansas.com, in the Participating Provider's office, or by contacting the Customer Service Department.	**Retail Pharmacy** **Tier 1A** - $3 Copayment (No Deductible) per prescription **Tier 1B** - $12 Copayment (No Deductible) per prescription **Tier 2** - $50 Copayment (No Deductible) per prescription **Tier 3** - $75 Copayment (No Deductible) per prescription **Tier 4** - 20% Coinsurance or $75 Copayment, which ever is greater up to $200 maximum per individual prescription. A separate catastrophic maximum of $2,500 per covered individual applies to Tier 4. **Mail Order (93 day supply)** **Tier 1A** - $9 Copayment (No Deductible) per prescription **Tier 1B** - $36 Copayment (No Deductible) per prescription **Tier 2** - $150 Copayment (No Deductible) per prescription **Tier 3** - $225 Copayment (No Deductible) per prescription **Tier 4** - Not Available	**Retail Pharmacy** **Tier 1A -** $3 Copayment (No Deductible) per prescription **Tier 1B -** $12 Copayment (No Deductible) per prescription **Tier 2 -** $50 Copayment (No Deductible) per prescription **Tier 3 -** 20% Coinsurance or $75 Copayment, which ever is greater up to $100 maximum per individual prescription. **Tier 4 -** 20% Coinsurance or $75 Copayment, which ever is greater up to $200 maximum per individual prescription. A separate catastrophic maximum of $3,500 per covered individual applies to Tier 4. **Mail Order (93 day supply)** **Tier 1A** - $9 Copayment (No Deductible) per prescription **Tier 1B** - $36 Copayment (No Deductible) per prescription **Tier 2** - $150 Copayment (No Deductible) per prescription **Tier 3** - 20% Coinsurance or $225 Copayment, which ever is greater up to $300 maximum per individual prescription.

Covered medications and supplies - continued on next page

Benefit Description	You pay	
Covered medications and supplies (cont.)	**High Option**	**Standard Option**
	Note: If there is no Tier 1 equivalent available, you will still have to pay the Tier 2 copayment. If there is a Tier 1 equivalent and you choose the Tier 2 drug, you will pay the Tier 2 copayment plus the difference in the average wholesale price between the Tier 1 and Tier 2 drug. The Ancillary charge does not apply to any deductible or catastrophic maximum. This applies to both formulary and non-formulary drugs.	**Tier 4** - Not Available Note: If there is no Tier 1 equivalent available, you will still have to pay the Tier 2 copayment. If there is a Tier 1 equivalent and you choose the Tier 2 drug, you will pay the Tier 2 copayment plus the difference in the average wholesale price between the Tier 1 and Tier 2 drug. The Ancillary charge does not apply to any deductible or catastrophic maximum. This applies to both formulary and non-formulary drugs.
• Insulin – Under retail pharmacy benefit, you can obtain up to a 3 month supply of insulin. • Diabetic supplies* – Under retail pharmacy benefit, you can obtain up to a 3 month supply of diabetic supplies (non-formulary supplies requires prior-authorization). • Oral and injectable contraceptive drugs – Under retail pharmacy benefit, you can obtain up to a 3 month supply.	**Retail Pharmacy** **Tier 1A** - $9 Copayment (No Deductible) per prescription **Tier 1B** - $36 Copayment (No Deductible) per prescription **Tier 2** - $150 Copayment (No Deductible) per prescription **Tier 3** - $225 Copayment (No Deductible) per prescription **Tier 4** - 20% Coinsurance or $225 Copayment, which ever is greater up to $600 maximum per individual prescription. Out-of-pocket maximum is $2,500 per covered individual.	**Retail Pharmacy** **Tier 1A** - $9 Copayment (No Deductible) per prescription **Tier 1B** - $36 Copayment (No Deductible) per prescription **Tier 2** - $150 Copayment (No Deductible) per prescription **Tier 3** - $225 Copayment (No Deductible) per prescription **Tier 4** - 20% Coinsurance or $225 Copayment, which ever is greater up to $600 maximum per individual prescription. Out-of-pocket maximum is $3,500 per covered individual.
Women's contraceptive drugs and devices • The morning after pill emergency contraceptives is covered if prescibed by a physician and purchased at a network pharmacy. This is an over-the-counter (OTC) drug.	Nothing	Nothing
Not covered: • *Drugs and supplies for cosmetic purposes* • *Medical supplies such as dressings and antiseptics*	*All charges*	*All charges*

Covered medications and supplies - continued on next page

Benefit Description	You pay	
Covered medications and supplies (cont.)	**High Option**	**Standard Option**
• *Medications used for cosmetic purposes or to enhance work or athletic performance (i.e. Nuvigil or Provigil for shift work, anabolic steroids and minoxidil lotion, retin A (tretinoin) for aging skin). Also excluded are drugs, oral or injectable, used to slow or reverse normal aging processes (i.e. growth hormone, testosterone, etc.).* • *Fertility drugs* • *Drugs obtained at a non-Plan pharmacy; except for out-of-area emergencies* • *Vitamins, nutrients and food supplements even if a physician prescribes or administers them, except as specified on the Formulary* • *Drugs available without a prescription or for which there is a non-prescription equivalent; except those designated by the plan* • *Appetite suppressants and other drugs to assist in weight control (except for the treatment of morbid obesity when authorized by us).* • *Nonprescription medicines; except those designated by the plan* • *Dosage forms of natural estrogen or progesterone; or any natural hormone replacement product, including but not limited to oral capsules, suppositories, creams and troches* • *Prescription drugs for non-covered services* • *Drugs for hair restoration* *Note: Physician prescribed over-the-counter and prescription drugs approved by the FDA to treat tobacco dependence are covered under the Tobacco cessation benefit. (See section 5(a) educational classes and programs)*	*All charges*	*All charges*

Section 5(g). Dental benefits

Important things to keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable when we determine they are dentally 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.
- We have no calendar year deductible for diagnostic and preventative services.
- Locate a Coventry Dental Provider at www.chckansas.com, under Member page, click on "Find a dentist" to search for a provider in your area or call customer service toll-free at 1-866-433-6391. If you are unable to locate a network provider in your area, you may seek covered dental service from a non-particiapting provider at no additional cost.
- There are no benefits for any service which is not specifically listed in this brochure.
- Some procedures and treatments may have specific age and frequency limitations as noted below.
- We cover hospitalization for dental procedures only when a non-dental physical impairment which makes hospitalization necessary to safeguard the health of the patient. Section 5(c) for inpatient benefits. We do not cover the dental procedure unless it is described below.
- Important Note**: IT IS YOUR RESPONSIBILITY TO BE INFORMED ABOUT YOUR DENTAL COVERAGE.**

Benefit Desription	You Pay After the calendar year deductible. . .	
Accidental injury benefit	**High Option**	**Standard Option**
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.	The remaining cost after a 25% reduction of participating specialist fees	The remaining cost after a 30% reduction of participating specialist fees

Dental Benefits	You Pay	
Dental services	**High Option**	**Standard Option**
Diagnostic: Oral examinations: once each twelve (12) months Diagnostic x-rays: bitewings once each twelve (12) months Full mouth x-rays: once each five (5) years	Nothing, No Deductible	Nothing, No Deductible
Preventive: Prophylaxis (cleanings) once every (12) months Topical Fluoride: once every (12) months for dependent children under age (19) Space maintainers for dependent children under age (14) and only for premature loss of primary molars	Nothing, No Deductible	Nothing, No Deductible

Dental services - continued on next page

Dental Benefits	You Pay	
Dental services (cont.)	**High Option**	**Standard Option**
Sealants: once per lifetime for dependent children under age (15) when applied to permanent molars, with no caries (decay) or restorations on any surface, and with the occlusal surface intact	Nothing, No Deductible	Nothing, No Deductible
Not covered: *All services which are not specifically listed in this brochure.*	*All charges*	*All charges*

Section 5(h). Special features

Feature	Description
Flexible benefits option	Under the flexible benefits option, we determine the most effective way to provide services. • We may identify medically appropriate alternatives to regular contract benefits as a less costly alternative. If we identify a less costly alternative, 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 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).
24 hour nurse line	Call FirstHelp anytime you or a family member experience health symptoms that need attention. Nurses are available to you and your family 24 hours a day, 7 days a week and are trained to handle your questions. Any member who visits an emergency room or urgent care center as a result of advice from FirstHelp will automatically have associated claims approved. With FirstHelp authorization, you will know in advance if medical services will be covered. You may call 1-800-622-9528 or for the hearing impaired call 1-800-735-2966.
Services for deaf and hearing impaired	The Kansas TDD relay number is 1-800-766-3777. The Missouri TDD relay number is 1-800-735-2966.
Transplant Network	In order to provide members requiring a transplant the opportunity for the best outcomes and experiences, we use our own Coventry Transplant Network.

Section 5. High Deductible Health Plan Benefits

See page 16 for how our benefits changed this year and page 137 for a benefits summary.

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Section 5. High Deductible Health Plan Benefits Overview

This Plan offers a High Deductible Health Plan (HDHP). The HDHP benefit package is described in this section. Make sure that you review the benefits that are available under the benefit product in which you are enrolled.

HDHP Section 5, which describes the HDHP benefits, is divided into subsections. Please read *Important things you should keep in mind* at the beginning of each subsection. Also read the general exclusions in Section 6; they apply to benefits in the following subsections. To obtain claim forms, claims filing advice, or more information about HDHP benefits, contact us at 1-800-969-3343 or on our website at www.chckansas.com.

Our HDHP option provides comprehensive coverage for high-cost medical events and a tax-advantaged way to help you build savings for future medical expenses. The Plan gives you greater control over how you use your health care benefits.

When you enroll in this HDHP, we establish either a Health Savings Account (HSA) or a Health Reimbursement Arrangement (HRA) for you. We automatically pass through a portion of the total health Plan premium to your HSA or credit an equal amount to your HRA based upon your eligibility. Your full annual HRA credit will be available on your effective date of enrollment.

With this Plan, preventive care is covered in full. As you receive other non-preventive medical care, you must meet the Plan's deductible before we pay benefits according to the benefits described in this Section. You can choose to use funds available in your HSA to make payments toward the deductible or you can pay toward your deductible entirely out-of-pocket, allowing your savings to continue to grow.

This HDHP includes five key components: preventive care; traditional medical coverage health care that is subject to the deductible; savings, catastrophic protection for out-of-pocket expenses, and, health education resources and account management tools.

- **Preventive care** — The Plan covers preventive care services, such as periodic health evaluations (e.g., annual physicals), screening services (e.g., mammograms), routine prenatal and well-child care and child immunizations. These services are covered at 100%, if you use a network provider and the services are described in Section 5. *Preventive care*.
- **Traditional medical coverage** — After you have paid the Plan's deductible, we pay benefits under traditional medical coverage described in the HDHP Section 5(b).

  Covered services include:
  - Medical services and supplies provided by physicians and other health care professionals
  - Hearing services and devices
  - Surgical and anesthesia services provided by physicians and other health care professionals
  - Hospital services; other facility or ambulance services
  - Emergency services/accidents
  - Mental health and substance abuse benefits
  - Prescription drug benefits
  - Dental benefits
- **Savings** — Health Savings Accounts or Health Reimbursement Arrangements provide a means to help you pay out-of-pocket expenses (See Section 5a Savings - HSAs and HRAs)

Health Savings Accounts (HSAs)

By law, HSAs are available to members who are not enrolled in Medicare, cannot be claimed as a dependent on someone else's tax return, have not received VA and/or Indian Health Services (IHS) benefits within the last three months, or do not have other health insurance coverage other than another high deductible health plan. In 2015, for each month you are eligible for an HSA premium pass through, we will contribute to your HSA $66.66 per month for a Self-Only enrollment or $133.33 per month for a Self and Family enrollment. In addition to our monthly contribution, you have the option to make additional tax-free contributions to your HSA, so long as total contributions do not exceed the limit established by law, which is $3,350 for an individual and $6,650 for family - see maximum contribution information in HDHP Section 5(c). You can use funds in your HSA to help pay your health plan deductible**.** You own your HSA, so the funds can go with you if you change plans or employment.

Federal tax tip: There are tax advantages to fully funding your HSA as quickly as possible. Your HSA contribution payments are fully deductible on your Federal tax return. By fully funding your HSA early in the year, you have the flexibility of paying medical expenses from tax-free HSA dollars or after tax out-of-pocket dollars. If you don't deplete your HSA and you allow the contributions and the tax-free interest to accumulate, your HSA grows more quickly for future expenses.

HSA features include:

- Your HSA is administered by Coventry Consumer Advantage (C3).
- Your contributions to the HSA are tax deductible
- You may establish pre-tax HSA deductions from your paycheck to fund your HSA up to IRS limits using the same method that you use to establish other deductions (i.e., Employee Express, MyPay, etc.)
- You can make tax-free withdrawals for qualified medical expenses for you, your spouse and dependents. (See IRS publication 502 for a complete list of eligible expenses.)
- Your unused HSA funds and interest accumulate from year to year
- It's portable - the HSA is owned by you and is yours to keep, even when you leave Federal employment or retire
- When you need it, funds up to the actual HSA balance are available
- Smart Payment features as described on page 14.

Important consideration if you want to participate in a Health Care Flexible Spending Account (HCFSA): If you are enrolled in this HDHP with a Health Savings Account (HSA), and start or become covered by a HCFSA health care flexible spending account (such as FSAFEDS offers – see Section 11), this HDHP cannot continue to contribute to your HSA. Similarly, you cannot contribute to an HSA if your spouse enrolls in an HCFSA. Instead, when you inform us of your coverage in an HCFSA, we will establish an HRA for you.

Health Reimbursement Arrangements (HRAs)

If you aren't eligible for an HSA, for example, you are enrolled in Medicare or have another health plan, we will administer and provide an HRA instead. You must notify us when you are ineligible for an HSA.

In 2015, we will give you an HRA credit of $800 per year for a Self-Only enrollment and $1,600 per year for a Self and Family enrollment. You can use funds in your HRA to help pay your health Plan deductible and/or for certain expenses that don't count toward the deductible.

HRA features include:

- For our HDHP option, the HRA is administered by Coventry Consumer Advantage (C3).

