Coventry Health Plan of Florida

http://www.chcflorida.com

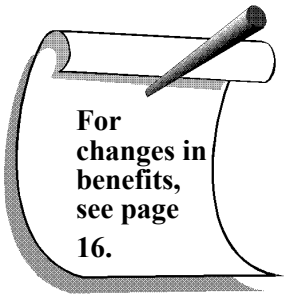
2014

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 8 for details.

Serving: South Florida (Broward, Miami-Dade, Martin, Palm Beach and St. Lucie counties)

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



Enrollment code for this Plan:

- **5E1 High Option - Self Only**
- **5E2 High Option - Self and Family**
- **5E4 Standard Option - Self Only**
- **5E5 Standard Option - Self and Family**
- **J41 High Deductible Health Plan (HDHP) - Self Only**
- **J42 High Deductible Health Plan (HDHP) - Self and Family**

Authorized for distribution by the:

United States
Office of Personnel Management

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

Important Notice from Coventry Health Plan of Florida About

Our Prescription Drug Coverage and Medicare

OPM has determined that the Coventry Health Plan of Florida 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. Thus you do not need to enroll in Medicare Part D and pay extra for prescription drug benefit 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 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'll 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 15th through December 7th) 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 Plan of Florida, Inc.under our contract (CS 2715) with the United States Office of Personnel Management, as authorized by the Federal Employees Health Benefits law. Customer service may be reached at 1/866-575-1882 or through our website: www.feds.chcflorida.com. The address for Coventry Health Plan of Florida, Inc. administrative offices is:

Coventry Health Care of Florida, Inc.
1340 Concord Terrace
Sunrise Florida 33323

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, 2014, unless those benefits are also shown in this brochure.

OPM negotiates benefits and rates with each plan annually. Benefit changes are effective January 1, 2014, and changes are summarized on page 15. 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 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.

The ACA establishes a minimum value for 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 Plan of Florida, 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 first.
- 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 for 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 claim history for accuracy to ensure we have not been billed for services that 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 (866) 575-1882 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 age 26 or over (unless he/she is 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 else who is not eligible for coverage, or enrolling in the Plan when you are no longer eligible.
- If your enrollment continues after you are no longer eligible for coverage (i.e. you have separated from Federal service) and premiums are not paid, you will be responsible for all benefits paid during the period in which premiums were not paid. You may be billed for services received directly by your provider. 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 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 tests or procedures.
- Don’t assume the results are fine if you do not get them when expected, be it in person, by phone, or by mail.
- Call your doctor and ask for your results.
- Ask what the results mean for your care.

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

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

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

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

Patient Safety Links

- www.ahrq.gov/path/beactive.htm. The Agency for Healthcare Research and Quality makes available a wide-ranging list of topics not only to inform consumers about patient safety but to help choose quality health care providers and improve the quality of care you receive.
- www.npsf.org. The National Patient Safety Foundation has information on how to ensure safer health care for you and your family.
- www.talkaboutrx.org. 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

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 Plan of Florida, Inc. preferred providers. This policy helps to protect you from preventable medical errors and improve the quality of care you receive.

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 called "Never Events." When a Never Event occurs, neither your FEHB plan nor you will incur costs to correct the medical error.

FEHB Facts

Coverage information

- **No pre-existing condition limitation**

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

- **Minimum essential coverage (MEC)**

  Coverage under this plan qualifies as minimum essential coverage (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**

  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.

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

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

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

  Also, your employing or retirement office can answer your questions, and give you a *Guide to Federal 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;
  - 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 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/insure/lifeevents. If you need assistance, please contact your employing agency, personnel/payroll office, or retirement office.

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 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, adopted children, and stepchildren	Natural, adopted children and stepchildren 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 spouses or their own children) are covered until their 26th birthday.
Children with or eligible for employer-provided health insurance	Children who are eligible for oe have their own employer-provided health insurance are covered until their 26th birthday.

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

- **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 2014 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 2013 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 entitiled to continuation of the benefits of the Plan during the continuance of the confinement but not beyond the 60th day after the end of the 31 day temporary extension.

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

- **Upon divorce**

If you are divorced from a Federal employee, Tribal employee, or an annuitant, you may not continue to get benefits under your former spouse's enrollment. This is the case even when the court has ordered your former spouse to provide health coverage to you. 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 Web site, www.opm.gov/healthcare-insurance/healthcare/plan-information/guides.

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

If you leave Federal or Tribal service, or if you lose coverage because you no longer qualify as a family member, you may be eligible for Temporary Continuation of Coverage (TCC). For example, you can receive TCC if you are not able to continue your FEHB enrollment after you retire, if you lose your Federal or Tribal job, if you are a covered dependent child and you turn 26, 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,* from your employing or retirement office or from www.opm.gov/healthcare-insurance. It explains what you have to do to enroll.

We also want to inform you that the Patient Protection and Affordable Care Act (ACA) did not eliminate TCC or change the TCC rules.

- **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 Market Place**

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.

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

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

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

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, or a Standard Option.

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 our High and Standard Options

We have Open Access benefits

Our HMO offers Open Access benefits. This means you can receive covered services from a participating provider without a required referral from you primary care physician or by another participating provider in the 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 or coinsurance.

Preventive care services

Preventive care services are 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 care services.

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 $1,500 for self only enrollment, or $3,000 family coverage, under the High Option or $2,500 for self only enrollment, or $5,000 for family coverage, under the Standard Option.

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.

Preventive care services

Preventive care services are generally paid as first dollar coverage or after a small deductible or copayment. First dollar coverage may be limited to a maximum dollar amount each year.

Annual deductible

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

Health Savings Account (HSA)

You are eligible for an HSA if you are enrolled in an HDHP, not covered by any other health plan that is not an HDHP (including a spouse's health plan, but does not include specific injury insurance and accident, disability, dental care, vision care, or long-term coverage), not enrolled in Medicare, not received VA or Indian Health Services (IHS) benefits within the last three 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 it 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. In addition, 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 an 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 $5,000 for self only enrollment, or $10,000 family coverage.

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 Plan of Florida, Inc. is a for-profit entity and has been operational since 1984.
- Coventry Health Plan of Florida received a three-year accreditation from the Accreditation Association for Ambulatory Health Care, Inc.
- Coventry Health Plan of Florida, Inc., is licensed by the Florida Financial Services Commission.

If you want more information about us, call 1-866-575-1882, or write to Coventry Health Care of Florida, Inc., 1340 Concord Terrace, Sunrise, Florida 33323. You may also contact us by fax at 954-846-8873 or visit our website feds.chcflorida.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 service area covers South Florida – Broward, Miami-Dade, Martin, Palm Beach and St. Lucie 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. Reciprocity arrangements do not exist in any other Coventry Health Plan of Florida, Inc. networks. If you or a family member moves, you do not have to wait until Open Season to change plans. Contact your employing or retirement office.

Section 2. Changes for 2014

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.

Program wide changes

Changes to High Option only

- Your share of non-Postal premium will increase for Self Only and Family. See page 118.
- Prescription copays are included in the out-of-pocket maximum.

Changes to Standard Option only

- Your share of non-Postal premium will decrease for Self Only and Family. See page 119.
- Prescription copays are included in the out-of-pocket maximum.

Changes to High Deductible Health Plan (HDHP) Option only

- Your share of non-Postal premium will increase for Self Only and Family. See page 120.
- No changes.

Clarification

High Option

- Habilitative therapy is covered for 60 visits during at least 2 consecutive months per calendar year at $30 per visit.

Standard Option

- Habilitative therapy is covered for 60 visits during at least 2 consecutive months per calendar year at $50 per visit.

High Deductible Health Plan (HDHP) Option

- Habilitative therapy is covered for 60 visits at least 2 consecutive months per calendar year. At hospital - 20% of charges after satisfaction of calendar year deductible; At freestanding facility - $25 per visit after satusfaction of calendar year deductible.

Section 3. How you get care

Identification cards

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

If you do not receive your ID card within 30 days after the effective date of your enrollment, or if you need replacement cards, call us at 1-866-575-1882 or write to us at **Coventry Health Care of Florida, Attn: Customer Service, 1340 Concord Terrace, Sunrise, Florida 33323**. You may also request replacement cards through our website at feds.chcflorida.com.

Where you get covered care

If you use our Open Access program you can receive covered services from a participating provider without a required referral from your primary care physician or by another participating provider in the network.

- **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 Web site.

- **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 Web site.

What you must do to get covered care

It depends on the type of care you need. First, you and each family member must choose a primary care physician. This decision is important since your primary care physician provides or arranges for most of your health care.

- **Primary care**

If you want to change primary care physicians or if your primary care physician leaves the Plan, call us. We will help you select a new one.

- **Specialty 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, your primary care physician will develop a treatment plan that allows you to see your specialist for a certain number of visits without additional referrals. Your primary care 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, talk to your primary care physician. Your primary care physician will decide what treatment you need. If he or she decides to refer you to a specialist, ask if you can see your current specialist. 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.
- If you are seeing a specialist and your specialist leaves the Plan, call your primary care physician, who will arrange for you to see another 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; or
  - 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 or specialist will make necessary hospital arrangements and supervise your care. This includes admission to a skilled nursing or other type of facility.

- **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 1-866-575-1882. 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 cases, the hospitalized family member's benefits under the new plan begin on the effective date of enrollment.

You need prior Plan approval for certain services

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

- **Inpatient hospital services**

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 most services. For certain services, however, your physician must obtain prior approval from us. Before giving approval, we consider if the service is covered, medically necessary, and follows generally accepted medical practice. You must obtain prior authorization for:

- Air ambulance (non-emergency)
- Ambulance Transport (non-emergency)
- Automatic Implantable Cardioverter Defibrillator (A.I.C.D.)
- Blepharoplasty
- Bone Growth Stimulators
- Breast Surgery for Benign Condition
- Clinitron Bed

- Cosmetic Surgery
- CTA/CCTA/CT
- Customized Wheelchairs
- DME
- Echo Stress
- Enhanced External Counter Pulsation
- Experimental/Investigational Services
- Extracorporeal Shock Wave Therapy/Orthotripsy
- Gastric Bypass/Banding
- Home Health Services
- Home Vents
- Hospice Care
- Hospital Admission
- Hospital Outpatient Services (all, includes diagnostic testing)
- Hyperbaric Treatments
- Infertility Assessment/Treatment
- Infusion/Home/Office Drug-Replacement
- Laparoscopic Hysterectomy
- Liquid Oxygen
- Manipulation Under Anesthesia
- Maternal fetal medicine
- MRA/MRI
- Neuropsychology
- Non-participating providers
- Nuclear Cardiology
- Nuclear Medicine
- Oral surgery
- Pain Management
- Panniculectomy/Abdominoplasty
- PET Scans
- Power Mobility Devices (power wheelchair and scooters)
- Prosthetics/Braces/Orthotics
- Rehabilitation Facility Inpatient Admission
- Rehabilitation Therapies (PT, ST, OT)
- Removal of Keloid/Lipomas
- Reproductive Endocrinology
- Rhinoplasty/Septoplasty
- Sclerotherapy for Vericose Veins
- Skilled Nursing Facility Admission
- Sleep Studies
- Transplant Evaluations/Transplants
- Ultrasound, Pregnant Uterus, Transvaginal (76817)
- Uvulopalatopharyngoplasty

- Vent/Sub-acute, Long Term Care Admission
- Wound care centers (non-emergency)
- Wound Vacs

Clinical information will be required to substantiate request. The above list is subject to change.