- Tax-free credit can be used to pay for qualified medical expenses for you and any individuals covered by this HDHP
- Unused credits carryover from year to year
- HRA credit does not earn interest
- HRA credit is forfeited if you leave Federal employment or switch health insurance plans
- Smart Pay features as described on page 14.
- An HRA does not affect your ability to participate in an FSAFEDS Health Care Flexible Spending Account (HCFSA). However, you must meet FSAFEDS eligibility requirements.

- **Catastrophic protection for out-of-pocket expenses**

When you use network providers, your annual maximum for out-of-pocket expenses (deductibles, coinsurance and copayments) for covered services is limited to $4,000 Self Only or $8,000 Self and Family. However, certain expenses do not count toward your out-of-pocket maximum and you must continue to pay these expenses once you reach your out-of-pocket maximum (such as expenses in excess of the Plan's benefit limit). Refer to Section 4 *Your catastrophic protection out-of-pocket maximum*, HDHP Section 5(b) *Traditional medical coverage subject to the deductible* for more details.

- **Health education resources and account management tools**

HDHP Section 5(i) describes the health education resources and account management tools available to you to help you manage your health care and your health care dollars.

Section 5. Savings – HSAs and HRAs

Feature Comparison	Health Savings Account (HSA)	Health Reimbursement Arrangement (HRA) Provided when you are ineligible for an HSA
Administrator	The Plan will establish an HSA for you with ***Coventry Consumer Advantage (C3),*** this HDHP's fiduciary (an administrator, trustee or custodian as defined by Federal tax code and approved by IRS). ***Coventry Consumer Advantage*** **(C3)** ***PO Box 7758*** ***London, KY 40742*** ***1-800-969-3343 or https://www.chckansas.com***	***Coventry Consumer Advantage (C3)*** ***PO Box 7758*** ***London, KY 40742*** ***1-800-969-3343 or https://www.chckansas.com***
Fees	Set-up fee, and monthly maintenance fee are paid by the HDHP as long as you are enrolled in the HDHP.	Set-up fee paid by the HDHP.
Eligibility	You must: • Enroll in this HDHP • Have no other health insurance coverage (does not apply to specific injury, accident, disability, dental, vision or long-term care coverage) • Not be enrolled in Medicare • Not be claimed as a dependent on someone else's tax return • Not have received VA and/or Indian Health Services (IHS) benefits in the last three months • Complete and return all banking paperwork	You must enroll in this HDHP. Eligibility is determined on the first day of the month following your effective day of enrollment and will be prorated for length of enrollment.
Funding	If you are eligible for HSA contributions, a portion of your monthly health plan premium is deposited to your HSA each month. Premium pass through contributions are based on the effective date of your enrollment in the HDHP.	Eligibility for the annual credit will be determined on the first day of the month and will be prorated for length of enrollment. The entire amount of your HRA will be available to you upon your enrollment.

	In addition, you may establish pre-tax HSA deductions from your paycheck to fund your HSA up to IRS limits using the same method that you use to establish other deductions (i.e. Employee Express, MyPay, etc.).	
• **Self Only enrollment**	For 2015, a monthly premium pass through of $66.66 will be made by the HDHP directly into your HSA each month.	For 2015, your HRA annual credit is $800 (prorated for mid-year enrollment).
• **Self and Family enrollment**	For 2015, a monthly premium pass through of $133.33 will be made by the HDHP directly into your HSA each month.	For 2015, your HRA annual credit is $1,600 (prorated for mid-year enrollment).
Contributions/credits	The maximum that can be contributed to your HSA is an annual combination of HDHP premium pass through and enrollee contribution funds, which when combined, do not exceed the maximum contribution amount set by the IRS of $3,350 for an individual and $6,650 for a family. If you enroll during Open Season, you are eligible to fund your account up to the maximum contribution limit set by the IRS. To determine the amount you may contribute, subtract the amount the Plan will contribute to your account for the year from the maximum allowable contribution. You are eligible to contribute up to the IRS limit for partial year coverage as long as you maintain your HDHP enrollment for 12 months following the last month of the year of your first year of eligibility. To determine the amount you may contribute, take the IRS limit and subtract the amount the Plan will contribute to your account for the year. If you do not meet the 12 month requirement, the maximum contribution amount is reduced by 1/12 for any month you were ineligible to contribute to an HSA. If you exceed the maximum contribution amount, a portion of your tax reduction is lost and a 10% penalty is imposed. There is an exception for death or disability.	The full HRA credit will be available, subject to proration, on the effective date of enrollment. The HRA does not earn interest.

	You may rollover funds you have in other HSAs to this HDHP HSA (rollover funds do not affect your annual maximum contribution under this HDHP). HSAs earn tax-free interest (does not affect your annual maximum contribution). Catch-up contribution discussed on page 76.	
• **Self Only enrollment**	You may make an annual maximum contribution of $3,350.	You cannot contribute to the HRA.
• **Self and Family enrollment**	You may make an annual maximum contribution of $6,650	You cannot contribute to the HRA.
Access funds	You can access your HSA by the following methods: • Debit Card • Withdrawal form • Smart Payment through www.chckansas.com, My Online Services	You can access your HRA by the following methods: • Withdrawal form • Smart Payment through www.chckansas.com, My Online Services
Distributions/withdrawals • **Medical**	You can pay the out-of-pocket expenses for yourself, your spouse or your dependents (even if they are not covered by the HDHP) from the funds available in your HSA. Non-reimbursed qualified medical expenses are allowable if they occur after the effective date of your enrollment in this Plan See *Availability of funds* below for information on when funds are available in the HSA. See IRS Publication 502 for a list of eligible medical expenses. Medicare premiums and other types of medical insurance premiums are also reimbursable. If you have signed up for EFT you can request reimbursement for any amount. Paper checks require $25.00 minimum before funds will be issued.	You can pay the out-of-pocket expenses for qualified medical expenses for individuals covered under the HDHP. Non-reimbursed qualified medical expenses are allowable if they occur after the effective date of your enrollment in this Plan. See *Availability of funds* below for information on when funds are available in the HRA. See IRS Publication 502 for a list of eligible medical expenses. Medicare premiums and ther types of medical insurance premiumsare also reimbursable. If you have signed up for EFT you can request reimbursement for any amount. Paper checks require $25.00 minimum before funds will be issued.
• **Non-medical**	If you are under age 65, withdrawal of funds for non-medical expenses will create a 20% income tax penalty in addition to any other income taxes you may owe on the accumulated funds.	Not applicable – distributions will not be made for anything other than non-reimbursed qualified medical expenses

	When you turn age 65, distributions can be used for any reason without being subject to the 20% penalty, however they will be subject to ordinary income tax.	
Availability of funds	Funds are not available for withdrawal until all the following steps are completed: • Your enrollment in this HDHP is effective (effective date is determined by your agency in accord with the event permitting the enrollment change). • The HDHP receives record of your enrollment and initially establishes your HSA account with the fiduciary by providing information it must furnish and by contributing the minimum amount required to establish an HSA. • The fiduciary sends you HSA paperwork for you to complete and the fiduciary receives the completed paperwork back from you.	The entire amount of your HRA will be available to you upon your enrollment in the HDHP.
Account owner	FEHB enrollee	HDHP
Portable	You can take this account with you when you change plans, separate or retire. If you do not enroll in another HDHP, you can no longer contribute to your HSA. See page 70 for HSA eligibility.	If you retire and remain in this HDHP, you may continue to use and accumulate credits in your HRA. If you terminate employment or change health plans, only eligible expenses incurred while covered under the HDHP will be eligible for reimbursement subject to timely filing requirements. Unused funds are forfeited.
Annual rollover	Yes, accumulates without a maximum cap.	Yes, accumulates without a maximum cap.

If you have an HSA

- **Contributions**

  All contributions are aggregated and cannot exceed the maximum contribution amount set by the IRS. You may contribute your own money to your account through payroll deductions, or you may make lump sum contributions at any time, in any amount not to exceed an annual maximum limit. If you contribute, you can claim the total amount you contributed for the year as a tax deduction when you file your income taxes. Your own HSA contributions are either tax-deductible or pre-tax (if made by payroll deduction). You receive tax advantages in any case. To determine the amount you may contribute, subtract the amount the Plan will contribute to your account for the year from the maximum contribution amount set by the IRS. You have until April 15 of the following year to make HSA contributions for the current year.

  If you newly enroll in an HDHP during Open Season and your effective date is after January 1st or you otherwise have partial year coverage, you are eligible to fund your account up to the maximum contribution limit set by the IRS as long as you maintain your HDHP enrollment for 12 months following the last month of the year of your first year of eligibility. If you do not meet this requirement, a portion of your tax reduction is lost and a 10% penalty is imposed. There is an exception for death or disability.

- **Catch-up contributions**

  If you are age 55 or older, the IRS permits you to make additional "catch-up" contributions to your HSA. The allowable catch-up contribution is $1,000. Contributions must stop once an individual is enrolled in Medicare. Additional details are available on the U.S. Department of Treasury website at www.ustreas.gov/offices/public-affairs/hsa/.

- **If you die**

  If you have not named a beneficiary, and you are married, your HSA becomes your spouse's; otherwise, your HSA becomes part of your taxable estate.

- **Qualified expenses**

  You can pay for "qualified medical expenses," as defined by IRS Code 213(d). These expenses include, but are not limited to, medical plan deductibles, diagnostic services covered by your plan, long-term care premiums, health insurance premiums if you are receiving Federal unemployment compensation, **physician prescribed** over-the-counter drugs, LASIK surgery, and some nursing services.

  When you enroll in Medicare, you can use the account to pay Medicare premiums or to purchase health insurance other than a Medigap policy. You may not, however, continue to make contributions to your HSA once you are enrolled in Medicare.

  For a detailed list of IRS-allowable expenses, request a copy of IRS Publication 502 by calling 1-800-829-3676, or visit the IRS website at www.irs.gov and click on "Forms and Publications." Note: Although **physician prescribed** over-the-counter drugs are not listed in the publication, they are reimbursable from your HSA. Also, insurance premiums are reimbursable under limited circumstances.

- **Non-qualified expenses**

  You may withdraw money from your HSA for items other than qualified health expenses, but it will be subject to income tax and if you are under 65 years old, an additional 20% penalty tax on the amount withdrawn.

- **Tracking your HSA balance**

  You will receive a periodic statement that shows the "premium pass through", withdrawals, and interest earned on your account. In addition, you will receive an Explanation of Payment statement when you withdraw money from your HSA. You may go to www.chckansas.com and view your account through My Online Services.

- **Minimum reimbursements from your HSA**

  You can request reimbursement in any amount. However, funds will not be disbursed until your reimbursement totals at least $25.

If you have an HRA

- **Why an HRA is established**

  If you don't qualify for an HSA when you enroll in this HDHP, or later become ineligible for an HSA, we will establish an HRA for you. If you are enrolled in Medicare, you are ineligible for an HSA and we will establish an HRA for you. You must tell us if you become ineligible to contribute to an HSA.

- **How an HRA differs**

  Please review the chart on page 72 which details the differences between an HRA and an HSA. The major differences are:

  - you cannot make contributions to an HRA
  - funds are forfeited if you leave the HDHP
  - an HRA does not earn interest
  - HRAs can only pay for qualified medical expenses, such as deductibles, copayments, and coinsurance expenses, for individuals covered by the HDHP. FEHB law does not permit qualified medical expenses to include 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.

Section 5. Preventive care

Important things you should keep in mind about these benefits:

- Preventive care services listed in this Section are not subject to the deductible.
- You must use providers that are part of our network.
- For all other covered expenses, please see Section 5 – *Traditional medical coverage subject to the deductible*.

Benefit Description	You pay
Preventive care, adult	
Routine screenings, such as: • Blood tests • Urinalysis • Total Blood Cholesterol • Routine Prostate Specific Antigen (PSA) test • Colorectal Cancer Screening, including - Fecal occult blood test - Sigmoidoscopy screening - Colonoscopy screening • Routine annual digital rectal exam (DRE) for men	Nothing, No Deductible
Well woman care; including, but not limited to: • Routine Pap test • Human papillomavirus testing for women age 30 and up once every three years • Annual counseling for sexually transmitted infections • Annual counseling for screeing for human immune-deficiency virus • Contraceptive methods and counseling • Screening and counseling for interpersonal and domestic violence	Nothing, No Deductible
Routine mammogram - covered for women age 35 and older, as follows: • From age 35 through 39, one during this five year period • From age 40 through 64, one every calendar year • At age 65 and older, one every two consecutive calendar years	Nothing, No Deductible
Note: A complete list of preventive care services recommended under the U.S. Preventive Services Task Force is available (USPSTF) online at http://www.uspreventiveservicestaskforce.org/uspstf/uspsabrecs.htm and HHS at www.healthcare.gov/prevention.	
Adult routine immunizations endorsed by the Centers for Disease Control and Prevention (CDC):	Nothing, No Deductible
Routine physicals which include: • One exam every 24 months up to age 65 • One exam every 12 months age 65 and older Routine exams limited to: • One routine eye exam every 12 months	Nothing, No Deductible

Preventive care, adult - continued on next page

Benefit Description	You pay
Preventive care, adult (cont.)	
• One routine hearing exam every 24 months	Nothing, No Deductible
Not covered: • *Physical exams and immunizations required for obtaining or continuing employment or insurance, attending schools or camp, athletic exams or travel.* • *Immunizations, boosters, and medications for travel.*	*All charges*
Preventive care, children	
Professional services, such as: • Well-child visits for routine examinations and care • Pediatric routine immunizations endorsed by the Centers for Disease Control and Prevention (CDC) and recommended by the American Academy of Pediatrics. Examinations, such as: • Routine eye exam through age 17 • Routine hearing exam through age 17	Nothing, No Deductible
Note: A complete list of preventive care services recommended under the U.S. Preventive Services Task Force is available (USPSTF) online at http://www.uspreventiveservicestaskforce.org/uspstf/uspsabrecs.htm and HHS at www.healthcare.gov/prevention.	
Not covered • *Physical exams and immunizations required for obtaining or continuing employment or insurance, attending schools or camp, or travel .* • *Immunizations, boosters, and medications for travel*	*All charges*

Section 5. Traditional medical coverage subject to the deductible

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-network preventive care is covered at 100% (see page 78) and is not subject to the calendar year deductible.
- The deductible is $2,500 Self Only or $5,000 Self and Family enrollment. The family deductible can be satisfied by one or more family members. The deductible applies to almost all benefits in Section 5. You must pay your deductible before your Traditional Medical Coverage may begin.
- Under Traditional Medical Coverage, you are responsible for your deductible for covered expenses.
- When you use network providers, you are protected by an annual catastrophic maximum on out-of-pocket expenses for covered services. After your copayments and deductibles total $4,000 Self Only or $8,000 Self and Family enrollment in any calendar year, you do not have to pay any more for covered services from network providers. However, certain expenses do not count toward your out-of-pocket maximum and you must continue to pay these expenses once you reach your out-of-pocket maximum (such as expenses in excess of the Plan's benefit limits, and payments for dental care services).
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost-sharing works. Also read Section 9 about coordinating benefits with other coverage including with Medicare.

Benefit Description	You pay After the calendar year deductible…
Deductible before Traditional medical coverage begins	
The deductible applies to almost all benefits in this Section. In the **You Pay** column, we say "No Deductible" when it does not apply. When you receive covered services from network providers, you are responsible for paying the allowable charges until you meet the deductible. After you meet the deductible and catastrophic out-of-pocket maximum, we pay the allowable charge for covered services.	100% of allowable charges until you meet the deductible of $2,500 for Self-Only or $5,000 for Self and family.

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

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- You must use providers that are part of our network.
- The deductible is $2,500 Self Only or $5,000 Self and Family enrollment. The family deductible can be satisfied by one or more family members. The deductible applies to almost all benefits in this Section, unless we indicate differently.
- After you have satisfied your deductible, coverage begins for traditional medical services.
- Under Traditional Medical Coverage, you will be responsible for your deductible, coinsurance and copayments for eligible medical expenses and prescriptions.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost-sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

Benefit Description	You pay After the calendar year deductible…
Diagnostic and treatment services	
Professional services of physicians • In physician's office • Adult routine immunizations endorsed by the Centers for Disease Control and Prevention (CDC) • In an urgent care center • During a hospital stay • In a skilled nursing facility • Office medical consultations • Second Surgical opinion • At home	20% of our allowance
Lab, X-ray and other diagnostic tests	
Tests, such as: • Blood tests • Urinalysis • Non-routine Pap tests • Pathology • X-rays • Non-routine mammograms • CAT Scans/MRI • Ultrasound • Electrocardiogram and EEG	20% of our allowance

Benefit Description	You pay After the calendar year deductible…
Maternity care	
Complete maternity (obstetrical) care, such as: • Prenatal care • Screening for gestational diabetes for pregnant women between 24-28 weeks gestation or first prenatal visit for women at a high risk. • Delivery • Postnatal care	20% of our allowance
Breastfeeding support, supplies and counseling for each birth	Nothing
Note: Here are some things to keep in mind: • You do not need to precertify your normal delivery; see below for other circumstances, such as extended stays for you or your baby. • You may remain in the hospital up to 48 hours after a regular delivery and 96 hours after a cesarean delivery. We will cover an extended inpatient stay if medically necessary but you, your representatives, your doctor, or your hospital must recertify the extended stay. • 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 only if we cover the infant under a Self and Family enrollment. Surgical benefits, not maternity benefits, apply towards circumcision the newborn. • We pay hospitalization and surgeon services for non-maternity care the same as for illness and injury.	
Not covered: Routine sonograms to determine fetal age, size or sex.	*All charges*
Family planning	
A range of voluntary family planning services, limited to: • Voluntary sterilization (See Surgical procedures Section 5 (b)) • Surgically implanted contraceptives • Injectable contraceptive drugs (such as Depo provera) • Intrauterine devices (IUDs) • Diaphragms Note: We cover oral contraceptives under the prescription drug benefit.	Nothing
Contraceptive counseling on an annual basis	Nothing
Not covered: • *Reversal of voluntary surgical sterilization* • *Genetic counseling.*	*All charges*

Benefit Description	You pay After the calendar year deductible…
Infertility services	
Diagnosis and treatment of infertility such as: • Artificial insemination: - Intravaginal insemination (IVI) - Intracervical insemination (ICI) - Intrauterine insemination (IUI)	20% of our allowance
Not covered: • *Assisted reproductive technology (ART) procedures, such as:* - *In Vitro fertilization* - *embryo transfer, gamete intra-fallopian transfer (GIFT) and zygote intra-fallopian transfer (ZIFT)* • *Services and supplies related to ART procedures* • *Cost of donor sperm* • *Cost of donor egg* • *Fertility drugs*	*All charges*
Allergy care	
• Testing and treatment • Allergy injections • Allergy serum	20% of our allowance
Not covered: Provocative food testing and sublingual allergy desensitization	*All charges*
Treatment therapies	
• Chemotherapy and radiation therapy Note: High dose chemotherapy in association with autologous bone marrow transplants is limited to those transplants listed under Organ/Tissue Transplants *(see Section 5b Surgical and anesthesia services provided by physicians and other health care).* • Respiratory and inhalation therapy - outpatient rehabilitation limited to 60 visits per condition • Dialysis - hemodialysis and peritoneal dialysis • Intraveneous (IV)/Infusion Therapy - Home IV and antibiotic therapy • Grownth hormone therapy (GHT) Note: Growth hormone is covered under the prescription drug benefit. Note: We only cover GHT when we preauthorize the treatment. Call 1-800-969-3343 for preauthorization. We will ask you to submit information that establishes that the GHT is medically necessary. Ask us to authorize GHT before you begin treatment. We will only cover GHT services and related services and supplies that we determine are medically necessary. See *Other services* under *You need prior Plan approval for certain services* in Section 3.	20% of our allowance

Benefit Description	You pay After the calendar year deductible…
Physical and occupational therapies	
60 visits per condition for the each of the following services: • Qualified physical therapists • Occupational therapists (Chiropractors coverage included in the visit limit, See Chiropractic) Note: We only cover therapy when a provider: • orders the care; • identifies the specific professional skills the patient requires and the medical necessity for skilled services; and • indicates the length of time the services are needed. Cardiac rehabilitation following a heart transplant, bypass surgery or a myocardial infarction is provided for up to 60 sessions. Habilitative Services – 60 visits per condition for the following services: physical, occupational and speech therapies. Habilitative services will be subject to the same copay and visits as rehabilitative services.	20% of our allowance
Not covered: • *Long-term rehabilitative therapy* • *Exercise programs*	*All charges*
Speech therapy	
60 visits per condition Habilitative Services – 60 visits per condition for the following services: physical, occupational and speech therapies. Habilitative services will be subject to the same copay and visits as rehabilitative services.	20% of our allowance
Hearing services (testing, treatment, and supplies)	
• For treatment related to illness or injury, including evaluation and diagnostic hearing tests performed by an M.D., D.O., or audiologist	20% of our allowance Note: For routine hearing screening performed during a child's preventive care visit, see Section 5(a) *Preventive care, children*
• External hearing aids • Implanted hearing-related devices, such as bone anchored hearing aids (BAHA) and cochlear implants	20% of our allowance Note: For benefits for the devices, see Section 5(a) *Orthopedic and prosthetic devices.*
Not covered: • *Hearing services that are not shown as covered*	*All charges*

Benefit Description	You pay After the calendar year deductible…
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)	20% of our allowance
• Annual eye refractions Note: See Preventive care	20% of our allowance
Not covered: • *Eyeglasses or contact lenses; or contact lens exams* • *Eye exercises and orthoptics* • *Radial keratotomy and other refractive surgery*	*All charges*
Foot care	
Routine foot care when you are under active treatment for a metabolic or peripheral vascular disease, such as diabetes. Note: See Orthopedic and prosthetic devices for information on podiatric shoe inserts.	20% of our allowance
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	
• Orthopedic devices such as braces • Artificial limbs and eyes • Stump hose • Externally worn breast prostheses and surgical bras, including necessary replacements following a mastectomy. External prosthetic devices, except those associated with reconstructive surgery after a mastectomy, are limited to two per member per calendar year. • Internal prosthetic devices, such as artificial joints, pacemakers, and surgically implanted breast implant following mastectomy. • Corrective orthopedic appliances for non-dental treatment of temporomandibular joint (TMJ) pain dysfunction syndrome. • Foot orthotics and ankle foot orthotics are covered for members who have diabetes with demonstrated peripheral neuropathy or the insert is needed for a shoe that is part of a covered brace.	20% of our allowance
• External hearing aids	20% of our allowance

Orthopedic and prosthetic devices - continued on next page

Benefit Description	You pay After the calendar year deductible…
Orthopedic and prosthetic devices (cont.)	
• Implanted hearing-related devices, such as bone anchored hearing aids (BAHA) and cochlear implants - we limit coverage to one (1) device per ear per every 24 months Note: For information on the professional charges for the surgery to insert an implant, see Section 5(b) *Surgical and anesthesia services.* For information on the hospital and/or ambulatory surgery center benefits, see Section 5(c) *Services provided by a hospital or other facility, and ambulance services.*	20% of our allowance
Not covered: • *Orthopedic and corrective shoes, arch supports, foot orthotics, heel pads and heel cups* • *Orthotics (regular or custom, including but not limited to ankle foot othotics or podiatric orthotics)* • *Lumbosacral supports* • *Corsets, trusses, elastic stockings, support hose, and other supportive devices* • *Dental braces, devices, and appliances* • *Braces for aid in sports activities* • *Internally implanted devices, equipment, and prosthetics related to treatment of sexual dysfunction* • *Repair and replacement of orthopedic and prosthetic devices, unless necessitated by normal growth* • *DOC bands (Dynamic Orthotic Cranial Bands)* • *Hearing aid batteries* • *Replacement hearing aid devices within the same 24 month period* • *Hearing devices that are not specificallylisted in the covered services section*	*All charges*
Durable medical equipment (DME)	
We cover rental or purchase, at our option, including repair and adjustment, of durable medical equipment prescribed by your Plan physician, such as oxygen and dialysis equipment. Under this benefit, we also cover: • Oxygen • Dialysis equipment • Hospital beds • Wheelchairs • Crutches • Walkers • Audible prescription reading devices • Speech generating devices • Blood glucose monitors • Insulin pumps	20% of our allowance

Durable medical equipment (DME) - continued on next page

Benefit Description	You pay After the calendar year deductible…
Durable medical equipment (DME) (cont.)	
Note: Call us at 1-800-969-3343 as soon as your Plan physician prescribes this equipment. We will arrange with a health care provider to rent or sell you durable medical equipment at discounted rates and will tell you more about this service when you call.	20% of our allowance
Not covered: • *Motorized wheelchairs* • *Comfort, convenience, or luxury items or features, including breast pumps, air conditioners, humidifiers and dehumidifiers.* • *Electric monitors of bodily functions, except for apnea monitors* • *Devices to perform medical testing of bodily fluids, excretions, or substances* • *Disposable supplies Electronically controlled cooling or heating compression therapy devices (such polar ice packs, Ice Man Cool Therapy, or Cryo-cuff)Home traction units*Replacement of lost equipment • *Repair, adjustment, or replacement necessitated by wear, tear, or misuse* • *Oral supplements and/or enteral feeding, either by mouth or by tube* • *More than one piece of durable medical equipment serving essentially the same function, except for replacement due to anatomical growth; spare equipment or alternate use equipment is not provided*	*All charges*
Home health services	
• Home health care ordered by a Plan physician and provided by a registered nurse (R.N.), licensed practical nurse (L.P.N.), licensed vocational nurse (L. V.N.), physical therapist, speech therapist, occupational therapist, or home health aide. • Services include intravenous therapy and medications (oxygen is covered under DME).	20% of our allowance
Not covered: • *Home care requested by, or the convenience of, the patient or the patient's family* • *Services primarily for hygiene, feeding, exercising, moving the patient, homemaking, companionship or giving oral medication* • *Home care that could appropriately be rendered in a Plan medical office, affiliated hospital, or skilled nursing facility* • *Home care that can be performed safely and effectively by people whom, in order to provide the care do not require medical licenses or certificates, or the presence of a supervising licensed nurse* • *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 After the calendar year deductible…
Chiropractic	
• Coverage limited to subluxation and manipulation • 60 visits per condition (visit limit includes physical and occupational therapies. See Physical and Occupational therapies) Note: We only cover therapy to restore bodily function when there has been a total or partial loss of bodily function due to illness or injury.	20% of our allowance
Alternative treatments	
No benefit	*All charges*
Not covered: • *Naturopathic services* • *Hypnotherapy* • *Biofeedback*	*All charges*
Educational classes and programs	
Coverage is available for up to six (6) nutritional counseling visits with a registered dietician for an covered condition, and especially for the following conditions: • High cholesterol • Obesity • High blood pressure • Diabetes	Nothing, No Deductible
Tobacco Cessation program including individual/group/telephone counseling, and for physician prescribed over the counter (OTC) and prescription drugs approved by the FDA to treat tobacco dependence. Enroll online at www.quitnet.com/coventrywellbeing or call 1-866-577-8210. A representative will ask you for your Authentication code which is your 11 digit Coventry ID number - and will then assist you in the completion of the registration process.	Nothing for the counseling for up to two quit attempts per year. Nothing for physician prescribed OTC and prescription drugs approved by the FDA to treat tobacco dependence.

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

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- You must use providers that are part of our network.
- The deductible is $2,500 Self Only or $5,000 Self and Family enrollment. The Self and Family deductible can be satisfied by one or more family members. The deductible applies to almost all benefits in this Section, unless we indicate differently.
- After you have satisfied your deductible, coverage begins for traditional medical services.
- Under Traditional Medical Coverage, you will be responsible for your deductible, coinsurance, and copayments for eligible covered services.
- The services listed below are for the charges billed by a physician or other health care professional for your surgical care. See Section 5(c) for charges associated with the facility (i.e. hospital, surgical center, etc.).
- **YOU MUST GET PRECERTIFICATION FOR SOME SURGICAL PROCEDURES.** Please refer to the precertification information in Section 3 to be sure which services require precertification.