- **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 800-528-2705 or 954-858-3437 before admission or services requiring prior authorization are rendered.

Next, provide the following information:

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

- **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 for 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 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.

- **Urgent care claims**

If you have an urgent care claim (i.e., when waiting for the regular time limit for your medical care or treatment could seriously jeopardize your life, health, or ability to regain maximum function, or in the opinion of a physician with knowledge of your medical condition, would subject you to severe pain that cannot be adequately managed without this care or treatment), we will expedite our review and notify you of our decision within 72 hours. If you request that we review your claim as an urgent care claim, we will review the documentation you provide and decide whether it is an urgent care claim by applying the judgment 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) the 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 claim on appeal be reviewed simultaneously by us and OPM. Please let us know that you would like a simultaneous review of your urgent care claim by OPM either in writing at the time you appeal our initial decision, or by calling us at 866-575-1882. 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 the simultaneous review. We will cooperate with OPM so they can quickly review your claim on appeal. In addition, if you did not indicate that your claim was a claim for urgent care, call us at 866-575-1882. 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 approval 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.

- **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

If prior approval is not given for services provided by a non-network facility/provider, the Healthplan shall have no liability or obligation whatsoever, on account of services or benefits sought or received by any member from any non-network physician, health professional, hospital or other health care facility, or other person, institution or organization.

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 to follow the entire disputed claims process detailed in Section 8.

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

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

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

1. Precertify your hospital stay or, if applicable, arrange for the 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 of the information was due. We will base our decision on the information we already have. We will write to you with our decision.

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.

Subject to a request for 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.

Copayments

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

Example: under the high option, when you see your primary care physician you pay a copayment of $15 per office visit and when you go in the hospital, you pay $150 per admission for the first 3 days.

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.

- The hospital deductible is $250 covered per person under High Option and $500 per covered person under Standard Option.
- The hospital deductible is $2,500 covered per person and $5,000 per family enrollment under High Deductible Health Plan.

Note: If you change plans during Open Season, you do not have to start a new deductible under your old plan between January 1st 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.

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 durable medical equipment.

Your catastrophic protection out-of-pocket maximum

After your High Option (copayments and annual hospital deductible) total $1,500 per person or $3,000 per family or, $2,500 per person or $5,000 per family enrollment on the Standard Option in any calendar year, you do not have to pay any more for covered services. However, vision care copayments do not count toward your catastrophic protection out-of-pocket maximum, and you must continue to pay copayments for these services.

When you use network providers, your annual maximum for out-of-pocket expenses for the High Deductible Health Plan (deductibles, coinsurance and copayments) for covered services is limited to $5,000 per person or $10,000 per family enrollment. However, vision care copayments 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 allowable amount or benefit maximum).

Be sure to keep accurate records of your copayments since you are responsible for informing us when you reach the maximum.

When Government facilities bill us

Facilities of the Department 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.

High and Standard Option Benefits

See page 16 for how our benefits changed this year. Pages 119 and 120 are a benefits summary of each option. Make sure that you review the benefits that are available under the option in 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 866-575-1882 or on our website at feds.chcflorida.com.

Each option offers unique features.

- **High Option** The High Option has lower copayments and higher premiums.
- **Standard Option** The Standard Option has higher copayments and lower premiums.

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.
- HMO Plans are Open Access.
- Each member must satisfy a hospital deductible of $250 if on the High Option or $500 if on the Standard Option for all services billed by a hospital, except emergency services. Facility copayments also apply to surgical services that appear in this section but are performed in an ambulatory surgical center or in the outpatient department of a hospital.
- 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	
Note: The hospital deductible applies to all inpatient and outpatient services at a hospital. We say "(no deductible)" when it does not apply.		
Diagnostic and treatment services	**High Option**	**Standard Option**
Professional services of physicians • In physician's office	$15 per office visit to your primary care physician or $30 per office visit to a specialist	$20 per office visit to your primary care physician or $50 per office visit to a specialist
Professional services of physicians		
• In an urgent care center	$40 per office visit	$50 per office visit
• During a hospital stay	Nothing	Nothing
• In a skilled nursing facility	Nothing	Nothing
• Office medical consultations	$30 per office visit	$50 per office visit
• Second surgical opinion	Nothing if performed by a plan physician or 40% of UCR if performed by a non-plan physician	$20 if performed by a primary care physician, $50 if performed by a specialist or 40% of UCR if performed by a non-plan physician
At home	$15 per visit from your primary care physician or $30 per visit from a specialist	$20 per visit from your primary care physician or $50 per visit from a specialist
Lab, X-ray and other diagnostic tests	**High Option**	**Standard Option**
Tests, such as: • Blood tests • Urinalysis • Non-routine Pap tests • Pathology	$15 per office visit to your primary care physician or $30 per office visit to a specialist Nothing when performed at a participating freestanding laboratory or radiology center Note: These services are subject to the annual deductible when performed in a hospital. See Section 5(c).	$20 per office visit to your primary care physician or $50 per office visit to a specialist Nothing when performed at a participating freestanding laboratory or radiology center Note: These services are subject to the annual deductible when performed in a hospital. See Section 5(c).

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

Benefit Description	You pay	
Lab, X-ray and other diagnostic tests (cont.)	**High Option**	**Standard Option**
• X-rays • Non-routine Mammograms • Electrocardiogram and EEG • CAT Scans/MRI • Ultrasound	Nothing when performed at a participating freestanding labratory or radiology center Note: These services are subject to the annual deductible when performed in a hospital. See Section 5(c).	$100 if performed at a participating freestanding laboratory or radiology center Note: These services are subject to the annual deductible when performed in a hospital. See Section 5(c).
Preventive care, adult	**High Option**	**Standard Option**

Routine physical every year which includes
 	
Routine screenings, such as:
• Total Blood Cholesterol
• Colorectal Cancer Screening , including
  • Fecal occult blood test
  • Sigmoidoscopy, screening – every five years starting at age 50
  • Colonoscopy screening – every ten years starting at age 50
	Nothing	Nothing

• Routine Prostate Specific Antigen (PSA) test - one annually for men 40 and older	Nothing	Nothing
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. • Screenings and counseling for interpersonal and domestic violence.	Nothing	Nothing
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	Nothing
Adult routine immunizations endorsed by the Centers for Disease Control and Prevention (CDC):	Nothing	Nothing
Not covered: • *Physical exams and immunizations required for obtaining or continuing employment or insurance, attending schools or camp, or travel.*	*All Charges*	*All Charges*

Benefit Description	You pay	
Preventive care, children	**High Option**	**Standard Option**
Childhood immunizations recommended by the American Academy of Pediatrics	Nothing	
Professional services, such as: Well-child care charges for routine examinations, immunizations and care (up to age 22) Examinations, such as: • Eye exams through age 17 to determine the need for vision correction, which include: • Hearing exams through age 17 to determine the need for hearing correction, which include: • Examinations done on the day of immunizations (up to age 22)	Nothing	Nothing
Not covered: • *Physical exams, required for obtaining or continuing employment or insurance, attending schools or camp, or travel.* • *Immunizations, boosters, and medications for travel*	*All charges*	*All charges*
Maternity care	**High Option**	**Standard Option**
Complete maternity (obstetrical) care, such as: • Prenatal care • Delivery • Postnatal care	Nothing for prenatal care or the first postpartum care visit; $30 per office visit for all postpartum care visits thereafter. Nothing for inpatient professional delivery services	One time $50 copay for prenatal care and the first postpartum care visit; $50 per office visit for all postpartum care visits thereafter. Nothing for inpatient professional delivery services
• Screening for gestational diabetes for pregnant women between 24-28 weeks gestation or first prenatal visit for women at a high risk.	Nothing	Nothing
• 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 16 for other circumstances, such as extended stays for you on 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.		

Maternity care - continued on next page

Benefit Description	You pay	
Maternity care (cont.)	**High Option**	**Standard Option**
• 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 to circumcision. • We pay hospitalization and surgeon services for non-maternity care the same as for illness and injury.		
Family planning	**High Option**	**Standard Option**
Contraceptive counseling on an annual basis	Nothing	Nothing
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 presciption drug benefit.	Nothing	Nothing
Not covered: • *Reversal of voluntary surgical sterilization* • *Genetic counseling*	*All charges*	*All charges*
Infertility services	**High Option**	**Standard Option**
Diagnosis and treatment of infertility such as: • Artificial insemination: - Intravaginal insemination (IVI) - Intracervical insemination (ICI) - Intrauterine insemination (IUI) • Fertility drugs Note: We cover injectible fertility drugs under medical benefits and oral fertility drugs under the prescription drug benefit.	$15 per office visit to your primary care physician or $30 per visit to a specialist	$20 per office visit to your primary care physician or $50 per visit to a specialist
Not covered: *Assisted reproductive technology (ART) procedures, such as:* • *In vitro fertilization* • *Embryo transfer, gamate intra-fallopian transfer (GIFT)*	*All charges*	*All charges*

Infertility services - continued on next page

Benefit Description	You pay	
Infertility services (cont.)	**High Option**	**Standard Option**
• *Zygote intra-fallopian transfer (ZIFT)* • *Services and supplies related to ART procedures* • *Drugs to treat infertility* • *Cost of donor sperm* • *Cost of donor egg*	*All charges*	*All charges*
Allergy care	**High Option**	**Standard Option**
• Testing and treatment • Allergy injections	$15 per office visit to your primary care physician or $30 per office visit to a specialist	$20 per office visit to your primary care physician or $50 per office visit to a specialist
• 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 on page 39. • Respiratory and inhalation therapy • Dialysis – hemodialysis and peritoneal dialysis • Intravenous (IV)/Infusion Therapy – Home IV and antibiotic therapy • Applied Behavior Analysis (ABA) Therapy for Autism Spectram Disorder • Growth hormone therapy (GHT) Note: Growth hormone is covered under the prescription drug benefit. Note: We only cover GHT when we preauthorize the treatment. 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* on page 16.	$15 per office visit to your primary care physician or $30 per office visit to a specialist	$20 per office visit to your primary care physician or $50 per office visit to a specialist
Not covered: • *Chelation therapy* • *Any furniture, plumbing, electrical or other fixtures to perform dialysis at home.*	*All Charges*	*All Charges*

Benefit Description	You pay	
Physical and occupational therapies	**High Option**	**Standard Option**
60 visits per calendar year; no less than 2 consecutive months of therapy for each condition for each of the following services: • Qualified physical therapists • Occupational therapists Note: We only cover therapy when a provider orders the care. Cardiac rehabilitation following a heart transplant, bypass surgery or a myocardial infarction is provided for up to 100 sessions.	$30 per office visit Nothing per visit during covered inpatient admission Note: The annual deductible and facility copayments apply to services billed by a hospital.	$50 per office visit Nothing per visit during covered inpatient admission Note: The annual deductible and facility copayments apply to services billed by a hospital.
Not covered: • *Long-term rehabilitative therapy* • *Exercise programs* • *Pulmonary rehabilitation*	*All charges*	*All charges*
Speech therapy	**High Option**	**Standard Option**
60 visit per calendar year; no less than 2 consecutive months of therapy for each condition.	$30 per office visit Nothing per visit during covered inpatient admission Note: The annual deductible and facility copayments apply to services billed by a hospital.	$50 per office visit Nothing per visit during covered inpatient admission Note: The annual deductible and facility copayments apply to services billed by a hospital.
Habilitative Therapy	**High Option**	**Standard Option**
60 visit per calendar year; no less than 2 consecutive months of therapy for each condition.	$30 per office visit. Nothing per visit during covered inpatient admission. Note: The annual deductible and facility copayments apply to services billed by a hospital.	$50 per office visit. Nothing per visit during covered inpatient admission. Note; The annual deductible and facility copayments apply to services billed by a hospital.
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 a M.D., D.O. or audiologist. Note: For routine hearing screening performed during a child's preventive care visit, see Section 5(a) *Preventive care, children.*	Nothing	Nothing
• External hearing aids • Implanted hearing-related devices, such as bone anchored hearing aids (BAHA) and cochlear implants	Nothing	Nothing

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

Benefit Description	You pay	
Hearing services (testing, treatment, and supplies) (cont.)	**High Option**	**Standard Option**
Note: For benefits for the devices, see Section 5(a) *Orthopedic and prosthetic devices.*	Nothing	Nothing
Not covered: *Hearing services that are not shown as covered*	*All charges*	*All charges*
Vision services (testing, treatment, and supplies)	**High Option**	**Standard Option**
• Annual eye refractions, including written lens prescription. Note: See *Preventive care, children* for eye exams for children.	$19 per office visit at a participating optometrist or $30 per office visit to a specialist	$19 per office visit at a participating optometrist or $50 per office visit to a specialist
• Frames (one pair of each calendar year from the Coventry Health Care of Florida Standard collection at a participating provider)	Nothing	Nothing
• One pair of frames or contact lenses to correct an impairment directly caused by accidental ocular injury or intraocular surgery (such as for cataracts)	$30 per office visit to a specialist	$50 per office visit to a specialist
• Standard Select Plan Frames (preselected collection)	Nothing	Nothing
• Single vision lenses	$20	$20
• Bifocal lenses	$25	$25
• Trifocal lenses	$30	$30
Contact Lenses • Medically necessary contact lenses (evaluation and fitting) in lieu of eyeglasses	Nothing	Nothing
• Daily wear contact lenses (Bausch & Lomb, Biomedics)	$10	$10
• Extended wear contact lenses (Bausch & Lomb)	$15	$15
• Disposable lenses (2 boxes of all clear spherical lens)	$48	$48
• All eyewear (including contact lenses) outside of the Standard Select plan (preselected collection)	Retail cost minus 20% discount	Retail cost minus 20% discount
Not covered: • *Eye exercises and orthoptics* • *Radial keratotomy and other refractive surgery*	*All Charges*	*All Charges*

Benefit Description	You pay	
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.	$15 per office visit to your primary care physician or $30 per visit to a specialist	$20 per office visit to your primary care physician or $50 per visit to a specialist
Not covered • *Cutting, triming 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 • Corrective orthopedic appliances for non-dental treatment of temporomandibular joint (TMJ) pain dysfunction syndrome • External hearing aids • Implanted hearing-related devices, such as bone anchored hearing aids (BAHA) and cochlear implants • Internal prosthetic devices , such as artificial joints, pacemakers, cochlear implants, and surgically implanted breast implant following mastectomy. Note: For information on the 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.	Nothing	Nothing
Not covered: • *Orthopedic and corrective shoes, arch supports, foot orthotics, heel pads and heel cups* • *Lumbosacral supports* • *Corsets, trusses, elastic stockings, support hose, and other supportive devices* • *Prosthetic replacements provided less than 3 years after the last one we covered*	*All Charges*	*All Charges*

Benefit Description	You pay	
Durable medical equipment (DME)	**High Option**	**Standard Option**
We cover rental or purchase of durable medical equipment, at our option, including repair and adjustment. Covered items include: • Oxygen • Dialysis equipment • Hospital beds • Wheelchairs • Crutches • Walkers • Audible prescription reading devices • Speech generating devices • Blood glucose monitors • Insulin pumps Note: Call us at (866) 575-1882 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.	Nothing	Nothing
Not covered: • *Motorized wheelchairs unless medically necessary to meet the minimum functional requirements of the member* • *More than one device for the same body part or more than one piece of equipment that serves the same function* • *Spare or alternate use devices* • *Adjust, repair or maintenance of devices which are worn or damaged as a result of abuse* • *Replacement of lost devices* • *Exercise equipment and bicycles* • *Elevators and chair lifts, plus home and automobile modifications* • *Air conditioners, humidifiers, dehumidifiers, air purifiers, pillows, whirlpools, spas, jacuzzis, and saunas* • *Any equipment that does not serve a medical purpose*	*All Charges*	*All Charges*

Benefit Description	You pay	
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.), or home health aide. • Services include oxygen therapy, intravenous therapy and medications. Note: See Section 5(a) Diagnostic and Treatment Services for the amount you pay for physician visits in the home.	Nothing	Nothing
Not covered: • *Nursing care requested by, or for the convenience of, the patient or the patient's family.* • *Home care primarily for personal assistance that does not include a medical component and is not diagnostic, therapeutic or rehabilitative.* • *Services primarily for hygiene, feeding, exercising, moving the patient, homemaking, companionship or giving oral medication.*	*All Charges*	*All Charges*
Chiropractic	**High Option**	**Standard Option**
• Manipulation of the spine and extremities • Adjunctive procedures such as ultrasound, electrical muscle stimulation, vibratory therapy, and cold pack application	$30 per office visit	$50 per office visit
Not covered: All services not deemed medically necessary.	*All charges*	*All charges*
Alternative treatments	**High Option**	**Standard Option**
Acupuncture - by a doctor of medicine or osteopathy for: • anesthesia • pain relief	$30 per office visit	$50 per office visit
Not covered: • *Naturopathic services* • *Hypnotherapy* • *Biofeedback*	*All Charges*	*All Charges*
Educational classes and programs	**High Option**	**Standard Option**
Coverage is provided for: Tobacco Cessation programs, including individual/group/telephone counseling, and for over the counter (OTC) and prescription drugs approved by the FDA to treat tobacco dependence.	Nothing for two counseling sessions for up to four quit attempts per year. Nothing for OTC and prescription drugs approved by the FDA to treat tobacco dependence.	Nothing for two counseling sessions for up to four quit attempts per year. Nothing for OTC and prescription drugs approved by the FDA to treat tobacco dependence.
• Diabetes self management	$30 per office visit	$50 per office visit

Educational classes and programs - continued on next page

Benefit Description	You pay	
Educational classes and programs (cont.)	**High Option**	**Standard Option**
• Childhood obesity education	Nothing	Nothing

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.
- 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 hospital deductible is: for the High Option $250 per person and for the Standard Option $500 per person. The hospital deductible applies to almost all benefits in this Section. We added "(No deductible)" to show when the hospital deductible does not apply.
- The amounts listed below are for the charges billed by a physician or other health care professional for your surgical care. We will also apply a facility copay to surgical services that appear in this section but are performed in an ambulatory surgical center or in the outpatient department of a hospital. Look in 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	
Note: The hospital deductible applies to all inpatient and outpatient services at a hospital. We say "(No deductible)" when it does not apply.		
Surgical procedures	**High Option**	**Standard Option**
A comprehensive range of services, such as: • Operative procedures • Treatment of fractures, including casting • Normal pre- and post-operative care by a surgeon • Correction of amblyopia and strabismus • Endoscopy procedures • Biopsy procedures • Removal of tumors and cysts • Correction of congenital anomalies (see *Reconstructive surgery*) • Surgical treatment of morbid obesity (bariatric surgery) • Insertion of internal prosthetic devices. See 5(a) - *Orthopedic and prosthetic devices* for device coverage information Note: Generally, we pay for internal prostheses (devices) according to where the procedure is done. For example, we pay Hospital benefits for pacemaker and Surgery benefits for insertion of the pacemaker.	$15 per office visit to your primary care physician or $30 per visit to a specialist Nothing for the physician's charge for surgery Note: See Section 5(c) for information on the applicable facility copayment and annual deductible. The deductible applies to all services billed by a hospital.	$20 per office visit to your primary care physician or $50 per visit to a specialist Nothing for the physician's charge for surgery Note: See Section 5(c) for information on the applicable facility copayment and annual deductible. The deductible applies to all services billed by a hospital.
• Voluntary sterilization (e.g., vasectomy)	$200 copayment	$200 copayment

Surgical procedures - continued on next page

Benefit Description	You pay	
Surgical procedures (cont.)	**High Option**	**Standard Option**
	Note: See Section 5(c) for information on the applicable facility copayment and annual deductible. The $250 annual deductible applies to all services billed by a hospital.	Note: See Section 5(c) for information on the applicable facility copayment and annual deductible. The $500 annual deductible applies to all services billed by a hospital.
Treatment of burns	$15 per office visit to your primary care physician or $30 per visit to a specialist Nothing for the physician's charge for surgery Note: See Section 5(c) for information on the applicable facility copayment and annual deductible. The deductible applies to all services billed by a hospital.	$20 per office visit to your primary care physician or $50 per visit to a specialist Nothing for the physician's charge for surgery Note: See Section 5(c) for information on the applicable facility copayment and annual deductible. The deductible applies to all services billed by a hospital.
Surgical treatment of morbid obesity (bariatric surgery) Note: you must satisfy all of the following criteria in order for us to consider the surgery: • Body mass Index (BMI) of 40 or more or a BMI of 35 if co-morbidities exist; • 18 years old or have documentation of completion of Bone Growth; • Failed attempted weight loss under the direction of MD or Presurgical weight loss regime; • Pre-operative psychological evaluation. Note: Bariatric surgery requires our prior approval. See Services requiring our prior approval on page 16.	$15 per office visit to your primary care physician or $30 per visit to a specialist Nothing for the physician's charge for surgery Note: See Section 5(c) for information on the applicable facility copayment and annual deductible. The deductible applies to all services billed by a hospital.	$20 per office visit to your primary care physician or $50 per visit to a specialist Nothing for the physician's charge for surgery Note: See Section 5(c) for information on the applicable facility copayment and annual deductible. The deductible applies to all services billed by a hospital.
Not covered: • *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	$15 per office visit to your primary care physician or $30 per visit to a specialist Nothing for the physician's charge for surgery	$20 per office visit to your primary care physician or $50 per visit to a specialist Nothing for the physician's charge for surgery