Benefit Description	You pay After the calendar year deductible…
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 • Removal of tumors and cysts • Circumcision of a newborn • Correction of congenital anomalies (see Reconstructive surgery).	20% of our allowance
• Surgical treatment of morbid obesity (bariatric surgery) Roux-en-Y Gastric Bypass, Laparoscopic Gastric Banding, and Vertical Banded Gastroplasty - a condition in which an individual weighs 100 pounds or 100% over his or her normal weight according to current underwriting standards; eligible members must be age 18 or over - the patient is an adult (≥ 18 years of age) with morbid obesity that has persisted for at least 3 years, and for which there is no treatable metabolic cause for the obesity;	20% of our allowance

Surgical procedures - continued on next page

Benefit Description	You pay After the calendar year deductible…
Surgical procedures (cont.)	
- there is presence of morbid obesity, defined as a body mass index (BMI) exceeding 40, or greater than 35 with documented co-morbid conditions (cardiopulmonary problems e.g., severe apnea, Pickwickian Syndrome, and obesity-related cardiomyopathy, severe diabetes mellitus, hypertension, or arthritis). (BMI is calculated by dividing a patient's weight (in kilograms) by height (in meters) squared. To convert pounds to kilograms, multiply pounds by 0.45. To convert inches to meters, multiply inches by .0254); - The patient has failed to lose weight (approximately 10% from baseline) or has regained weight despite participation in a three month physician-supervised multidisciplinary program within the past six months that included dietary therapy, physical activity and behavior therapy and support; - The patient has been evaluated for restrictive lung disease and received surgical clearance by a pulmonologist, if clinically indicated; has received cardiac clearance by a cardiologist if there is a history of prior phen-fen or redux use, and the patient has agreed, following surgery, to participate in a multidisciplinary program that will provide guidance on diet, physical activity and social support; and, - The patient has completed a psychological evaluation and has been recommended for bariatric surgery by a licensed mental health professional (this must be documented in the patient's medical record) and the patient's medical record reflects documentation by the treating psychotherapist that all psychosocial issues have been identified and addressed; and the psychotherapist indicates that the patient is likely to be compliant with the post-operative diet restrictions. • Insertion of internal prosthetic devices. See 5(a) – Orthopedic and prosthetic devices for device coverage information • Treatment of burns • Voluntary sterilization (e.g., tubal ligation, vasectomy) Note: Generally, we pay for internal prostheses (devices) according to where the procedure is done. For example, we pay Hospital benefits for a pacemaker and Surgery benefits for insertion of the pacemaker.	20% of our allowance
Not covered: • *Surgical treatment of morbid obesity (bariatric surgery) Jujunoileal Bypass, Gastric Stapling, Duodenal Switch, and Biliopancreatic Diversion* • *Reversal of voluntary sterilization* • *Routine treatment of conditions of the foot; see Foot care*	*All charges*

Benefit Description	You pay After the calendar year deductible…
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; webbed fingers; and webbed toes. • All stages of breast reconstruction surgery following a mastectomy, such as: - surgery to produce a symmetrical appearance of breasts; - treatment of any physical complications, such as lymphedemas; - breast prostheses and surgical bras and replacements (see Prosthetic devices) Note: If you need a mastectomy, you may choose to have the procedure performed on an inpatient basis and remain in the hospital up to 48 hours after the procedure	20% of our allowance
Not covered: • *Cosmetic surgery – any surgical procedure (or any portion of a procedure) performed primarily to improve physical appearance through change in bodily form, except repair of accidental injury* • *Surgeries related to sex transformation* • *Hair pieces*	*All charges*
Oral and maxillofacial surgery	
Oral surgical procedures, limited to: • Reduction of fractures of the jaws or facial bones; • Surgical correction of cleft lip, cleft palate or severe functional malocclusion; • Removal of stones from salivary ducts; • Excision of leukoplakia or malignancies; • Excision of cysts and incision of abscesses when done as independent procedures; • Other surgical procedures that do not involve the teeth or their supporting structures; and • Treatment of TMJ (non-dental).	20% of our allowance
Not covered: • *Oral implants and transplants* • *Procedures that involve the teeth or their supporting structures (such as the periodontal membrane, gingiva, and alveolar bone)* • *TMJ related dental work*	*All charges*

Benefit Description	You pay After the calendar year deductible…
Organ/tissue transplants	

• These **solid organ transplants** are subject to medical necessity and experimental /investigational review by the Plan. Refer to Other Services in Section 3 for prior authorization procedures. Transplant services must be performed at a participating Center of Excellence. We approve and designate where all transplants must be performed including hospitals for specific transplant procedures. If you would like to know about a specific facility, please contact Customer Service.
 	
Solid organ transplants limited to:
- Cornea
- Heart
- Heart/lung
- Kidney
- Liver
- Pancreas*
- Kidney/Pancreas
- Lung: single / bilateral / lobar
- Intestinal transplants
  • Isolated small intestine
  • Small intestine with the liver
  • Small intestine with multiple organs such as the liver, stomach, and pancreas
- Autologous pancreas islet cell transplant (as an adjunct to total or near total pancreatectomy) only for patients with chronic pancreatitis.
 	
*We limit the coverage for pancreas (only) transplants to patients who have insulin dependent (or Type 1) diabetes mellitus when we find that exogenous treatment with insulin is ineffective.
	20% of our allowance

These **tandem blood or marrow stem cell transplants for covered transplants** are subject to medical necessity review by the Plan. Refer to *Other services* in Section 3 for prior authorization procedures. Autologous tandem transplants for • AL Amyloidosis • Multiple myeloma (de novo and treated) • Recurrent germ cell tumors (including testicular cancer)	20% of our allowance
Blood or marrow stem cell transplants limited to the stages of the following diagnoses. For the diagnoses listed below, the medical necessity limitation is considered satisfied if the patient meets the staging description. Allogeneic (donor) transplants for: • Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia • Advanced Hodgkin's lymphoma with recurrence (relapsed) • Advanced non-Hodgkin's lymphoma with recurrence (relapsed)	20% of our allowance

Organ/tissue transplants - continued on next page

Benefit Description	You pay After the calendar year deductible…
Organ/tissue transplants (cont.)	
• Aggressive non-Hodgkin's lymphoma • Acute myeloid leukemia • Advanced Myeloproliferative Disorder (MPDs) • Advanced Neuroblastoma • Amyloidosis • Chronic lymphocytic lymphoma /small lymphocytic lymphoma (CLL/SLL) • Hemoglobinopathy • Infantile malignant osteopetrosis • Kostmann's syndrome • Leukocyte adhesion deficiencies • Marrow Failure and Related Disorders (i.e. Fanconi's, PNH, Pure Red Cell Aplasia) • Mucolipidosis (e.g. Gaucher's disease, metachromatic leukodystrophy, adrenoleukodystrophy) • Mucopolysaccharidosis (e.g. Hunter's Syndrome, Hurler's syndrome, Sanfillippo's syndrome, Maroteauxlamy syndrome variants) • Myelodysplasia/Myelodysplastic syndromes • Paroxysmal Nocturnal Hemoglobinuria • Phagocytic / Hemophagocytic deficiency diseases (e.g. Wiskott-Aldrich syndrome) • Severe combined immuno-deficiency disease • Severe or very severe aplastic anemia • Sickle cell anemia Autologous transplants for: • Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia • Advanced Hodgkin's lymphoma with recurrence (relapsed) • Advanced non-Hodgkin's lymphoma with recurrence (relapsed) • Amyloidosis • Advanced Neuroblastoma • Multiple Myeloma • Testicular, Mediastinal, Retroperitoneal, and ovarian germ cell tumors	20% of our allowance
Mini Transplants performed in a clinical trial setting (non-myeloblative, reduced intensity conditioning or RIC) for members with a diagnosis listed below are subject to medical necessity review by the Plan. Refer to Other Services in Section 3 for prior authorization procedures: Allogeneic transplants for: • Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia • Advanced Hodgkin's lymphoma with recurrence (relapsed)	20% of our allowance

Organ/tissue transplants - continued on next page

Benefit Description	You pay After the calendar year deductible…
Organ/tissue transplants (cont.)	
• Advanced non-Hodgkin's lymphoma with recurrence (relapsed) • Acute myeloid leukemia • Advanced Myeloproliferative Disorder (MPDs) • Amyloidosis • Chronic lymphocytic lymphoma /small lymphocytic lymphoma (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 immuno-deficiency disease • Severe or very severe aplastic anemia Autologous transplants for: • Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia • Advanced Hodgkin's lymphoma with recurrence (relapsed) • Advanced non-Hodgkin's lymphoma with recurrence (relapsed) • Amyloidosis • Neuroblastoma • Breast cancer • Epithelial ovarian cancer	20% of our allowance
These **blood or marrow stem cell transplants** are covered only in a National Cancer Institute or National Institutes of health **approved clinical trial** or a Plan-designated center of excellence and if approved by the Plan's medical director in accordance with the Plan's protocols. If you are a participant in a clinical trial, the Plan will provide benefits for related routine care that is medically necessary (such as doctor visits, lab tests, x-rays and scans, and hospitalization related to treating the patient's condition) if it is not provided by the clinical trial. Section 9 has additional information on costs related to clinical trials. We encourage you to contact the Plan to discuss specific services if you participate in a clinical trial. Allogeneic transplants for: • Advanced Hodgkin's lymphoma • Advanced non-Hodgkin's lymphoma • Chronic inflammatory demyelination polyneuropathy (CIDP) • Early stage (indolent or non-advanced) small cell lymphocytic lymphoma Mini-transplants (non-myeloblative allogeneic, reduced intensity conditioning or RIC) for • Acute lymphocytic or non-lymphocytic leukemia • Advanced Hodgkin's lymphoma	20% of our allowance

Organ/tissue transplants - continued on next page

Benefit Description	You pay After the calendar year deductible…
Organ/tissue transplants (cont.)	
• Advanced non-Hodgkin's lymphoma • Breast Cancer • Chronic lymphocytic leukemia • Chronic myelogenous leukemia • Colon cancer • Chronic lymphocytic lymphoma /small lymphocytic lymphoma (CLL/SLL) • Early stage (indolent or non-advanced) small cell lymphocytic lymphoma • Multiple Myeloma • Multiple sclerosis • Myeloproliferative Disorder (MPDs) • Myelodysplasia/Myelodysplastic syndromes • Non-small lung cancer • Ovarian cancer • Prostate cancer • Renal cell carcinoma • Sarcomas • Sickle cell anemia (pediatric only) Autologous Transplants for • Advanced Childhood kidney cancers • Advanced Ewing sarcoma • Advanced Hodgkin's lymphoma • Advanced non-Hodgkin's lymphoma • Breast Cancer • Childhood rhabdomyosarcoma • Chronic myelogenous leukemia • Chronic lymphocytic lymphoma /small lymphocytic lymphoma (CLL/SLL) • Early stage (indolent or non-advanced) small cell lymphocytic lymphoma • Epithelial Ovarian Cancer • Mantle Cell (Non-Hodgkin lymphoma) • Multiple sclerosis • Small cell lung cancer • Systemic lupus erythematosus • Systemic sclerosis	20% of our allowance
NOTE: We cover related medical and hospital expenses of the donor when we cover the recipient. We cover donor testing for the actual solid organ or up to four bone marrow /stem cell transplant donors in addition to the testing of family members. After referral to a transplant facility, the following will apply:	20% of our allowance

Organ/tissue transplants - continued on next page

Benefit Description	You pay After the calendar year deductible…
Organ/tissue transplants (cont.)	
• If our Medical Director or the referral facility decides you do not satisfy criteria for a transplant, we only pay for covered services you receive before that decision is made • We, and the Plan providers are not responsible for finding, furnishing, or ensuring the availability of a bone marrow or organ donor • We cover reasonable medical and hospital expenses as long as the expenses are directly related to a covered transplant of the donor or an individual identified as a potential donor, even if a member • Unless otherwise authorized by our Medical Director, we provide transplants only at approved Transplant Network facilities	20% of our allowance
Not covered: • *Donor screening tests and donor search expenses, except as shown above.* • *Any related conditions or complications for a member who is donating an organ or tissue when the recipient is not a member* • *Outpatient immunosuppressive agents* • *Any transplant procedure that is performed in a facility that has not been designated by the Medical Director as a approved transplant facility* • *Implants of non-human or 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	20% of our allowance

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.
- Plan physicians must provide or arrange your care and you must be hospitalized in a Plan facility.
- The deductible is $2,500 for Self Only enrollment and $5,000 for Self and Family enrollment each calendar year. The Self and Family deductible can be satisfied by one or more family members. The deductible applies to all benefits in this Section.
- After you have satisfied your deductible, your Traditional medical coverage begins.
- Under your Traditional medical coverage, you will be responsible for your deductible , coinsurance, and copayments for eligible covered services.
- Be sure to read Section 4, *Your costs for covered services* for valuable information about how cost-sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- 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 HDHP Sections 5(a) or (b).
- **YOUR PHYSICIAN MUST GET PRECERTIFICATION FOR HOSPITAL STAYS.** Please refer to the precertification information shown in Section 3.