Reconstructive surgery - continued on next page

Benefit Description	You pay	
Reconstructive surgery (cont.)	**High Option**	**Standard Option**
• Surgery to correct a codition 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 palate; birth marks; and webbed fingers and toes. • All stages of breast recontruction 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.	$15 per office visit to your primary care physician or $30 per visit to a specialist Nothing for the physician's charge for surgery Note: See Section 5(c) for information on the applicable facility copayment and annual deductible. The deductible applies to all services billed by a hospital.	$20 per office visit to your primary care physician or $50 per visit to a specialist Nothing for the physician's charge for surgery Note: See Section 5(c) for information on the applicable facility copayment and annual deductible. The deductible applies to all services billed by a hospital.
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*	*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; and • Other surgical procedures that do not involve the teeth or their supporting structures.	$15 per office visit to your primary care physician or $30 per visit to a specialist Nothing for the physician's charge for surgery Note: See Section 5(c) for information on the applicable facility copayment and annual deductible. The deductible applies to all services billed by a hospital.	$20 per office visit to your primary care physician or $50 per visit to a specialist Nothing for the physician's charge for surgery Note: See Section 5(c) for information on the applicable facility copayment and annual deductible. The deductible applies to all services billed by a hospital.
Not covered: • *Oral implants and transplants* • *Procedures that involve the teeth or their supporting structures (such as the periodontal membrane, gingiva, and alveolar bone)*	*All charges*	*All charges*

Benefit Description	You pay	
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. We cover related medical and hospital expenses of donor when the expenses are not covered by the donor's insurance and when the transplant recipient is a HealthAmerica member approved for transplant services. Solid organ transplants limited to: • Cornea • Heart • Heart/lung • Intestinal transplants - 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 toal or near total pancreatectomy) only for patients with chronic pancreatitis. • Kidney • Liver • Lung: single/bilateral/lobar • 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 in ineffective. 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. These transplants are limited to the stages of the following diagnoses. The medical necessity is considered satisfied if the patient meets the staging description. • Autologous tandem transplants for	$15 per office visit to your primary care physician or $30 per visit to a specialist Nothing for the physician's charge for surgery. Note: See Section 5(c) for information on the applicable facility copayment and annual deductible. The deductible applies to all services billed by a hospital.	$20 per office visit to your primary care physician or $50 per visit to a specialist Nothing for the physician's charge for surgery. Note: See Section 5(c) for information on the applicable facility copayment and annual deductible. The deductible applies to all services billed by a hospital.

Organ/tissue transplants - continued on next page

Benefit Description	You pay	
Organ/tissue transplants (cont.)	**High Option**	**Standard Option**
- AL Amyloidosis - Multiple myeloma (de novo and treated) - Recurrent germ cell tumors (including testicular cancer)	$15 per office visit to your primary care physician or $30 per visit to a specialist Nothing for the physician's charge for surgery. Note: See Section 5(c) for information on the applicable facility copayment and annual deductible. The deductible applies to all services billed by a hospital.	$20 per office visit to your primary care physician or $50 per visit to a specialist Nothing for the physician's charge for surgery. Note: See Section 5(c) for information on the applicable facility copayment and annual deductible. The deductible applies to all services billed by a hospital.
Blood or marrow stem cell transplants limited to the stages of the following disgnoses. 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 reccurrence (relapsed) • Advanced non-Hodgkin's lymphoma with reccurrence (relapsed) • Acute myeloid leukemia • Advanced Myeloproliferative Disorders (MPDs) • Advanced neuroblastoma • Amyloidosis • Chronic lymphocytic lymphoma/small lymphocytic lymphoma (CLL/SLL) • Hemoglobinopathy • Infant 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	$15 per office visit to your primary care physician or $30 per visit to a specialist Nothing for the physician's charge for surgery. Note: See Section 5(c) for information on the applicable facility copayment and annual deductible. The deductible applies to all services billed by a hospital.	$20 per office visit to your primary care physician or $50 per visit to a specialist Nothing for the physician's charge for surgery. Note: See Section 5(c) for information on the applicable facility copayment and annual deductible. The deductible applies to all services billed by a hospital.

Organ/tissue transplants - continued on next page

Benefit Description	You pay	
Organ/tissue transplants (cont.)	**High Option**	**Standard Option**
• Phagocytic/Hemophagocytic deficiency diseases (e.g., Wiskott-Aldrich syndrome) • Severe combined immunodeficiency • Severe or very severe aplastic anemia • Sickle cell anemia • X-linked lymphoproliferative syndrome **Autologous transplants for** • Acute lymphocytic or nonlymphocytic (i.e., myelogenous) leukemia • Advanced Hodgkin's lymphoma with reccurrence (relapsed) • Advanced non-Hodgkin's lymphoma with reccurrence (relapsed) • Amyloidosis • Breast Cancer • Ependymoblastoma • Epithelial ovarian cancer • Ewing's sarcoma • Multiple myeloma • Medulloblastoma • Pineoblastoma • Neuroblastoma • Testicular, Mediastinal, Retroperitoneal, and ovarian germ cell tumors	$15 per office visit to your primary care physician or $30 per visit to a specialist Nothing for the physician's charge for surgery. Note: See Section 5(c) for information on the applicable facility copayment and annual deductible. The deductible applies to all services billed by a hospital.	$20 per office visit to your primary care physician or $50 per visit to a specialist Nothing for the physician's charge for surgery. Note: See Section 5(c) for information on the applicable facility copayment and annual deductible. The deductible applies to all services billed by a hospital.
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: **Allogenic transplants for** • Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia • Advanced Hodgkin's lymphoma with reccurance (relapsed) • Advanced non-Hodgkin's lymphoma with reccurance (relapsed) • Acute myeloid leukemia • Advanced Myeloproliferative Disorders (MPDs) • Amyloidosis	$15 per office visit to your primary care physician or $30 per visit to a specialist Nothing for the physician's charge for surgery Note: See Section 5(c) for information on the applicable facility copayment and annual deductibe. The deductible applies to all services billed by a hospital.	$20 per office visit to your primary care physician or $50 per visit to a specialist Nothing for the physician's charge for surgery Note: See Section 5(c) for information on the applicable facility copayment and annual deductibe. The deductible applies to all services billed by a hospital.

Organ/tissue transplants - continued on next page

Benefit Description	You pay	
Organ/tissue transplants (cont.)	**High Option**	**Standard Option**
• Chronic lymphocytic leukemia/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 Homoglobinuria • Severe combined immunodeficiency • Severe or very severe aplastic anemia **Autologous transplants for** • Acute lymphocytic or nonlymphocytic (i.e., myelogenous) leukemia • Advanced Hodgkin's lymphoma with reccurence (relapsed) • Advanced non-Hodgkin's lymphoma with reccurence (relapsed) • Amyloidosis • Neuroblastoma	$15 per office visit to your primary care physician or $30 per visit to a specialist Nothing for the physician's charge for surgery Note: See Section 5(c) for information on the applicable facility copayment and annual deductibe. The deductible applies to all services billed by a hospital.	$20 per office visit to your primary care physician or $50 per visit to a specialist Nothing for the physician's charge for surgery Note: See Section 5(c) for information on the applicable facility copayment and annual deductibe. The deductible applies to all services billed by a hospital.
These blood or marrow stem cell transplants 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. These blood and marrow stem cell transplants are covered if the following are met: • The trial is a NCI and/or NIH sponsored trial, or • The trial is conducted at an approved NCI center; and • The trial is approved by the Plan's Medical Director in accordance with the Plan's protocals. **Allogeneic transplants for** • Advanced Hodgkin's lymphoma • Advanced non-Hodgkin's lymphoma • Beta Thalassemia Major	$15 per office visit to your primary care physician or $30 per visit to a specialist Nothing for the physician's charge for surgery Note: See Section 5(c) for information on the applicable facility copayment and annual deductibe. The deductible applies to all services billed by a hospital.	$20 per office visit to your primary care physician or $50 per visit to a specialist Nothing for the physician's charge for surgery Note: See Section 5(c) for information on the applicable facility copayment and annual deductibe. The deductible applies to all services billed by a hospital.

Organ/tissue transplants - continued on next page

Benefit Description	You pay	
Organ/tissue transplants (cont.)	**High Option**	**Standard Option**
• Chronic inflammatory demyelination polyneuropathy (CIDP) • Early stage (indolent or non-advanced) small cell lymphocytic lymphoma • Multiple myeloma • Multiple sclerosis • Sickle Cell anemia Mini-transplants (non-myeloblative allogenic, 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 disorders (MDDs) • Myelodysplasia/Myelodysplastic Syndromes • Non-small lung cancer • Ovarian cancer • Prostate cancer • Renal cell carcinoma • Sarcomas • Sickle cell anemia **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)	$15 per office visit to your primary care physician or $30 per visit to a specialist Nothing for the physician's charge for surgery Note: See Section 5(c) for information on the applicable facility copayment and annual deductibe. The deductible applies to all services billed by a hospital.	$20 per office visit to your primary care physician or $50 per visit to a specialist Nothing for the physician's charge for surgery Note: See Section 5(c) for information on the applicable facility copayment and annual deductibe. The deductible applies to all services billed by a hospital.

Organ/tissue transplants - continued on next page

Benefit Description	You pay	
Organ/tissue transplants (cont.)	**High Option**	**Standard Option**
• 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	$15 per office visit to your primary care physician or $30 per visit to a specialist Nothing for the physician's charge for surgery Note: See Section 5(c) for information on the applicable facility copayment and annual deductibe. The deductible applies to all services billed by a hospital.	$20 per office visit to your primary care physician or $50 per visit to a specialist Nothing for the physician's charge for surgery Note: See Section 5(c) for information on the applicable facility copayment and annual deductibe. The deductible applies to all services billed by a hospital.
Coventry Transplant Network (CTN) - NOTE: We cover related medical and hospital expenses of the donor when we cover the recipient. We cover donor screening tests and donor search expenses for the actual solid organ or up to four bone marrow/stem cell transplant donors in addition to the testing of family members.		
Not covered: • *Donor screening tests and donor search expenses, except as those shown above* • *Donor expenses related to donating organs or tissue to a non-member recipient* • *Implants of artificial organs* • *Transplants not specifically listed as covered*	*All charges*	*All charges*
Anesthesia	**High Option**	**Standard Option**
Professional services provided in – • Hospital (inpatient) • Hospital outpatient department • Skilled nursing facility	Note: See Section 5 (c) for information on the applicable facility copayment and annual deductible. The deductible applies to all services billed by a hospital.	Note: See Section 5 (c) for information on the applicable facility copayment and annual deductible. The deductible applies to all services billed by a hospital.
Professional services provided in – • Office	$15 per office visit to your primary care physician or $30 per visit to a specialist Note: See Section 5(c) for information on the applicable facility copayment and annual deductible. The deductible applies to all services billed by a hospital.	$20 per office visit to your primary care physician or $50 per visit to a specialist Note: See Section 5(c) for information on the applicable facility copayment and annual deductible. The deductible applies to all services billed by a hospital.

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.
- In this Section, unlike Sections 5(a) and 5(b), the hospital deductible applies to only a few benefits. We added "(hospital deductible applies)" when it applies. The hospital deductible is: $250 per person on the High Option or $500 per person on the Standard Option.
- 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	
Note: The hospital deductible applies only when we say below: "(hospital deductible applies)".		
Inpatient hospital	**High Option**	**Standard Option**
Room and board, such as • Ward, semiprivate, or intensive care accommodations • General nursing care • Meals and special diets Note: If you want a private room when it is not medically necessary, you pay the additional charge above the semiprivate room rate.	$150 per day up to a maximum of $450 after $250 hospital deductible per person is satisfied	$150 per day for the first five days after $500 hospital deductible per person is satisfied
Other hospital services and supplies, such as: • Operating, recovery, maternity, and other treatment rooms • Prescribed drugs and medicines • Diagnostic laboratory tests and X-rays • Dressings, splints, casts, and sterile tray services • Medical supplies and equipment, including oxygen • Blood or blood plasma, if not donated or replaced • Administration of blood and blood products • Anesthetics, including nurse anesthetist services • Take-home items • Medical supplies, appliances, medical equipment, and any covered items billed by a hospital for use at home (Note: hospital deductible applies.)	Nothing after the inpatient hospital copay and the $250 hospital deductible per person	Nothing after the inpatient hospital copay and the $500 hospital deductible per person
Not covered	*All Charges*	*All Charges*

Inpatient hospital - continued on next page

Benefit Description	You pay	
Inpatient hospital (cont.)	**High Option**	**Standard Option**
• *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*	*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 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.	$50 copay for outpatient surgery performed at a freestanding participating facility $100 copay after the $250 hospital deductible for services performed in a hospital setting	$150 copay for outpatient surgery performed at a freestanding participating facility $250 copay after the $500 hospital deductible for services performed in a hospital setting
Not covered: Blood and blood derivatives replaced by the member	*All Charges*	*All Charges*
Extended care benefits/Skilled nursing care facility benefits	**High Option**	**Standard Option**
The plan provides a comprehensive range of benefits for up to 100 days per calendar year when you are hospitalized under the care of a Plan physician. All medically necessary services are covered. • Bed, board and general nursing care • Drugs, biological, supplies and equipment ordinarily provided or arranged by the skilled nursing facility when prescribed by a Plan physician.	Nothing	Nothing
Not covered: Custodial care	*All Charges*	*All Charges*

Benefit Description	You pay	
Hospice care	**High Option**	**Standard Option**
Hospice care: up to 210 days per lifetime The Plan covers supportive and palliative care for a terminally ill member. Coverage is provided in the home or a hospice facility. Services include inpatient, outpatient care and family counseling; these services are provided under the direction of a Plan physician who certifies that the patient is in terminal stages of illness, with a life expectancy of approximately six months or less.	Nothing	Nothing
Not covered: Independent nursing, homemaker services	*All Charges*	*All Charges*
Ambulance	**High Option**	**Standard Option**
• Local professional ambulance service when medically appropriate • Air Ambulance limited to situation where ground transportation is not medically appropriate – prior plan authorization required. Note: See 5(d) for non-emergency service.	Nothing	Nothing

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.
- We do not have a hospital deductible for emergency room 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 you believe endangers your life or could result in serious injury or disability, and requires immediate medical or surgical care. 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:

If you are in an emergency situation, please call your primary doctor. In extreme emergencies, if you are unable to contact your doctor, contact the local emergency system (e.g., the 911 telephone system) or go to the nearest hospital emergency room. Be sure to tell the emergency room personnel that you are a Plan member so they can notify the Plan. You or a family member should notify the Plan within 48 hours unless it is not reasonably possible to do so. It is your responsibility to ensure that the Plan has been notified timely.

If you need to be hospitalized, the Plan must be notified within 48 hours or the first working day following your admission, unless it is not reasonably possible to notify the Plan in that time. If you are hospitalized in non-Plan facilities and Plan doctors believe care can be better provided in a Plan hospital, you will be transferred when medically feasible with ambulance charges covered in full.

Emergencies within our service area: Benefits are available for care from non-Plan provider in a medical emergency only if delay in reaching a Plan provider would result in death, disability or significant jeopardy to your condition.

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

Emergencies outside our service area: Benefits are available for any medically necessary service that is immediately required because of injury or unforeseen illness.

If you need to be hospitalized, the Plan must be notified within 48 or on the first working day following your admission, unless it was not reasonably possible to notify the Plan in that time. If you are hospitalized in non-Plan facilities and Plan doctors believe care can be better provided in a Plan hospital, you will be transferred when medically feasible with any ambulance charges covered in full.

Benefit Description	You pay	
Emergency within our service area	**High Option**	**Standard Option**
• Emergency care at a doctor's office	$15 per visit to primary care physician / $30 per visit to specialist	$20 per visit to primary care physician / $50 per visit to specialist
• Emergency care at an urgent care center	$40 per visit	$50 per visit
• Emergency care as an outpatient or inpatient at a hospital, including doctors' services Note: We waive the ER copay if you are admitted to the hospital.	$150 per visit	$150 per visit
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	$15 per visit to PCP / $30 per visit to Specialist	$20 per visit to PCP / $50 per visit to Specialist
• Emergency care at an urgent care center	$40 per visit	$50 per visit
• Emergency care as an outpatient at a hospital, including doctors' services	$150 per hospital emergency room visit	$150 per hospital emergency room visit
Not covered: • *Elective care or non-emergency care and follow-up care recommended by non-Plan providers that has not been approved by the Plan or provided by Plan providers* • *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*
Ambulance	**High Option**	**Standard Option**
• Professional ambulance service when medically appropriate. • Air Ambulance limited to situation where ground transportation is not medically appropriate – prior plan authorization required. Note: See 5(d) for non-emergency service.	Nothing	Nothing

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

You need to get Plan approval (preauthorization) for services and follow a treatment plan we approve in order to get benefits. When you receive services as part of an approved treatment plan, cost-sharing and limitations for Plan mental health and substance abuse benefits are no greater than for similar benefits for other illnesses and conditions.

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.
- All services provided in a hospital setting are subject to the hospital deductible, $250 per person under High Option or $500 per person under Standard Option. Daily copayments for inpatient hospital admissions and other facility charges may also 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:
- We will provide medical review criteria or reasons for treatment plan denials to enrollees, members 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	
Note: The hospital deductible applies to almost all benefits in this Section. We say "(No deductible)" when it does not apply.		
Professional services	**High Option**	**Standard Option**
When part of a treatment plan we approve, 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)	$15 per office visit to your primary care physician and $30 per office visit to a specialist	$20 per office visit to your primary care physician and $50 per office visit to a specialist

Professional services - continued on next page

Benefit Description	You pay	
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	$15 per office visit to your primary care physician and $30 per office visit to a specialist	$20 per office visit to your primary care physician and $50 per office visit to a specialist
Diagnostics	**High Option**	**Standard Option**
• Outpatient Diagnostic tests provided 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	$15 per office visit to your primary care physician and $30 per office visit to a specialist Nothing when performed at a participating free-standing laboratory center After the $250 hospital deductible, nothing for services performed and billed by a hospital	$20 per office visit to your primary care physician and $50 per office visit to a specialist $50 when performed at a participating free-standing laboratory center After the $500 hospital deductible, nothing for services performed and billed by a hospital
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	$150 per day for the first three (3) days per admission, after you have satisfied a $250 hospital deductible	$150 per day for the first five (5) days per admission, after you have satisfied a $500 hospital deductible
Not covered	**High Option**	**Standard Option**
Services that are not part of a preauthorized approved treatment plan. *Note: OPM will base its review of disputes about treatment plans on the treatment plan's clinical appropriateness. OPM will generally not order us to pay or provide one clinically appropriate treatment plan in favor of another.*	*All charges*	*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:

Prior to seeking mental health and substance abuse treatment, you must call Psych/Care at 1-800-221-5487. Psych/Care is a managed behavioral health care firm with over 500 providers in our service area. You do not need a referral from your primary care physician or authorization from us. A Psych/Care provider will evaluate you and develop a treatment plan.

Once the treatment plan has been approved, you must follow it. If you need inpatient care, your Psych/Care provider will arrange it for you. Call Psych/Care for a list of participating providers in your area.

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.
- Certain drugs require prior authorization from us. Your physician must obtain our prior authorization for certain drugs and all Tier IV high technology and self-administered drugs.
- We do not have a 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 plan physician or licensed dentist must write the prescription.
- **Where you can obtain them.** You may fill the prescription at a participating pharmacy. Please see the complete listing of participating pharmacies in our provider directory.
- **We use a formulary.** The formulary is a list of medications, both brand and generic, that we approve as covered medication. Plan pharmacies dispense prescription medication to our members based on our formulary list. However, we cover non-formulary drugs prescribed by a Plan doctor. You must pay a higher copay for non-formulary drugs. Our formulary has 5 tiers of prescription drug coverage. Tier 1A includes low cost select generic drugs. Tier 1B includes low cost generic formulary drugs. Tier 2 includes brand name formulary drugs. Tier 3 includes high cost, mostly brand name non-formulary drugs that usually have generic or brand name alternatives in Tiers 1 or 2. Tier 4 includes high technology and self-administered drugs, including growth hormone. Tier 4 drugs require our prior authorization. If you'd like a copy of our formulary, please call us at 1-866-575-1882.
- **These are the dispensing limitations.**You may obtain a 30-day supply at a Plan pharmacy or a 90-day supply via mail order. Mail order is available for maintenance medications only. A 90-day vacation supply may also be obtained from a Plan pharmacy once a year. Plan pharmacies will not dispense refills in excess of the number specified by the physician or refill medication more than 12 months after the original date of the prescription. You may obtain a refill up to 6 days before your prescription runs out. A generic equivalent will be dispensed if it is available, unless your physician specifically requires a name brand drug. When your physician requires a name brand drug, the physician must specify "Dispense as Written" on the prescription or you will have to pay the difference in cost between the name brand drug and the generic.
- **Prior authorization process for medication other than self-injectable drugs.** Our prescription drug formulary is based on the principles of providing and promoting safe, efficacious and cost-effective medications for our members. In order to monitor drug therapy duplication, abuse, misuse, and interactions, we administer a prior authorization (PA) requirement for certain drugs. Our prior authorization program operates in the following manner.