Benefit Description	You pay After the calendar year deductible. . .
Inpatient hospital	
Room and board, such as • Ward, semiprivate, or intensive care accommodations • General nursing care • Meals and special diets • Special duty nursing when medically necessary Note: If you want a private room when it is not medically necessary, you pay the additional charge above the semiprivate room rate.	20% of our allowance
Other hospital services and supplies, such as: • Operating, recovery, maternity, and other treatment rooms • Prescribed drugs and medicines • Diagnostic laboratory tests and X-rays • Administration of blood and blood products • Blood or blood plasma, if not donated or replaced • Dressings, splints, casts, and sterile tray services • Medical supplies and equipment, including oxygen • Anesthetics, including nurse anesthetist services • Medical supplies, appliances, medical equipment, and any covered items billed by a hospital for use at home	20% of our allowance

Inpatient hospital - continued on next page

Benefit Description	You pay After the calendar year deductible. . .
Inpatient hospital (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. We must authorize benefits for the administration of general anesthesia and for hospital services related to dental care, when the following members receive these services: • A dependent child age five and under; • A member who is severely disabled; or • A member who has a medical behavioral condition which requires hospitalization or general anesthesia when dental care is provided. A participating provider must administer the general anesthesia whether or not the dental services are provided in a hospital, surgical center or office.	20% of our allowance
Not covered: • *Custodial care* • *Non-covered facilities, such as nursing homes, schools* • *Personal comfort items, such as telephone, television, barber services, guest meals and beds* • *Private nursing care, except when medically necessary* • *Take home items*	*All charges*
Outpatient hospital or ambulatory surgical center	
• Operating, recovery, and other treatment rooms • Prescribed drugs and medicines • Diagnostic laboratory tests, X-rays, and pathology services • Administration of blood, blood plasma, and other biologicals • Blood and blood plasma, if not donated or replaced • Pre-surgical testing • Dressings, casts, and sterile tray services • Medical supplies, including oxygen • Anesthetics and anesthesia service Note: – We cover hospital services and supplies related to dental procedures when necessitated by a non-dental physical impairment. We do not cover the dental procedures. We must authorize benefits for the administration of general anesthesia and for hospital services related to dental care, when the following members receive these services: • A dependent child age five and under; • A member who is severely disabled; or • A member who has a medical behavioral condition which requires hospitalization or general anesthesia when dental care is provided.	20% of our allowance

Outpatient hospital or ambulatory surgical center - continued on next page

Benefit Description	You pay After the calendar year deductible. . .
Outpatient hospital or ambulatory surgical center (cont.)	
A participating provider must administer the general anesthesia whether or not the dental services are provided in a hospital, surgical center or office.	20% of our allowance
Not covered: Blood and blood derivatives not replaced by the member	*All charges*
Extended care benefits/Skilled nursing care facility benefits	
A comprehensive range of benefits covered for 60 days per calendar year when full-time skilled nursing care is necessary and confinement in a skilled nursing facility is medically appropriate as determined by a Plan doctor and approved by the Plan. All necessary services are covered, including: • Bed, board and general nursing care • Drugs, biologicals, supplies, and equipment ordinarily provided and arranged by the skilled nursing facility when prescribed by a Plan doctor.	20% of our allowance
Not covered: • *Custodial care*	*All charges*
Hospice care	
• Supportive and palliative care for a terminally ill member is covered in the home or hospice facility. Services include inpatient and outpatient care and family counseling. These services are provided under the direction of a Plan doctor who certifies that the patient is in the terminal stages of illness, with a life expectancy of approximately six months or less.	20% of our allowance
Not covered: • *Services in the member's home outside of the service area* • *Any service for which the hospice does not customarily charge the member, or his or her family* • *Independent nursing, homemaker services*	*All charges*
Ambulance	
• Local professional ambulance service to the nearest hospital equipped to handle your medical condition when medically appropriate. • Air ambulance when medically appropriate.	20% of our 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.
- The deductible is $2,500 for Self Only enrollment and $5,000 for Self and Family enrollment each calendar year. The Self and Family deductible can be satisfied by one or more family members. The deductible applies to all benefits in this Section.
- After you have satisfied your deductible, your Traditional medical coverage begins.
- Under your Traditional medical coverage, you will be responsible for your deductible, coinsurance, and copayments for your eligible covered services.
- Be sure to read Section 4, *Your costs for covered services,* for valuable information about how cost-sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

What is a medical emergency?

A medical emergency is the sudden and unexpected onset of a condition or an injury that manifests itself by symptoms of sufficient severity that would lead a prudent layperson to believe that immediate care is required. Some problems are emergencies because, if not treated promptly, they might become more serious; examples include deep cuts and broken bones. Others are emergencies because they are potentially life-threatening, such as heart attacks, strokes, poisonings, gunshot wounds, or sudden inability to breathe. There are many other acute conditions that we may determine are medical emergencies – what they all have in common is the need for quick action.

What to do in case of emergency:

In a life-threatening emergency, call the local emergency system (e.g., the local 911 telephone system), or go to the nearest emergency facility. Be sure to tell the paramedics, or emergency room personnel that you are a Coventry Health Care of Kansas, Plan member so they can notify us. You or a family member must notify the Plan within 48 hours, or as soon as reasonably possible. It is your responsibility to ensure that the Plan has been timely notified.

Emergencies within our service area:

If your symptoms are not life-threatening, contact a primary care physician, who is on call 24 hours a day, seven days a week. During after hours or weekends, your physician my use an answering service, therefore your physician or covering physician will generally return your call within 30 minutes. We also provide **FirstHelp**, which is available to our members 24 hours a day, seven days a week by calling **1-800-622-9528**. With this service, registered nurses are available to help you to the appropriate level of care or provide medical advice.

If you need to be hospitalized and are admitted to a non-Plan facility, call Customer Service at 1-800-969-3343. You must notify us about your medical emergency within a reasonable time period as dictated by the circumstances. If you are hospitalized in a non-Plan hospital and a Plan physician believes your care can be provided in one of our Plan hospitals, we will transfer you when medically feasible with any ambulance charges covered in full.

To be covered by this Plan, any follow-up care recommended by non-Plan providers must be approved by the Plan.

We also provide access to Take Care Clinics (Walgreens), Minute Clinics (CVS Pharmacy), and several urgent care centers which are open on evenings, weekends and holidays, and are designed to give our members fast, effective quality care for non-emergent conditions such as: sprains, influenza, sore throats, ear infections, minor lacerations, and upper respiratory infections.

Emergencies outside our service area:

Benefits are available for any medically necessary health service that is immediately required because of injury or unforeseen illness. If you are hospitalized, the Plan must be notified within 48 hours on the first working day following your admission, unless it is not reasonably possible to notify the Plan within that time. If a Plan physician believes your care can be provided in one of our Plan hospitals, we will transfer you when medically feasible with any ambulance charges covered in full.

To be covered by this Plan, any follow-up care recommended by non-Plan providers must be approved by the Plan.

Benefit Description	You pay After the calendar year deductible…
Emergency within our service area	
• Emergency care at a doctors' office • Emergency care at an urgent care center, Take Care Clinics (Walgreens), and Minute Clinics (CVS Pharmacy) • Emergency care as an outpatient at a hospital, including doctors' services	20% of our allowance
Not covered: Elective care or non-emergency care	*All charges*
Emergency outside our service area	
• Emergency care at a doctors' office • Emergency care at an urgent care center, Take Care Clinics (Walgreens), and Minute Clinics (CVS Pharmacy) • Emergency care as an outpatient at a hospital, including doctors' services	20% of our allowance
Not covered: • *Elective care or non-emergency care* • *Emergency care provided outside the service area if the need for care could have been foreseen before leaving the service area* • *Medical and hospital costs resulting from a normal full-term delivery of a baby outside the service area*	*All charges*
Ambulance	
• Local professional ambulance service to the nearest hospital equipped to handle your medical condition when medically appropriate. • Air ambulance when medically appropriate.	20% of our allowance

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

Important things to keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- The deductible is $2,500 for Self Only enrollment and $5,000 for Self and Family enrollment each calendar year. The Self and Family deductible can be satisfied by one or more family members. The deductible applies to all benefits in this Section.
- After you have satisfied your deductible, your Traditional medical coverage begins.
- Under your Traditional medical coverage, you will be responsible for your deductible, coinsurance and copayments for eligible covered services.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost-sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- **YOU MUST GET PREAUTHORIZATION FOR THESE SERVICES.** Benefits are payable only when we determine the care is clinically appropriate to treat your condition and only when you receive the care as part of a treatment plan that we approve. The treatment plan may include services, drugs, and supplies described elsewhere in this brochure. To be eligible to receive full benefits, you must follow the preauthorization process and get Plan approval of your treatment plan with MHNet Behavioral Health at 1-866-607-5970. They can be reached 24 hours a day, 7 days a week to answer questions and assist you in choosing appropriate services. Your mental health provider will obtain subsequent authorizations for treatment.
- We will provide medical review criteria or reasons for treatment plan denials to enrollees, patient or providers upon request or as otherwise required.
- OPM will base its review of disputes about treatment plans on the treatment plan's clinical appropriateness. OPM will generally not order us to pay or provide one clinically appropriate treatment plan in favor of another.

Benefit Description	You pay After the calendar year deductible…
Professional Services	
We cover professional services by licensed professional mental health and substance abuse practitioners when acting within the scope of their license, such as psychiatrists, psychologists, clinical social workers, licensed professional counselors, or marriage and family therapists.	Your cost-sharing responsibilities are no greater than for other illnesses or conditions.
Diagnosis and treatment of psychiatric conditions, mental illness, or mental disorders. Services include: • Diagnostic evaluation • Crisis intervention and stabilization for acute episodes • Medication evaluation and management (pharmacotherapy) • Psychological and neuropsychological testing necessary to determine the appropriate psychiatric treatment • Treatment and counseling (including individual or group therapy visits) • Diagnosis and treatment of alcoholism and drug abuse, including detoxification, treatment and counseling	20% of our allowance

Professional Services - continued on next page

Benefit Description	You pay After the calendar year deductible…
Professional Services (cont.)	
• Professional charges for intensive outpatient treatment in a provider's office or other professional setting • Electroconvulsive therapy	20% of our allowance
Diagnostics	
• Outpatient diagnostic test provided and billed by a licensed mental health and substance abuse practitioner • Outpatient diagnostic test provided and billed by a laboratory, hospital or other covered facility • Inpatient diagnostic test provided and billed by a hospital or other covered facility	20% of our allowance
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 accomodations, general nursing care, meals and special diets, and other hopsital services	20% of our allowance
Outpatient hospital or other covered facility	
Outpatient service 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	20% of our allowance
Not covered	
• Services that are not part of a preauthorized approved treatment plan	All charges

Preauthorization

To be eligible to receive these benefits you must obtain a treatment plan and follow all of the following network authorization processes.

MHNet Behavorial Health, is contracted by Coventry Health Care of Kansas, Inc., to provide a network of providers who offer a variety of therapeutic services on an inpatient and outpatient basis.

All inpatient and outpatient treatment must be authorized through MHNet Behavorial Health, at 1-866-607-5970.

In-network limitation

We may limit your benefits if you do not obtain an approved treatment plan.

Section 5(f). Prescription drug benefits

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

- We cover prescribed drugs and medications, as described in the chart beginning on the next page.
- 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.
- Members must make sure their physicians obtain prior approval/authorizations for certain prescription drugs and supplies before coverage applies. Prior approval/authorizations must be renewed periodically.
- The deductible is $2,500 for Self Only enrollment and $5,000 for Self and Family enrollment each calendar year. The Self and Family deductible can be satisfied by one or more family members. The deductible applies to all benefits in this Section.
- After you have satisfied your deductible, your Traditional medical coverage begins.
- Under your Traditional medical coverage, you will be responsible for your coinsurance amounts for eligible medical expenses or copayments for eligible prescriptions.
- Be sure to read Section 4, *Your costs for covered services,* for valuable information about how cost-sharing works. Also, read Section 9 about coordinating benefits with other coverage, including with Medicare

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 or certified Physician Assistant, Nurse Practitioner and Psychologist must prescribe your medication.

Where you can obtain them. You may fill the prescription at a participating pharmacy. You may obtain maintenance medication through Express Scripts, our mail order prescription drug program by calling the phone number on the back of your ID card.

We use a formulary. A formulary is a list of specific generic and brand name prescription drugs authorized by the Health Plan, and subject to periodic review and modification. Since there may be more than one brand name of a prescription drug, not all brands of the same prescription drug (e.g., different manufactures) may be included in the Formulary. If you would like information on whether a specific drug is included in our drug formulary, please call the Customer Service Department at the number on the back of your ID card. If your physician specifically prescribes a non-formulary drug because it is medically necessary, you will receive the non-formulary drug at the Plan non-formulary copayment.

These are the dispensing limitations. Prescription drugs will be dispensed in the quantity determined by the prescribing provider. The following also apply:

- One (1) applicable copayment is due each time a prescription is filled or refilled at a retail pharmacy for up to a thirty-one (31) day supply.
- Mail order drugs are obtained through Express Scripts, our mail order prescription drug program, and may be dispensed with three (3) applicable copayment(s) for a ninety-three (93) day supply. To order prescriptions or refills please contact the Customer Service number on the back of your ID card or visit the website www.express-scripts.com available 24 hours a day – 7 days a week.
- To promote appropriate utilization, or following manufacturer's recommendations, certain plan approved medications may have a quantity limit on the amount of medication dispensed and Prior Authorization must be obtained prior to dispensing.
- We reserve the right to include only one dosage or form of a drug on our Formulary when the same drug (i.e., a drug with the same active ingredient) is available in different dosages or forms (i.e., dissolvable tablets, capsules, etc) from the same or different manufacturers. The product, in the dosage or form, that is listed on the Formulary will be Covered at the applicable Member Responsibility. The drug, product or products, in different forms or dosages or from the same or different manufacturers, not listed on the Formulary will be excluded from coverage.

- Coverage of Prescription Drugs, therapeutic devices or supplies requiring a Prescription Order and prescribed by a Prescribing Provider is limited to Plan approved drugs, devices, supplies, or spacers for metered dose inhalers.

Members called to active military duty in a time of national or other emergency who need to obtain a greater-than-normal supply of prescribed medications should call us at the number on the back of your ID card.

- If a brand name prescription drug is dispensed, and an equivalent generic prescription is available, you pay an ancillary charge in addition to the brand name copayment. The ancillary charge will be due whether or not the prescribing provider indicates that the pharmacy is to "Dispense as Written." The ancillary charge is the difference between the average wholesale price of the brand name and the maximum allowable cost price of the generic prescription. Copayments and ancillary charges do not apply to the catastrophic protection out-of-pocket maximum.

Why use generic drugs? Generic drugs are lower-priced drugs that are the therapeutic equivalent to more expensive brand-name drugs. They must contain the same active ingredients and must be equivalent in strength and dosage to the original brand-name product. Generics cost less than the equivalent brand-name product. The U.S. Food and Drug Administration sets quality standards for generic drugs to ensure that these drugs meet the same standards of quality and strength as brand-name drugs. Generic drugs are indicated on the formulary listing of prescription drugs.

When you do have to file a manual claim. When you receive drugs from a Plan pharmacy and present your ID card, you do not have to file a manual claim. For a covered out-of-area emergency, you will need to file a claim when you receive drugs from a non-Plan pharmacy.