We provide our participating physicians with a list of medications that require our prior authorization before they can be dispensed by a Plan pharmacy. Your Plan physician must complete and submit a PA form to Coventry Health Care of Florida (Coventry) to begin the authorization process. If you try to fill the prescription at a pharmacy and we have not authorized the medication, the pharmacist will advise you that your physician must obtain prior authorization for the medication before it can be dispensed. Your physician should call 1-866-847-8279 to obtain a PA form and must complete and fax it to 954-858-3386. If PA is urgent and you need the medication immediately, the physician can call the Rx phone number and speak to a Coventry's clinical pharmacist during office hours. After office hours, pharmacies can call Coventry's round-the-clock Pharmacy Benefit Manager at 1-800-922-1557 to obtain an authorization for a one-time 7-day supply of a non-formulary medication.

- **Prior authorization process for self-injectable drugs.** The prior approval process for requesting self-injectable medication is very similar to PA for other medication. The only difference is that the prescription must be filled by a Specialty Pharmacy. The physician completes a request form and faxes it to the Specialty Pharmacy and the specialty pharmacy forwards it to Coventry's Pharmacy Department for approval. If you have any questions about the prior authorization process, please contact 1-866-575-1882.
- **Why use generic drugs?** Generic drugs offer a safe and economic way to meet your prescription drug needs. The generic name of a drug is its chemical name; the name brand is the name under which the manufacturer advertises and sells a drug. Under federal law, generic and name brand drugs must meet the same standards for safety, purity, strength, and effectiveness. A generic prescription costs you – and us – less than a name brand prescription.
- **When you do have to file a claim.** There are no claims to file when you use a Plan pharmacy or our mail order program. If you have an emergency while outside our service area, and you fill a prescription at a non-Plan pharmacy, you must submit a claim for reimbursement. We will reimburse up to the amount we would have paid if you had used a plan pharmacy.
- **If you are a military reservist called to active duty or are a member requiring a supply of medication during a national emergency,** call us at 1-866-847-8279 for assistance with obtaining your medication.

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 • Disposable needles and syringes for the administration of covered medications • Diabetic supplies, including insulin syringes, needles, glucose test tablets, test strips, and solution • Drugs for sexual dysfunction Note: Drugs for sexual dysfunctions have special dispensing limits and guidelines. Please contact us for details. These drugs are not available under our mail-order program. For a copy of Tier 1A drugs covered visit www.feds.chcflorida.com. Note: Tier 4 includes: High technology and select self-injectable specialty pharmacy medications. These drugs are not available under our mail-order program. Tier 4 drugs require our prior authorization. We periodically review and update the list of medications. Please contact us to verify if your drug is on Tier 4. These drugs have specific characteristics such as: usually injectable; high in cost; and require special handling and special training to use.	**Retail Pharmacy** (up to 30-day supply per prescription unit or refill): • Tier 1A - $3; select generic formulary; • Tier 1B - $20; generic formulary; • Tier 2 - $40; name brand formulary; • Tier 3 - $60; non-formulary; • Tier 4 - 20% of negotiated rate up to $100 per month out-of-pocket limit to a maximum of $1,200 per calendar year (except for diabetic supplies). Tier 4 drugs require prior authorization. Note: If there is no generic equivalent available, you will still have to pay the brand name or non-formulary copay. **Mail-Order Pharmacy** (up to a 90-day supply of maintenance medication): • Tier 1A - $3; select generic formulary; • Tier 1B - $60; generic formulary; • Tier 2 - $120; name brand formulary;	**Retail Pharmacy** (up to 30-day supply per prescription unit or refill): • Tier 1A - $3; select generic formulary; • Tier 1B - $10; generic formulary; • Tier 2 - $50; name brand formulary; • Tier 3 - $70; non-formulary; • Tier 4 - 20% of negotiated rate up to $100 per month out-of-pocket limit to a maximum of $1,200 per calendar year (except for diabetic supplies). Tier 4 drugs require prior authorization. Note: If there is no generic equivalent available, you will still have to pay the brand name or non-formulary copay. **Mail-Order Pharmacy** (up to a 90-day supply of maintenance medication): • Tier 1A - $3; select generic formulary; • Tier 1 - $10 generic formulary; • Tier 2 - $100 name brand formulary;

Covered medications and supplies - continued on next page

Benefit Description	You pay	
Covered medications and supplies (cont.)	**High Option**	**Standard Option**
	• Tier 3 - $180; non-formulary. Note: We have no Tier 4 under mail-order. Therefore, high technology and self-injectable specialty pharmacy medications are available through Tier 4 retail.	• Tier 3 - $210 non-formulary. Note: We have no Tier 4 under mail-order. Therefore, high technology and self-injectable specialty pharmacy medications are available through Tier 4 retail.
Note: Over-the-counter and prescription drugs approved by the FDA to treat tobacco dependence are covered under the Tobacco cessation benefit and require a written prescription by an approved provide (See Page 35).	• Drugs for smoking cessation (combined with all Tobacco cessation services) including "Over the Counter" (OTC) products require a script to obtain with no charge. Should the drug be indicated for multiple purposes, members are required to ask their doctor to submit a Prior Authorization Form with supporting documentation as to the indicated use of the medicine/ product. • All of the OTC Tobacco cessation products are approved for OTC use in adults 18 years of age or older. • Users under 18 years of age are to consult with their doctor prior to use. • Individuals who continue to smoke, chew tobacco, use snuff or use a nicotine patch or other nicotine containing products should not use. • All OTC products have the same indication.	• Drugs for smoking cessation (combined with all smoking cessation services) including "Over the Counter" (OTC) products require a script to obtain with no charge. Should the drug be indicated for multiple purposes, members are required to ask their doctor to submit a Prior Authorization Form with supporting documentation as to the indicated use of the medicine/ product. • All of the OTC smoking cessation products are approved for OTC use in adults 18 years of age or older. • Users under 18 years of age are to consult with their doctor prior to use. • Individuals who continue to smoke, chew tobacco, use snuff or use a nicotine patch or other nicotine containing products should not use. • All OTC products have the same indication.
Women's contraceptive drugs and devices	Nothing	Nothing
Not covered • *Drugs and supplies for cosmetic purposes* • *Drugs to enhance athletic performance* • *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* • *Nonprescription medicines*	*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**
• *Drugs given to you while you are a patient in a hospital, skilled nursing facility, convalescent hospital, hospice or other facility where drugs are ordinarily provided by the facility to its patients.* • *Refills in excess of the number specified by the physician or refills dispensed more than 12 months after the the original date of the prescription.* • *Drugs provided to you by this plan, but which are lost, stolen or destroyed.* • *Drugs for the treatment of obesity, unless medically necessary for the treatment or morbid obesity.*	*All Charges*	*All Charges*

Section 5(g). Dental benefits

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- If you are enrolled in a Federal Employees Dental/Vision Insurance Program (FEDVIP) Dental Plan, your FEHB Plan will be First/Primary payor of any Benefit payments and your FEDVIP Plan is secondary to your FEHB Plan. See Section 9 Coordinating benefits with other coverage.
- Plan dentists must provide or arrange your care.
- We cover hospitalization for dental procedures only when a non-dental physical impairment exists which makes hospitalization necessary to safeguard the health of the patient. See Section 5(c) for inpatient hospital benefits. We do not cover the dental procedure unless it is described below.
- 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	
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.	$30 per office visit	$50 per office visit

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 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).
Services for deaf and hearing impaired	If you are hearing or speech impaired and use a telephone device for the deaf, you may call 1-888-444-7352 Monday through Friday from 8 a.m. to 6 p.m.
High risk pregnancies	Coventry Health Care of Florida offers a dedicated OB Case Management unit, coordinating and monitoring all phases of care through the member's pregnancy.
Centers of excellence for transplants	Coventry Health Care of Florida utilizes Centers of Excellence for transplant services. Please call us at 1-866-575-1882 for more information.
Travel benefit/services overseas	Limited to ER services world-wide must submit translated documents. (E.R. notes, receipts of paid services)

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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 about these benefits* 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 866-575-1882 or on our Web site at feds.chcflorida.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 benefit chart on page 68. 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, child and adult immunizations, tobacco cessation programs, obesity weight loss programs, disease management and wellness programs. These services are covered at 100% if you use a network provider and the services are described in Section 5 *Preventive care. You do not have to meet the deductible before using these services.*

Traditional medical coverage

After you have paid the Plan's deductible, we pay benefits under traditional medical coverage described in Section 5. The Plan typically pays 80% for in-network.

Covered services include:

- Medical services and supplies provided by physicians and other health care professionals
- 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 page 63 for more details).

Health Savings Accounts (HSA)

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 2014, for each month you are eligible for an HSA premium pass through, we will contribute to your HSA $83.34 per month for a Self Only enrollment or $166.67 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 $3,300 for an individual and $6,550 for a family. See maximum contribution information on page 66. 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 Health Equity
- 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.)
- Your HSA earns tax-free interest
- 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.

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 (HRA)

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 that you are ineligible for an HSA.

In 2014, we will give you an HRA credit of $1,000 per year for a Self Only enrollment and $2,000 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.

- Entire HRA credit (prorated from your effective date to the end of the plan year) is available from your effective date of enrollment.
- 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.
- 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 $5,000 per person or $10,000 per family enrollment. 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 allowable amount or benefit maximum). Refer to Section 4 Your catastrophic protection out-of-pocket maximum and HDHP Section 5 *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)
Administrator	The Plan will establish an HSA for you with Coventry Consumer Choice, this HDHP's fiduciary (an administrator, trustee or custodian as defined by Federal tax code and approved by IRS.) ***Health Equity*** ***15 West Scenic Pointe Drive*** ***Suite 400*** ***Draper, UT 84020*** ***Please refer to the number on your ID card***	is the HRA fiduciary for this Plan.
Fees	Set-up fee is paid by the HDHP.	None.
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. 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.).	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.
Self Only enrollment	For 2014, a monthly premium pass through of $83.34 will be made by the HDHP directly into your HSA each month.	For 2014, your HRA annual credit is $1,000 (prorated for mid-year enrollment).
Self and Family enrollment	For 2014, a monthly premium pass through of $166.67 will be made by the HDHP directly into your HSA each month.	For 2014, your HRA annual credit is $2,000 (prorated for mid-year enrollment).
Contributions/credits		The full HRA credit will be available, subject to proration, on the effective date of enrollment. The HRA does not earn interest.