Benefit Description	You pay After the calendar year deductible…
Covered medications and supplies	
We cover the following medications and supplies prescribed by a Plan physician and obtained from a Plan pharmacy or through our mail order program: • Drugs and medicines that by Federal law of the United States require a physician's prescription for their purchase, except those listed as *Not covered.* • Insulin • Diabetic supplies, including insulin syringes, needles, glucose test tablets and test tape * • Disposable needles and syringes for the administration of covered medications. • Drugs for sexual dysfunction • Injectable contraceptive drugs (such as Depo Provera) • Immunosuppressant drugs required after a covered transplant* • Growth hormones and other self-administered injectables* • Vitamin D for adults 65 and older To find Your Prescription Drug, its applicable Tier and any Prior Authorization requirements, visit Our searchable Formulary on Our website www.chckansas.com, in the Participating Provider's office, or by contacting the Customer Service Department. *Note: Non-formulary diabetic supplies, etc., Immunosuppressants, and GHT require prior-authorization.	**Retail Pharmacy** **Tier 1A** - 20% of our allowance **Tier 1B** - 20% of our allowance **Tier 2** - 20% of our allowance **Tier 3** - 20% of our allowance **Tier 4** - 20% of our allowance **Mail Order (93 day supply)** **Tier 1A** - 20% of our allowance **Tier 1B** - 20% of our allowance **Tier 2** - 20% of our allowance **Tier 3** - 20% of our allowance **Tier 4** - 20% of our allowance

Covered medications and supplies - continued on next page

Benefit Description	You pay After the calendar year deductible…
Covered medications and supplies (cont.)	
	Note: If there is no Tier 1 equivalent available, you will still have to pay the Tier 2 cost share. If there is a Tier 1 equivalent and you choose the Tier 2 drug, you will pay the Tier 2 cost share plus the difference in the average wholesale price between the Tier 1 and Tier 2 drug. Ancillary charges do not apply to your deductible or catastrophic maximum. This applies to both formulary and non-formulary drugs.
• Insulin – Under retail pharmacy benefits, you can obtain up to a 3 month supply of insulin • Diabetic supplies – Under retail pharmacy benefits, you can obtain up to a 3 month supply of diabetic supplies (non-formulary supplies requires prior-authorization) • Oral and injectable contraceptive drugs – Under retail pharmacy benefits, you can obtain up to a 3 month supply of oral contraceptive drugs	**Retail Pharmacy** 20% of our allowance
Women's contraceptive drugs and devices	Nothing
Not covered: • *Drugs and supplies for cosmetic purposes* • *Medical supplies such as dressings and antiseptics* • *Medications used for cosmetic purposes or to enhance work or athletic performance (i.e. Nuvigil or Provigil for shift work, anabolic steroids and minoxidil lotion, retin A (tretinoin) for aging skin). Also excluded are drugs, oral or injectable, used to slow or reverse normal aging processes (i.e. growth hormone, testosterone, etc.).* • *Fertility drugs* • *Drugs obtained at a non-Plan pharmacy; except for out-of-area emergencies* • *Vitamins, nutrients and food supplements even if a physician prescribes or administers them, except as specified on the Formulary* • *Drugs available without a prescription or for which there is a non-prescription equivalent; except those designated by the plan* • *Appetite suppressants and other drugs to assist in weight control (except for the treatment of morbid obesity when authorized by us).* • *Nonprescription medicines; except those designated by the plan* • *Dosage forms of natural estrogen or progesterone; or any natural hormone replacement product, including but not limited to oral capsules, suppositories, creams and troches* • *Prescription drugs for non-covered services* • *Drugs for hair restoration*	*All charges*

Covered medications and supplies - continued on next page

Benefit Description	You pay After the calendar year deductible…
Covered medications and supplies (cont.)	
Note: Physician prescribed over-the-counter and prescription drugs approved by the FDA to treat tobacco dependence are covered under the Tobacco cessation benefit. *(See section 5(a)* Educational classes and programs*)*	*All charges*

Section 5(g). Dental benefits

Important things to keep in mind about these benefits:

- This is summary of benefits only. All benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable when we determine they are dentally necessary.
- If you are enrolled in a Federal Employees Dental/Vision Insurance Program (FEDVIP), 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.
- Locate a Coventry Dental Provider at www.chckansas.com, under Member page, click on "Find a dentist" to search for a provider in your area or call customer service toll-free at 1-866-433-6391. If you are unable to locate a network provider in your area, you may seek covered dental services from a non-participating provider at no cost.
- The deductible is $2,500 for Self Only enrollment and $5,000 for Self and Family enrollment each calendar year. The Self and Family deductible can be satisfied by one or more family members. The deductible applies to almost all benefits in this Section unless we indicate differently.
- There are no benefits for any service which is not specifically listed in this brochure.
- Some procedures and treatments may have specific age and frequency limitations as noted below.
- We cover hospitalization for dental procedures only when a non-dental physical impairment which makes hospitalization necessary to safeguard the health of the patient. Section 5(c) for inpatient benefits. We do not cover the dental procedure unless it is described below.
- Important Note: **IT IS YOUR RESPONSIBILITY TO BE INFORMED ABOUT YOUR DENTAL COVERAGE.**

Benefit Description	You pay After the calendar year deductible
Accidental injury benefit	
We cover emergency 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.	20% of our allowance
Dental Benefits	
Diagnostic: Oral examinations: once each twelve (12) months Diagnostic x-rays: bitewings once each twelve (12) months Full mouth x-rays: once each five (5) years	20% of our allowance
Preventive: Prophylaxis (cleanings) once every (12) months Topical Fluoride: once every (12) months for dependent children under age (19) Space maintainers for dependent children under age (14) and only for premature loss of primary molars Sealants: once per lifetime for dependent children under age (15) when applied to permanent molars, with no caries (decay) or restorations on any surface, and with the occlusal surface intact	Nothing, No Deductible
Not covered:	*All charges*

Dental Benefits - continued on next page

Benefit Description	You pay After the calendar year deductible
Dental Benefits (cont.)	
All services which is not specifically listed in this brochure.	*All charges*

Section 5(h). Special features

Special feature	Description
Flexible benefits option	Under the flexible benefits option, we determine the most effective way to provide services. • We may identify medically appropriate alternatives to regular contract benefits as a less costly alternative. If we identify a less costly alternative, 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).
24 hour nurse line	Call **FirstHelp** anytime you or a family member experience health symptoms that need attention. Nurses are available to you and your family 24 hours a day, 7 days a week and are trained to handle your questions. Any member who visits an emergency room or urgent care center as a result of advice from **FirstHelp** will automatically have associated claims approved. With **FirstHelp** authorization, you will know in advance if medical services will be covered. You may call **1-800-622-9528** or for the hearing impaired call **1-800-735-2966**.
Services for deaf and hearing impaired	The Kansas TDD relay number is 1-800-766-3777. The Missouri TDD relay number is 1-800-735-2966.
Transplant Network	In order to provide members requiring a transplant the opportunity for the best outcomes and experiences, we use our own Coventry Transplant Network.

Section 5(i). Health education resources and account management tools

Special features	Description
Health education resources	Visit the Health Information section of our website at www.chckansas.com for information to help you take command of your health. This section is organized in simple, user-friendly, sections: • ***Assess Your Health***– where you will find a simple, free, online health risk assessment tool to benchmark your wellness, and better understand your overall health status and risks. • ***About Your Health***– for information about a specific condition or general preventive guidelines. • ***Patient Safety*** • ***WebMD***– our link to this health site also provides wellness and disease information to help improve health. ***Prescription Drug*** educational materials are also accessible through our website, through a link to our pharmacy benefit manager, Medco. There, you will find: • Detailed information about a wide range of prescription drugs; • A drug interaction tool to help easily determine if a specific drug can have any adverse interactions with each other, with over-the-counter drugs, or with herbals and vitamins; • Facts about why FDA-approved generic drugs should be a first choice for effective, economical treatment. Another key health information tool that we make available to you is our online quality tools, powered by HealthShare. You can review the frequency of procedures performed by a provider, knowing the correlation between frequency of service and quality of outcomes. We post additional quality outcome information, such as re-admission rates within 30 days, post operative complications, and even death rates. We also publish an e-newsletter to keep you informed on a variety of issues related to your good health. Visit our website at www.chckansas.com for back editions of this publication, *Living Well.* In addition, we augment our health education tools with access to our ***First Help***. Experienced RNs are available through an inbound call center 24 hours a day, seven days per week, to assist you and help you to maximize your benefits, by providing clinical and economic information to make an informed decision on how to proceed with care.
Account management tools	For each HSA and HRA account holder, we maintain a complete claims payment history online through Coventry Health Care of Kansas, Inc.'s password-protected, self-service functionality, My Online Services, at www.chckansas.com. • You will receive an EOB after every claim. **If you have an HSA:** • You will receive a quarterly statement from the HSA administrator outlining your account balance and activity for the month. • You may also access your account on-line at www.chckansas.com. • Smart Payment online tools at www.chckansas.com through My Online Services. **If you have an HRA:** • Your HRA balance will be available online through www.chckansas.com

	• You may also access your account and review your activity on a daily basis online, via My Online Services, at www.chckansas.com. • Smart Payment online tools at www.chckansas.com through My Online Services.
Consumer choice information	• As a member of this HDHP, you may choose any provider. However, you will receive discounts when you see a network provider. Our provider search function on our website www.chckansas.com, is updated every week. It lets you easily search for a participating physician based on the criteria *you* choose, such as provider specialty, gender, secondary languages spoken, or hospital affiliation. You can even specify the maximum distance you're willing to travel and, in most instances, get driving directions and a map to the offices of identified providers. • Pricing information for medical care is available at www.chckansas.com. There, you will find our ***Health Services Pricing Tools***, which provide average cost information for some the most common categories of service. The easy-to-understand information is sorted by categories of service, including physician office visits, diagnostic tests, surgical procedures, and hospitalization. • Pricing information for prescription drugs is available through our link to the website of our pharmacy benefit manager, Caremark (which you can access via www.chckansas.com. Through a password-protected account, you will have the ability to estimate prescription costs before ordering. • Link to online pharmacy through to the website of our pharmacy benefit manager, Caremark which you can access via www.chckansas.com. Educational materials on the topics of HSAs, HRAs and HDHPs are available at www.chckansas.com.
Care support	• Our complex case management programs offer special assistance to members with intricate, long term medical needs. Our disease management program fosters a proactive approach to managing care from prevention through treatment and management. Your physician can help arranged for participation in these programs, or you can simply contact our member service department. • Patient safety information is available online at www.chckansas.com. Care support is also available to you, in the form of a relationship that we have established with the *College of American Pathologists* for e-mail reminder notifications. We'll send a message to the e-mail address you provide on a scheduled basis, reminding you to arrange for screening tests.

Non-FEHB benefits available to Plan members

The benefits on this page are not part of the FEHB contract or premium, and you cannot file an FEHB disputed claim about them. This is not an Insurance program. Benefits are subject to change without notice.

GLOBAL FIT

With a healthier lifestyle, you can be fitter, feel better and enjoy life more. GlobaFit, our healthy living benefit provider, gives you and your family big savings to help you live right and feel your best. Let the sun shine on a healthier new you. You can make it happen. GlobalFit makes it affordable. **Call GlobalFit for more information at 1-800-294-1500 or visit online at** www.globalfit.com**.**

Exercise & Gyms

- Guaranteed lowest rates at thousands of gyms
- Global Fit Virtual Gym with easy to follow videos and community support
- Exclusive low rates on home equipment

Weight Loss & Nutrition

- GlobalFit Virtual Nutrition Coach for balanced nutrition and real results
- Nutrisystem at $30.00 off their best advertised price
- Health Coaching for professional 1-on-1 phone and online help

We are committed to supporting your health. We provide education materials and wellness programs that support your efforts - free of charge - to take accountability for your health and prevent illness. The Well*Being* program is available to you and your covered family members.

Health Risk Assessment - We encourage you to take advantage of a health risk assessment every year, which is available through My Online Services on our website, www.chckansas.com.

Kids Health - is a rich online resource for all facets of child health. There are three sections, one each for Parents, Teens and Kids. Each section provides topics and information targeted for that specific audience. The Kids and Teen sections contain games and video clips that engage the interests of the child. Log onto My Online Services at www.chckansas.com.

Wellness Reminders - We send you reminders about important prevention services. Examples include flu shot and immunization reminders and mammography screenings. Look for your reminder in the mail.

QualSight, Inc.

QualSight is a value-added service available to you. The QualSight program is not an insurance plan. the Qual Sight program is available to you to provide access to QualSight preferred pricing for LASIK surgery.

QualSight offers a Laser Vision Correction plan that is easily accessible and affordable for the millions of Americans who could benefit from the LASIK procedure. LASIK is the most popular elective procedure. With QualSight you can save 40% to 50% off the national average traditional price for LASIK. **You may access this program by calling QualSight at 1-877-213-3937 or going online to** www.qualsight.com/coventry.

EyeMed Vision Care

You now have new options to save on eyewear through a materials discount program offered by EyeMed Vision Care. The EyeMed SELECT network offers you the choice of leading optical retailers including LensCrafters, Pearle Vision, Sears Optical, Target Optical, JCPenny Optical, as well as thousands of private practitioners, all near where you work and shop. Log onto www.eyemedvisioncare.com or call **1-866-211-2417** to find a participating provider near you. Please use Plan ID: 9240086 and Name: Coventry Health Care of KS.

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 it is medically necessary to prevent, diagnose, or treat your illness, disease, injury, or condition. For information on obtaining prior appoval for specific services, such as transplants, see Section 3** ***When you need prior Plan approval for certain services.***

We do not cover the following:

- Care by non-Plan providers except for authorized referrals or emergencies (see Emergency services/accidents).
- Services, drugs, or supplies you receive while you are not enrolled in this Plan.
- Services, drugs, or supplies not medically necessary or not within the Plan's utilization policies and procedures.
- Services, drugs, or supplies not required according to accepted standards of medical, dental, or psychiatric practice.
- Educational classes, programs, and other rehabilitative therapies not otherwise listed as covered.
- Experimental or investigational procedures, treatments, drugs or devices (see specifics regarding transplants).
- Services, drugs, or supplies related to abortions, except when the life of the mother would be endangered if the fetus were carried to term, or when the pregnancy is the result of an act of rape or incest .
- Services, drugs, or supplies related to sex transformations.
- 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.
- 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.
- 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.

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. When you see Plan physicians, receive services at Plan hospitals and facilities, or obtain your prescription drugs at Plan pharmacies, you will not have to file claims. Just present your identification card and pay your copayment, coinsurance, or deductible.

You will only need to file a claim when you receive emergency services from non-plan providers. Sometimes these providers bill us directly. Check with the provider.

If you need to file the claim, here is the process:

Medical and hospital benefits

In most cases, providers and facilities file claims for you. Physicians must file on the form CMS-1500, Health Insurance Claim Form. Your facility will file on the UB-04 form. For claims questions and assistance, contact us at 1-800-969-3343, or at our website at www.chckansas.com.

When you must file a claim – such as for services you received outside the Plan's service area – submit it on the CMS-1500 or a claim form that includes the information shown below. Bills and receipts should be itemized and show:

- Covered member's name, date of birth, address, phone number and ID number
- Name and address of the physician or facility that provided the service or supply
- Dates you received the services or supplies
- Diagnosis
- Type of each service or supply
- The charge for each service or supply
- A copy of the explanation of benefits, payments, or denial from any primary payor – such as the Medicare Summary Notice (MSN)
- Receipts, if you paid for your services

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

Submit your claims to:

CoventryHealth Care of Kansas, Inc.
P.O. Box 7109
London, KY 40742

Deadline for filing your claim

Send us all of 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, unless timely filing was prevented by administrative operations of Government or legal incapacity, provided the claim was submitted as soon as reasonably possible.

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,w e 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.

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, we will permit a health care professional with knowledge of your medical condition 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

If you live in a county where at least 10 percent of the population is literate only in a non-English language (as determined by the Secretary of Health and Human Services), we will provide language assistance in that non-English language. You can request a copy of your Explanation of Benefits (EOB) statement, related correspondence, oral language services (such as telephone customer assistance), and help with filing claims and appeals (including external reviews) in the applicable non-English language. The English versions of your EOBs and related correspondence will include information in the non-English language about how to access language services in that non-English language.

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

Section 8. The disputed claims process

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

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 Coventry Health Care of Kansas, Inc., P.O. Box 7109, London, KY 40742 or calling (800) 969-3343.

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 judgement (i.e., medically necessity, experimental/ investigational), we will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgement and who was not involved in making the initial decision.

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

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

Disagreements between you and the HDHP fiduciary regarding the administration of an HSA or HRA are not subject to the disputed claims process.

Step	Description
1	Ask us in writing to reconsider our initial decision. You must: a) Write to us within six (6) months from the date of our decision; and b) Send your request to us at: Coventry Health Care of Kansas, Inc., Attn: Member Appeals, 9401 Indian Creek Parkway, Overland Park, KS 66210 ; and c) Include a statement about why you believe our initial decision was wrong, based on specific benefit provisions in this brochure; and d) Include copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms. e) Your email address (optional), if you would like to receive our decision via email. Please note that by giving us your email, you may receive our decision more quickly. We will provide you, free of charge and in a timely manner, with any new or additional evidence considered, relied upon, or generated by us or at our direction in connection with your claim and any new rationale for our claim decision. We will provide you with this information sufficiently in advance of the date that we are required to provide you with our reconsideration decision to allow you a reasonable opportunity to respond to us before that date. However, our failure to provide you with new evidence or rationale in sufficient time to allow you to timely respond shall not invalidate our decision on reconsideration. You may respond to that new evidence or rationale at the OPM review stage described in step 4.

Step	Description
2	In the case of a post-service claim, we have 30 days from the date we receive your request to: a) Pay the claim or, 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 Professional Management, Healthcare and Insurance, Federal Employee Insurance Operations, Health Insurance 3, 1900 E Street, NW, Washington, DC 20415-3630. Send OPM the following information: • A statement about why you believe our decision as 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 hte 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 as a right to file a disputed claim with OPM. Parties acting as your representative, such as medical providers, must include a copy of your specific written consent with the review request. However, for urgent care claims, a health care professional with knowledge of your medical condition may act as your authorized representative without your expression consent. Note: The above deadlines may be extended if you show that you were unable to meet the deadline because of reasons beyond your control.
4	OPM will review your disputed claim request and will use the information it collects from you and us to decide whether our decision is correct. OPM will send you a final decision with 60 days. There are no other administrative appeals. If you do not agree with OPM's decision, your only recourse is to sue. If you decide to file a lawsuit, 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 800-969-3343. 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 Health Insurance 3 at 202-606-0737 between 8 a.m. and 5 p. m. Eastern Time.

Please remember that we do not make decisions about plan eligibility issues. For example, we do not determine whether you or a dependent are 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 health plan or has automobile insurance that pays health care expenses without regard to fault. This is called "double coverage."

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

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

When we are the secondary payor, we will determine our allowance. After the primary plan pays, we will pay what is left of our allowance or the difference between the Primary Plan allowance and what is paid by the Primary Plan, up to our regular benefit. We will not pay more than our allowance. Your co-insurance, copayment, or deductible will still apply to the FEHB benefit.

- **TRICARE and CHAMPVA**

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

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

- **Workers' Compensation**

We do not cover services that:

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

Once OWCP or similar agency pays its maximum benefits for your treatment, we will cover your care. You must use our providers.

- **Medicaid**

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

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

When other Government agencies are responsible for your care

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

When others are responsible for injuries

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

If you do not seek damages you must agree to let us try. This is called subrogation. If you need more information, contact us for our subrogation procedures.

When you have Federal Empolyees Dental and Vision Insurance Program (FEDVIP) coverage

Some FEHB plans already cover some dental and vision services. When you are covered by more than one vision/dental plan, coverage provided under your FEHB Plan remains as your primary coverage. FEDVIP coverage pays secondary to that coverage. When you enroll in a dental and/or vision plan on BENEFEDS.com, you will be asked to provide information on your FEHB Plan so that your Plans can coordinate benefits. Providing your FEHB information may reduce your out-of-pocket cost.

Clinical Trials

An approved clinical trial includes a phase I, phase II, phase III, or phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition and is either Federally funded; conducted under an investigational new drug application reviewed by the Food and Drug Administration; 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 for related care as follows, if it is not provided by the clinical trial:

Routine care costs – costs for routine services such as doctor visits, lab tests, x-rays and scans, and hospitalizations related to treating the patient's condition, whether the patient is in a clinical trial or is receiving standard therapy. These costs are covered by this plan.

Extra care costs – costs related to taking part in a clinical trial such as additional tests that a patient may need as part of the trial, but not as part of the patient's routine care. This plan does not cover these costs.

Research costs – costs related to conducting the clinical trial such as research physician and nurse time, analysis of results, and clinical tests performed only for research purposes. These costs are generally covered by the clinical trials, this plan does not cover these costs.

When you have Medicare

- **What is Medicare?**

Medicare is a Health Insurance Program for:

- People 65 years of age or older
- Some people with disabilities under 65 years of age
- People with End-Stage Renal Disease (permanent kidney failure requiring dialysis or a transplant)

Medicare has four parts:

- Part A (Hospital Insurance). Most people do not have to pay for Part A. If you or your spouse worked for at least 10 years in Medicare-covered employment, you should be able to qualify for premium-free Part A insurance. (If you were a Federal employee at any time both before and during January 1983, you will receive credit for your Federal employment before January 1983.) Otherwise, if you are age 65 or older, you may be able to buy it. Contact 1-800-MEDICARE (1-800-633-4227) (TTY: 1-877-486-2048) for more information.
- Part B (Medical Insurance). Most people pay monthly for Part B. Generally, Part B premiums are withheld from your monthly Social Security check or your retirement check.

- Part C (Medicare Advantage). You can enroll in a Medicare Advantage plan to get your Medicare benefits. We offer a Medicare Advantage plan. Please review the information on coordinating benefits with Medicare Advantage plans on the next page.

- Part D (Medicare prescription drug coverage). There is a monthly premium for Part D coverage. Before enrolling in Medicare Part D, please review the important disclosure notice from us about the FEHB prescription drug coverage and Medicare. The notice is on the first inside page of this brochure. For people with limited income and resources, extra help in paying for a Medicare prescription drug plan is available. For more information about this extra help, visit the Social Security Administration online at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY: 1-800-325-0778).

- **Should I enroll in Medicare?**

The decision to enroll in Medicare is yours. We encourage you to apply for Medicare benefits 3 months before you turn age 65. It's easy. Just call the Social Security Administration toll-free number 1-800-772-1213 (TTY: 1-800-325-0778) to set up an appointment to apply. If you do not apply for one or more Parts of Medicare, you can still be covered under the FEHB Program.

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

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

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

- **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 are enrolled 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 1-866-969-3343 or see our website at www.chckansas.com.

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

- Medical services and supplies provided by physicians and other health care professionals. If you are enrolled in Medicare Part B, we will waive your out-of-pocket costs including copayments and coinsurance. After the primary plan pays, we will pay what is left of our allowance, up to our regular benefit. We will not pay more than our allowance.

- **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.

- **Medicare Advantage (Part C)**

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

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

This Plan and our Medicare Advantage plan: We have no Medicare Advantage Plan.

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 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)**

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 the claims for your prescription drug costs that are not covered by Medicare Part D and consider them for payment under the FEHB plan.

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

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

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

Section 10. Definitions of terms we use in this brochure

Calendar year

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

Clinical Trials Cost Categories

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. These costs are generally covered by the clinical trials. This plan does not cover these costs.

Coinsurance

Coinsurance is the percentage of our allowance that you must pay for your care. You may also be responsible for additional amounts. See Section 4.

Copayment

A copayment is a fixed amount of money you pay when you receive covered services. See Section 4.

Cost-sharing

Cost-sharing is the general term used to refer to your out-of-pocket costs (e.g., deductible, coinsurance, and copayments) for the covered care you receive.

Covered services

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

Custodial care

Care that is primarily for meeting personal needs: such as walking, getting in and out of bed, bathing, dressing, shopping, eating and preparing meals, performing general household services, or taking medicine. Custodial care that lasts 90 days or more is sometimes know as Long term care.

Deductible

A deductible is a fixed amount of covered expenses you must incur for certain covered services and supplies before we start paying benefits for those services. See Section 4.

Experimental or investigational service

A health product or service is deemed experimental if one or more of the following criteria are met:

- Any drug not approved for use by the FDA; any FDA approved drug prescribed for an off-label use whose effectiveness is unproven based on clinical evidence reported in peer-reviewed medical literature; or, any drug that is classified as IND (investigational new drug) by the FDA. As used herein, off-label prescribing means prescribing prescription drugs for treatments other than those stated in the labeling approved by the FDA.
- Any health product or service that is subject to Institutional Review Board (IRB) review or approval;
- Any health product or service that is the subject of a clinical trial that meets criteria for Phase I, II, or III as set forth by FDA regulations;

- Any health product or service whose effectiveness is unproven based on clinical evidence reported in peer-reviewedmedical literature.

Formulary

A list of specific generic and brand name Prescription and Specialty Drugs Authorized by the Plan, and subject to periodic review and modification at least annually by the Plan's Pharmacy and Therapeutics Committee. The Formulary is available for review in the searchable Formulary on Our website, www.chckansas.com, in the Participating Provider's office, or by contacting the Customer Service Department. Please note: Inclusion of a drug within the Formulary does not guarantee that Your health care provider will prescribe that drug for a particular medical condition or illness.

- **Prior-Authorization**

Some drugs require authorization in order for them to be Covered Services. Drugs requiring authorization are identified within the Formulary with "PA" next to the name of the drug

- **Specialty Drug**

Those drugs listed on the Specialty Drug Formulary and identified with an "SP" and are typically identified as "Tier 4". Specialty Drugs are typically used to treat rare or complex disease. These drugs frequently require special handling, close clinical monitoring and management and Pre-Certification prior to being dispensed.

Group health coverage

Health care benefits that are available as a result of your employment, or the employment of your spouse, and that are offered by an employer or through membership in an employee organization. Health care coverage may be insured or indemnity coverage, self-insured or self-funded coverage, or coverage through health maintenance organizations or other managed care plans.

Health care professional

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

Medical necessity

Health services and supplies which are deemed by the Plan to medically appropriate and (1) necessary to meet the basic health needs of the Plan member; (2) rendered in the most cost-efficient manner and type of setting appropriate for the delivery of the health service; (3) consistent in type, frequency and duration of treatment with relevant guidelines of national medical, research or health care coverage organizations and governmental agencies; (4) consistent with the diagnosis of the condition; (5) required for reasons other than the comfort or convenience of the Plan member or his or her provider; and (6) of demonstrated medical value. The fact that a Physician has performed or prescribed a procedure or treatment, or the fact that it may be the only treatment for a particular injury or sickness, does not mean that the procedure or treatment is medically necessary.

Our allowance

Our allowance is the amount we use to determine our payment and your coinsurance for covered services. When you receive services or supplies from Plan providers, it is the amount that we set for the services or supplies if we were to charge for them.

Peer-reviewed medical literature

It refers to the requirement that medical literature on a topic is only considered relevant if it is a scientific study, which has been published in the English language (mostly American) medical literature only after review by academic experts for structure of study and validity of conclusions, prior to acceptance for publication; and

Based on a methodology used by certain authoritative bodies (including The National Cancer Institute PDQ Guidelines for Cancer Treatment and the International Consensus Conference on Bone Marrow Transplantation), the medical literature is graded for its quality using a 2-by-2 grid based on two parameters: strength of the evidence and effectiveness. Strength of evidence is graded from the highest level of evidence to the lowest, as follows:

1. Level 1: Randomized, controlled trial
2. Level 2: Cohort/Case Control Study
3. Level 3: Systematic Literature Review

4. Level 4: Large consecutive case series
5. Level 5: Small consecutive case series
6. Level 6: Textbook chapters (opinion of a respected authority)
7. Level 7: Case report

Effectiveness is evaluated using 4 measurements:

1. Is the proposed treatment harmful or beneficial?
2. Do the results favor the study (experimental) group or the control group?
3. Is the outcome considered statistically weak or strong?
4. Is the study design weak or strong?