	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 $3,300 for an individual and $6,550 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. 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 66.	
Self Only enrollment	You may make an annual maximum contribution of $2,300.	You cannot contribute to the HRA.
Self and Family enrollment	You may make an annual maximum contribution of $4,550.	You cannot contribute to the HRA.
Access funds	You can access your HSA by the following methods: • Debit card • Withdrawal form • Checks	For qualified medical expenses under your HDHP, you will be automatically reimbursed when claims are submitted through the HDHP. For expenses not covered by the HDHP, such as orthodontia, a reimbursement form will be sent to you upon your request.
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. See IRS Publication 502 for a list of eligible medical expenses.	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. Physician prescribed over-the-counter drugs and Medicare premiums are also reimbursable. Most other types of medical insurance premiums are not reimbursable.
• **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 withdrawn funds. 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.	Not applicable – distributions will not be made for anything other than non-reimbursed qualified medical expenses.
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. 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.
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 63 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 data 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 Web site at www.ustreas.gov/offices/public-affairs/hsa/ .

If you die

If you do not have a named beneficiary, if you are married, it becomes your spouse's HSA; otherwise, it 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 Web site 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.
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 63 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 - one annually for men age 50 and older • Colorectal Cancer Screening , including: - Fecal occult blood test yearly starting at age 50 - Sigmoidoscopy screening – every five years starting at age 50 - Colonoscopy screening – every ten years starting at age 50 • Routine annual digital rectal exam (DRE) for men age 40 and older	Nothing
• 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 on an annual basis. - Annual counseling and screening for human immune-deficiency virus - Contraceptive methods and counseling - Screening and counseling for interpersonal and domestic violence	Nothing
• Adult routine immunizations endorsed by the Centers for Disease Control and Prevention (CDC):	Nothing
• 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	Nothing

Preventive care, adult - continued on next page

Benefit Description	You Pay
Preventive care, adult (cont.)	
- At age 65 and older, one every two consecutive calendar years	Nothing
• Routine physicals which include: - One exam every 24 months up to age 65 - One exam every 12 months age 65 and older	Nothing
• Routine exams limited to: - One routine eye exam every 12 months - One routine OB/GYN exam every 12 months including 1 Pap smear and related services - One routine hearing exam every 24 months	
Not covered: • *Physical exams required for obtaining or continuing employment or insurance, attending schools or camp, athletic exams or travel.* • *Immunizations, boosters, and medications for travel or work-related exposure.*	*All charges*
Preventive care, children	
Professional services, such as: • Well-child care charges for routine examinations, immunizations and care (up to age 26) • Childhood immunizations recommended by the American Academy of Pediatrics Examinations, such as: • Eye exam through age 17 to determine the need for vision correction • Hearing exams through age 17 to determine the need for hearing correction	Nothing
Not covered: • *Physical exams required for obtaining or continuing employment or insurance, attending schools or camp, or travel.* • *Immunizations, boosters, and medications for travel.*	*All charges*

Benefit Description	You Pay
Dental Preventive Care	
Preventive care limited to: • Prophylaxis (cleaning of teeth) – limited to 2 treatments per calendar year • Fluoride applications (limited to 1 treatment per calendar year and for children under age 16) • Sealants – (once every 3 years, from the last date of service, on permanent molars for children under age 16) • Space maintainer (primary teeth only) • Bitewing x-rays (one set per calendar year) • Complete series x-rays (one complete series every 3 years) • Periapical x-rays • Routine oral evaluations (limited to 2 per calendar year)	Nothing

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 68) and is not subject to the calendar year deductible.
- The deductible is $2,500 per person or $5,000 per family enrollment. The family deductible can be satisfied by one or more family members. The deductible applies to almost all benefits under Traditional medical coverage. You must pay your deductible before your Traditional medical coverage may begin.
- Under Traditional medical coverage, you are responsible for your coinsurance and copayments 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 coinsurance, copayments and deductibles total $5,000 per person or $10,000 per 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 maximum, or if you use out-of-network providers, amounts in excess of the Plan allowance).
- In-network benefits apply only when you use a network provider. When a network provider is not available, out-of-network benefits 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.

Benefits Header	You Pay
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.	100% of allowable charges until you meet the deductible of $2,500 per person or $5,000 per family enrollment
After you meet the deductible, we pay the allowable charge (less your coinsurance or copayment) until you meet the annual catastrophic out-of-pocket maximum.	In-network: After you meet the deductible, you pay the indicated coinsurance or copayments for covered services. You may choose to pay the coinsurance and copayments from your HSA or HRA, or you can pay for them out-of-pocket. Out-of-network: After you meet the deductible, you pay the indicated coinsurance based on our Plan allowance and any difference between our allowance and the billed amount.

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.
- 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 unless we indicate differently.
- After you have satisfied your deductible, coverage begins for traditional medical services.
- Under your Traditional medical coverage, you will be responsible for your coinsurance amounts or copyaments 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
Diagnostic and treatment services	
Professional services of physicians • In physician's office • Office medical consultations • Second surgical opinion • At home	After deductible, $10 per office visit to your primary care physician; $25 per office visit to a specialist
• In an urgent care center	After deductible, $25 copay
• During a hospital stay • In a skilled nursing facility	After deductible, 20% coinsurance
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	After deductible, 20% coinsurance

Benefit Description	You pay
Maternity care	
Complete maternity (obstetrical) care, such as: • Prenatal care • Delivery • Postnatal care	After deductible, a one time $25 copay
• Screening for gestational diabetes for pregnant women between 24-28 weeks gestation or first prenatal visit for women at a high risk. • 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 page 16 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. Surgical benefits, not maternity benefits, apply to circumcision. • We pay hospitalization and surgeon services for non-maternity care the same as for illness and injury.	
Family planning	
Contraceptive counseling on an annual basis	Nothing
A range of voluntary family planning services, limited to: • Surgically implanted contraceptives • Injectable contraceptive drugs (such as Depo provera) • Intrauterine devices (IUDs) • Diaphragms • Voluntary sterilization Note: We cover oral contraceptives under the prescription drug benefit.	At hospital: After deductible, 20% coinsurance At freestanding facility: After deductible, $200 copay
Not covered: • *Reversal of voluntary surgical sterilization* • *Genetic counseling.*	*All Charges*
Infertility services	
Diagnosis and treatment of infertility such as: • Artificial insemination: • Intravaginal insemination (IVI) • Intracervical insemination (ICI) • Intrauterine insemination (IUI) • Fertility drugs	After deductible, $25 copay

Infertility services - continued on next page

Benefit Description	You pay
Infertility services (cont.)	
Note: We cover Injectable fertility drugs under medical benefits and oral fertility drugs under the prescription drug benefit.	After deductible, $25 copay
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*	*All charges*
Allergy care	
• Testing and treatment • Allergy injections	After deductible, $10 per office visit to your primary care physician; $25 per office visit to a specialist
• Allergy serum	Nothing
Not covered: Proactive 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 on page 81. • Respiratory and inhalation therapy • Dialysis – hemodialysis and peritoneal dialysis • Intravenous (IV)/Infusion Therapy – Home IV and antibiotic therapy • Applied Behavior Analysis (ABA) Therapy for Autism Spectrum Disorder • Growth hormone therapy (GHT) Note: Growth hormone is covered under the prescription drug benefit. Note: We only cover GHT when we preauthorize the treatment. 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* on page 18.	After deductible, $10 per office visit to your primary care physician; $25 per office visit to a specialist At hospital: After deductible, 20% coinsurance At freestanding facility: After deductible, $25 copay
Not covered: • *Chelation therapy* • *Any furniture, plumbing, electrical or other fixtures to perform dialysis at home.*	*All charges*

Benefit Description	You pay
Physical and occupational therapies	
60 visits per calendar year; no less than 2 consecutive months of therapy for each condition for each of the following services: • Qualified physical therapists • Speech therapists • Occupational therapists Note: We only cover therapy when a provider orders the care. Cardiac rehabilitation following a heart transplant, bypass surgery or a myocardial infarction is provided for up to 100 sessions.	At hospital: After deductible, 20% coinsurance At freestanding facility: After deductible, $25 copay
Not covered: • *Long-term rehabilitative therapy* • *Exercise programs* • *Pulmonary rehabilitation*	*All charges*
Speech therapy	
60 visits per calendar year; no less than 2 consecutive months of therapy for each condition.	At hospital: After deductible, 20% coinsurance At freestanding facility: After deductible, $25 copay
Habilitative Therapy	
60 visits per calendar year; no less than 2 consecutive months of therapy for each condition.	At hospital: After deductible, 20% coinsurance At freestanding facility: After deductible, $25 copay
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 Note: For routine hearing screening performed during a child's preventive care visit, see Section 5(a) *Preventive care, children.*	After deductible, $10 per office visit to your primary care physician; $25 per office visit to a specialist At hospital: After deductible, 20% coinsurance At freestanding facility: After deductible, $25 copay
• External hearing aids • Implanted hearing-related devices, such as bone anchored hearing aids (BAHA) and cochlear implants Note: For benefits for the devices, see Section 5(a) *Orthopedic and prosthetic devices.*	After deductible, $25 copay

Benefit Description	You pay
Vision services (testing, treatment, and supplies)	
• Annual eye refractions, including written lens prescription. Note: see Preventive care, children for eye exams for children.	$19
Frames (one pair each calendar year from the Coventry Health Care of Florida Standard collection at a participating provider)	Nothing
• One pair of frames to correct an impairment directly caused by accidental ocular injury or intraocular (such as for cataracts)	Nothing
• Single vision lenses • Bifocal lenses • Trifocal lenses	$20 $25 $30
Contact Lenses • Medically necessary contact lenses (evaluation and fitting) in lieu of eyeglasses • Daily wear contact lenses (Bausch & Lomb, Biomedics) • Extended wear contact lenses (Bausch & Lomb) • Disposable lenses (2 boxes of all clear spherical lens)	 Nothing $10 $15 $48
• All eyewear (including contact lenses) outside of the Standard Select plan (preselected collection)	Retail cost minus 20% discount
Not covered: • *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.	After deductible, $25 per office visit to a specialist
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	
• Artificial limbs and eyes; • Stump hose • Externally worn breast prostheses and surgical bras, including necessary replacements following a mastectomy • Corrective orthopedic appliances for non-dental treatment of temporomandibular joint (TMJ) pain dysfunction syndrome. • External hearing aids • Implanted hearing-related devices, such as bone anchored hearing aids (BAHA) and cochlear implants	After deductible, 20% coinsurance