After evaluating the peer-reviewed medical literature according to the methodology described above, a conclusion is drawn that the preponderance of evidence favors the proposed new technology as being proven (and therefore standard of care), or conversely unproven (i.e. investigational/experimental).

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.

Preventive Services

The preventive health services referenced in Section 5 shall be covered in full and are not subject to cost-sharing requirements (including copayments, coinsurance or deductible), in a manner consistent with Section 2713 of Federal H.R. 3590.

• Items or services with an "A" or "B" rating from the United States Preventive Task Force;

• Immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control Prevention (ACIP – CDC);

• Preventive care and screenings for infants, children, and adolescents as provided for in the comprehensive guidelines supported by the Health Resources and Services Administration (HRSA);

• Additional preventive care and screenings for women (including breast cancer screening and mammography screenings) not described above;

A list of the preventive services covered is available on the website at www.chckansas.com or will be mailed to you upon request. You may request the list by calling the Customer Service number on your identification card

Urgent care claims

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

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

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

	If you believe your claim qualifies as an urgent care claim, please contact our Customer Service Department at 1-800-969-3343. 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 Coventry Health Care of Kansas, Inc.
You	You refers to the enrollee and each covered family member.

Section 11. Other Federal Programs

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

Important information about three Federal programs that complement the FEHB Program

First, the **Federal Flexible Spending Account Program**, also known as FSAFEDS, lets you set aside pre-tax money from your salary to reimburse you for eligible dependent care and/or health care expenses. You pay less in taxes so you save money. Participating employees save an average of about 30% on products and services they routinely pay for out-of-pocket.

Second, the **Federal Employees Dental and Vision Insurance Program (FEDVIP)** provides comprehensive dental and vision insurance at competitive group rates. There are several plans from which to choose. Under FEDVIP you may choose self only, self plus one, or self and family coverage for yourself and any eligible dependents.

Third, the **Federal Long Term Care Insurance Program (FLTCIP)** can help cover long term care costs, which are not covered under the FEHB Program.

The Federal Flexible Spending Account Program (FSAFEDS)

What is an FSA?

It is an account where you contribute money from your salary **BEFORE** taxes are withheld, then incur eligible expenses and get reimbursed. You pay less in taxes so you save money. **Annuitants are not eligible to enroll.**

There are three types of FSAs offered by FSAFEDS. Each type has a minimum annual election of $100. The maximum annual election for a health care flexible spending account (HCFSA) or a limited expense health care spending account (LEX HCFSA) is $2,500 per person. The maximum annual election for a dependent care flexible spending account (DCFSA) is $5,000 per household.

- **Health Care FSA (HCFSA)** – Reimburses you for eligible out-of-pocket health care expenses (such as copayments, deductibles, prescriptions, **physician prescribed** over-the-counter medications and drugs, vision and dental expenses, and much more) for you and your tax dependents, including adult chidren (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 providers 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.

- **Limited Expense Health Care FSA (LEX HCFSA**) – Designed for employees enrolled in or covered by a High Deductible Health Plan with a Health Savings Account. Eligible expenses are limited to out-of-pocket dental and vision care expenses for you and your tax dependents adult chidren (through the end of the calendar year in which they turn 26).
- **Dependent Care FSA (DCFSA)** – Reimburses you for eligible **non-medical** day care expenses for your children under age 13 and/or for any person you claim as a dependent on your Federal Income Tax return who is mentally or physically incapable of self-care. You (and your spouse if married) must be working, looking for work (income must be earned during the year), or attending school full-time to be eligible for a DCFSA.
- If you are a new or newly eligible employee you have 60 days from your hire date to enroll in HCFSA or LEX HCFSA and/or DCFSA, but you must enroll before October 1. If you are hired or become eligible on or after October 1, you must wait and enroll during the Federal Benefits Open Season held each fall.

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

The Federal Employees Dental and Vision Insurance Program (FEDVIP)

Important Information	The Federal Employees Dental and Vision Insurance Program (FEDVIP) is separate and different from the FEHB Program. **This Program provides comprehensive dental and vision insurance at competitive group rates with no pre-existing condition limitations for enrollment.** FEDVIP is available to eligible Federal and Postal Service employees, retirees, and their eligible family members on an enrollee-pay-all basis. Employee premiums are withheld from salary on a pre-tax basis.
Dental Insurance	All dental plans provide a comprehensive range of services, including: • Class A (Basic) services, which include oral examinations, prophylaxis, diagnostic evaluations, sealants and x-rays. • Class B (Intermediate) services, which include restorative procedures such as fillings, prefabricated stainless steel crowns, periodontal scaling, tooth extractions, and denture adjustments. • Class C (Major) services, which include endodontic services such as root canals, periodontal services such as gingivectomy, major restorative services such as crowns, oral surgery, bridges and prosthodontic services such as complete dentures. • Class D (Orthodontic) services with up to a 12-month waiting period. Most FEDVIP dental plans cover adult orthodonia. Review your FEDVIP dental plan's brochure for information on this benefit.
Vision Insurance	All vision plans provide comprehensive eye examinations and coverage for your choice of either lenses and frames or for contact lenses. Other benefits such as discounts on LASIK surgery may also be available.
Additional Information	You can find a comparison of the plans available and their premiums on the OPM website at www.opm.gov/dental and www.opm.gov/vision. These sites also provide links to each plan's website, where you can view detailed information about benefits and preferred providers.
How do I enroll?	You enroll on the Internet at www.BENEFEDS.com. For those without access to a computer, call 1-877-888-3337 (TTY: 1-877-889-5680).

The Federal Long Term Care Insurance Program (FLTCIP)

It's important protection	The Federal Long Term Care Insurance Program (FLTCIP) can help pay for the potentially high cost of long term care services, which are not covered by FEHB plans. Long term care is help you receive to perform activities of daily living – such as bathing or dressing yourself - or supervision you receive because of a severe cognitive impairment such as Alzheimer's disease. For example, long term care can be received in your home from a home health aide, in a nursing home, in an assisted living facility or in adult day care. To qualify for coverage under the FLTCIP, you must apply and pass a medical screening (called underwriting). Federal and U.S. Postal Service employees and annuitants, active and retired members of the uniformed services, and qualified relatives are eligible to apply. Certain medical conditions, or combinations of conditions, will prevent some people from being approved for coverage. You must apply to know if you will be approved for enrollment. For more information, call 1-800-LTC-FEDS (1-800-582-3337) (TTY: 1-800-843-3557), or visit www.ltcfeds.com.

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

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Summary of benefits for the High Option of Coventry Health Care of Kansas, Inc. - 2015

- **Do not rely on this chart alone.** All benefits are provided in full unless indicated and are subject to the definitions , limitations, and exclusions in this brochure. On this page we summarize specific expenses we cover; for more detail, look inside.
- If you want to enroll or change your enrollment in this Plan, be sure to put the correct enrollment code from the cover on your enrollment form.
- We only cover services provided or arranged by Plan physicians, except in emergencies.

High Option Benefits	You pay	Page
Medical services provided by physicians:		
Diagnostic and treatment services provided in the office	$30 for PCP and OB/GYN; $60 Specialist, No Deductible	29
Services provided by a hospital:		
• Inpatient	25% of our allowable, after Deductible	51
• Outpatient	25% of our allowable, after Deductible	52
Emergency benefits:		
• In-area	$300 per visit, No Deductible; waived if admitted to hospital	56
• Out-of-area	$300 per visit, No Deductible; waived if admitted to hospital	56
Mental health and substance abuse treatment:	Regular cost-sharing	58
Prescription drugs:		
• Retail pharmacy	$3/$12/$50/$75/20%, No Deductible	60
• Mail order	$9/$36/$150/$225, No Deductible	60
Dental care: (Preventive Care)	Nothing, No Deductible	64
Vision care: (Preventive Care)	Nothing, No Deductible	36
Special features: Flexible Benefits Option, 24 hour nurse line, Services for deaf and hearing impaired, Transplant Network		66
Deductible	$1,000 Self Only $3,000 Self and Family	24
Protection against catastrophic costs (out-of-pocket maximum)**:**	$5,000 Self Only $10,000 Self Only and Family	24

Summary of benefits for the Standard Option of Coventry Health Care of Kansas, Inc. - 2015

- **Do not rely on this chart alone.** All benefits are provided in full unless indicated and are subject to the definitions, limitations, and exclusions in this brochure. On this page we summarize specific expenses we cover; for more detail, look inside.
- If you want to enroll or change your enrollment in this Plan, be sure to put the correct enrollment code from the cover on your enrollment form.
- We only cover services provided or arranged by Plan physicians, except in emergencies.

Standard Option Benefits	You Pay	Page
Medical services provided by physicians:		
Diagnostic and treatment services provided in the office	$30 for PCP and OB/GYN; $60 Specialist, No Deductible	29
Services provided by a hospital:		
• Inpatient	30% of our allowance, after Deductible	51
• Outpatient	30% of our allowance, after Deductible	52
Emergency benefits:		
• In-area	30% of our allowance, No Deductible; waived if admitted to hospital	56
• Out-of-area	30% of our allowance, No Deductible; waived if admitted to hospital	56
Mental health and substance abuse treatment:	Regular cost-sharing	58
Prescription drugs:		
• Retail pharmacy	$3/$12/$50/20%/20%, No Deductible	60
• Mail order	$9/$36/$150/20% or $225, No Deductible	60
Dental care: (Preventive Care)	Nothing, No Deductible	64
Vision care: (Preventive Care)	Nothing, No Deductible	35
Special features: Flexible Benefits Option, 24 hour nurse line, Services for deaf and hearing impaired, Transplant Network		66
Deductible	$2,000 Self Only $6,000 Self and Family	24
Protection against catastrophic costs (out-of-pocket maximum)**:**	$4,000 Self Only $8,000 Self and Family	25

Summary of benefits for the HDHP of Coventry Health Care of Kansas, Inc. - 2015

Do not rely on this chart alone. All benefits are subject to the definitions, limitations, and exclusions in this brochure. On this page we summarize specific expenses we cover; for more detail, look inside. If you want to enroll or change your enrollment in this Plan, be sure to put the correct enrollment code from the cover on your enrollment form.

In 2015 for each month you are eligible for the Health Savings Account (HSA), we will deposit $66.66 per month for Self Only enrollment or $133.33 per month for Self and Family enrollment to your HSA. For the HSA, you may use your HSA or pay out of pocket to satisfy your calendar year deductible of $2,500 for Self Only and $5,000 for Self and Family. Once you satisfy your calendar year deductible and catastrophic out-of-pocket maximum, Traditional medical coverage begins.

For the Health Reimbursement Arrangement (HRA), your health charges are applied to your annual HRA Fund of $800 for Self Only and $1,600 for Self and Family. Once your HRA is exhausted, you must satisfy your calendar year deductible. Once your calendar year deductible is satisfied, Traditional medical coverage begins.

HDHP Benefits	After the deductible, you pay	Page
In-network medical and dental preventive care	Nothing, No Deductible	78
Medical services provided by physicians:		
• Diagnostic and treatment services provided in the office	20% of our allowable	81
Preventive services:		
• Routine screenings, physicals and child immunizations	Nothing, No Deductible	78
Services provided by a hospital:		
• Inpatient	20% of our allowable	97
• Outpatient	20% of our allowable	98
Emergency benefits:		
• In-area • Out-of-area	20% of our allowable	101
Mental health and substance abuse treatment:	20% of our allowable	102
Prescription drugs:		
• Retail pharmacy • Mail order	20% of our allowable	104
Dental care: (Preventive Services)	Nothing, No Deductible	108
Vision care: (Preventive Services)	Nothing, No Deductible	85
Special features: Flexible Benefits Option, 24 hour nurse line, Services for deaf and hearing impaired, Transplant Network		110
Deductible:	$2,500 Self Only $5,000 Self and Family	24
Protection against catastrophic costs (your catastrophic out-of-pocket maximum)	$4,000 Self Only $8,000 Self and Family	25

2015 Rate Information for - Coventry Health Care of Kansas, Inc.

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

Postal rates apply to Postal Service employees. They are shown in special Guides published for APWU (including Material Distribution Center and Operating Services) NALC, NPMHU and NRLCA Career Postal Employees (see RI 70-2A); Information Technology/Accounting Services employees (see RI 70-2IT); Nurses (see RI 70-2N); Postal Service Inspectors and Office of Inspector General (OIG) law enforcement employees and Postal Career Executive Service employees (see RI 70-2IN); and non-career employees (see RI 70-8PS).

Postal Category 1 applies to career employees who are members of the APWU, NALC, NPMHU, or NRLCA bargaining units.

Postal Category 2 rates apply to career non-bargaining unit, non-executive, non-law enforcement employees, and non-law enforcement Inspection Service and Forensics employees.

For further assistance, Postal Service employees should call:

Human Resources Shared Service Center

1-877-477-3273, option 5

TTY: 1-866-260-7507

Postal rates do not apply to non-career postal employees, postal retirees, or associate members of any postal employee organization who are not career postal employees. Refer to the applicable Guide to Federal Benefits.

Premiums for Tribal employees are shown under the monthly non-postal column. The amount shown under employee contribution is the maximum you will pay. Your Tribal employer may choose to contribute a higher portion of your premium. Please contact your Tribal Benefits Officer for exact rates.

Type of Enrollment	Enrollment Code	Non-Postal Premium				Postal Premium	
		Biweekly		Monthly		Biweekly	
		Gov't Share	Your Share	Gov't Share	Your Share	Category 1 Your Share	Category 2 Your Share
High Option Self Only	HA1	$183.33	$61.11	$397.22	$132.40	$48.28	$61.11
High Option Self and Family	HA2	$430.85	$143.61	$933.50	$311.16	$113.46	$143.61
Standard Option Self Only	HA4	$196.15	$65.38	$424.99	$141.66	$51.65	$65.38
Standard Option Self and Family	HA5	$448.57	$166.03	$971.90	$359.73	$134.88	$166.03
HDHP Option Self Only	9H1	$202.01	$69.45	$437.69	$150.47	$55.42	$69.45
HDHP Option Self and Family	9H2	$448.57	$189.38	$971.90	$410.33	$158.23	$189.38