Orthopedic and prosthetic devices - continued on next page

Benefit Description	You pay
Orthopedic and prosthetic devices (cont.)	
• Internal prosthetic devices, such as artificial joints, pacemakers, and surgically implanted breast implant following mastectomy. 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.*	After deductible, 20% coinsurance
Not covered: • *Orthopedic and corrective shoes, arch supports, foot orthotics, heel pads and heel cups* • *Lumbosacral supports* • *Corsets, trusses, elastic stockings, support hose, and other supportive devices* • *Prosthetic replacements provided less than {3} years after the last one we covered*	*All charges*
Durable medical equipment (DME)	
We cover rental or purchase of durable medical equipment, at our option, including repair and adjustment. Covered items include: • Oxygen • Dialysis equipment • Hospital beds • Wheelchairs • Crutches • Walkers • Audible prescription reading devices • Speech generating devices • Blood glucose monitors, test strips, lancet • Insulin pumps Note: Call us at 866-575-1882 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.	After deductible, 20% coinsurance Diabetes supplies: After deductible, same as Rx Brand copay per month
Not covered: • *Motorized wheelchairs unless medically necessary to meet the minimum functional requirements of the member* • *More than one device for the same body part or more than one piece of equipment that serves the same function* • *Spare or alternate use devices* • *Adjust, repair or maintenance of devices which are worn or damaged as a result of abuse* • *Replacement of lost devices* • *Exercise equipment and bicycles* • *Elevators and chair lifts, plus home and automobile modifications*	*All charges*

Durable medical equipment (DME) - continued on next page

Benefit Description	You pay
Durable medical equipment (DME) (cont.)	
• *Air conditioners, humidifiers, dehumidifiers, air purifiers, pillows, whirlpools, spas, jacuzzis, and saunas* • *Any equipment that does not serve a medical purpose*	*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.), or home health aide. • Services include oxygen therapy, intravenous therapy and medications.	After deductible, 20% coinsurance
Not covered: • *Nursing care requested by, or for the convenience of, the patient or the patient's family.* • *Home care primarily for personal assistance that does not include a medical component and is not diagnostic, therapeutic, or rehabilitative.* • *Services primarily for hygiene, feeding, exercising, moving the patient, homemaking, companionship or giving oral medication.*	*All charges*
Chiropractic	
• Manipulation of the spine and extremities • Adjunctive procedures such as ultrasound, electrical muscle stimulation, vibratory therapy, and cold pack application	After deductible, $10 per office visit to your primary care physician; $25 per office visit to a specialist
Not covered: *All services not deemed medically necessary.*	*All charges*
Alternative treatments	
Acupuncture – by a doctor of medicine or osteopathy for: • anesthesia, • pain relief	After deductible, $10 per office visit to your primary care physician; $25 per office visit to a specialist
Not covered: • *Naturopathic services* • *Hypnotherapy* • *Biofeedback*	*All charges*
Educational classes and programs	
Coverage is provided for: Tobacco Cessation programs, including individual/group/telephone counseling, and for over the counter (OTC) and prescription drugs approved by the FDA to treat tobacco dependence	Nothing for counseling for up to two quit attempts per year. Nothing for OTC and prescription drugs approved by the FDA to treat tobacco dependence.
• Diabetes self managemen • Childhood obesity education	Nothing

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

- 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 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.
- After you have satisfied your deductible, your Traditional medical coverage begins.
- Under your Traditional medical coverage, you will be responsible for your coinsurance amounts or copayments for eligible medical expenses and prescriptions.
- The amounts listed below are for the charges billed by a physician or other health care professional for your surgical care. Look in Section 5(c) for charges associated with the facility (i.e. hospital, surgical center, etc.).
- **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.

Benefits Description	You pay
Surgical procedures	
A comprehensive range of services, such as: • Operative procedures • Treatment of fractures, including casting • Normal pre- and post-operative care by the surgeon • Correction of amblyopia and strabismus • Endoscopy procedures • Biopsy procedures • Removal of tumors and cysts • Correction of congenital anomalies (see *Reconstructive surgery*) • Insertion of internal prosthetic devices . See 5(a) *Orthopedic and prosthetic devices* for device coverage information • Treatment of burns 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.	At hospital: After deductible, 20% coinsurance At ambulatory surgical center: After deductible, $50 copay
• Voluntary sterilization (e.g., tubal ligation, vasectomy)	At hospital: After deductible, 20% coinsurance At freestanding facility: After deductible, $200 copay
• Treatment of burns	After deductible, $10 per office visit to your primary care physician; $25 per office visit to a specialist
Surgical treatment of morbid obesity (bariatric surgery)	After deductible, $10 per office visit to your primary care physician; $25 per office visit to a specialist

Surgical procedures - continued on next page

Benefits Description	You pay
Surgical procedures (cont.)	
Note: you must satisfy all of the following criteria in order for us to consider the surgery: • Body mass Index (BMI) of 40 or more or a BMI of 35 if co-morbidities exist; • 18 years old or have documentation of completion of Bone Growth; • Failed attempted weight loss under the direction of MD or Presurgical weight loss regime; • Pre-operative psychological evaluation. Note: Bariatric surgery requires our prior approval. See Services requiring our prior approval on page 16.	After deductible, $10 per office visit to your primary care physician; $25 per office visit to a specialist
Not covered: • *Reversal of voluntary sterilization* • *Routine treatment of conditions of the foot; see Foot care*	*All charges*
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; birthmarks; and webbed fingers and toes. • All stages of breast reconstruction surgery following a mastectomy, such as: • surgery to produce a symmetrical appearance of breasts; • treatment of any physical complications, such as lymphedemas; • breast prostheses and surgical bras and replacements (see Prosthetic devices) 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.	At hospital: After deductible, 20% coinsurance At ambulatory surgical center: After deductible, $50 copay
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*	*All charges*

Benefits Description	You pay
Oral and maxillofacial surgery	
Oral surgical procedures, limited to: • Reduction of fractures of the jaws or facial bones; • Surgical correction of cleft lip, cleft palate or severe functional malocclusion; • Removal of stones from salivary ducts; • Excision of leukoplakia or malignancies; • Excision of cysts and incision of abscesses when done as independent procedures; and • Other surgical procedures that do not involve the teeth or their supporting structures.	At hospital: After deductible, 20% coinsurance At ambulatory surgical center: After deductible, $50 copay
Not covered: • *Oral implants and transplants* • *Procedures that involve the teeth or their supporting structures (such as the periodontal membrane, gingiva, and alveolar bone)*	*All charges*
Organ/tissue transplants	
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. * 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 in ineffective. We cover related medical and hospital expenses of donor when the expenses are not covered by the donor's insurance and when the transplant recipient is a HealthAmerica member approved for transplant services. Solid organ transplants limited to: • Cornea • Heart • Heart/lung • Intestinal transplants • Small intestine • Small intestine with the liver • Small intestine with multiple organs, such as the liver, stomach, and pancreas • Kidney • Liver • Lung: single/bilateral/lobar • Pancreas • Autologous pancreas islet cell transplant (as an adjunct to total or near total pancreatectomy) only for patients with chronic pancreatitis	After deductible, 20% coinsurance

Organ/tissue transplants - continued on next page

Benefits Description	You pay
Organ/tissue transplants (cont.)	
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)	After deductible, 20% coinsurance
These blood or marrow stem cell transplants are not subject to medical necessity review by the Plan. Physicians measure many features of leukemia or lymphoma cells to gain insight into its aggressiveness or likelihood of response to various therapies. Some of these include the presence or absence of normal and abnormal chromosomes, the extension of the disease throughout the body, and how fast the tumor cells can grow. These analyses may allow physicians to determine which diseases will respond to chemotherapy or which ones will not respond to chemotherapy and may require a transplant. **Allogeneic (donor) transplants for:** • Acute lymphocytic or non-lymphocytic leukemia • Advanced Hodgkin's lymphoma with recurrence (relapsed) • Advanced non-Hodgkin's lymphoma with recurrence (relapsed) • Acute myeloid leukemia • Advanced Myeloproliferative Disorders (MPDs) • Advanced neuroblastoma • Amyloidosis • Chronic lymphocytic lymphoma/small lymphocytic lymphoma (CLL/SLL) • Hemoglobinopathy • Infant 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 immunodeficiency • Severe or very severe aplastic anemia • Sickle cell anemia • X-linked lymphoproliferative syndrome	After deductible, 20% coinsurance

Organ/tissue transplants - continued on next page

Benefits Description	You pay
Organ/tissue transplants (cont.)	
Autologous transplants for • Acute lymphocytic or nonlymphocytic (i.e., myelogenous) leukemia • Advanced Hodgkin's lymphoma with recurrence (relapsed) • Advanced non-Hodgkin's lymphoma with recurrence (relapsed) • Amyloidosis • Breast Cancer • Ependymoblastoma • Epithelial ovarian cancer • Ewing's sarcoma • Multiple myeloma • Medulloblastoma • Pineoblastoma • Neuroblastoma • Testicular, Mediastinal, Retroperitoneal, and ovarian germ cell tumors	After deductible, 20% coinsurance
Mini-transplants performed in a clinical trial setting (non-myeloablative, 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 Disorders (MPDs) • Amyloidosis • Chronic lymphocytic leukemia/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 immunodeficiency • Severe or very severe aplastic anemia **Autologous transplants for** • Acute lymphocytic or nonlymphocytic (i.e., myelogenous) leukemia • Advanced Hodgkin's lymphoma with reccurrence (relapsed) • Advanced non-Hodgkin's lymphoma with reccurrence (relapsed) • Amyloidosis • Neuroblastoma	After deductible, 20% coinsurance

Organ/tissue transplants - continued on next page

Benefits Description	You pay
Organ/tissue transplants (cont.)	
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 - Beta Thalassemia Major - Chronic inflammatory demyelination polyneuropathy (CIDP) - Early stage (indolent or non-advanced) small cell lymphocytic lymphoma - Multiple myeloma - Multiple sclerosis - Sickle Cell anemia • Mini-transplants (non-myeloablative allogeneic, reduced intensity conditioning or RIC) for - Acute lymphocytic or non-lymphocytic (i.e., myelogenous) 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 disorders (MDDs) - Myelodysplasia/Myelodysplastic Syndromes - Non-small cell lung cancer - Ovarian cancer - Prostate cancer - Renal cell carcinoma - Sarcomas - Sickle cell anemia • Autologous Transplants for - Advanced Childhood kidney cancers	After deductible, 20% coinsurance

Organ/tissue transplants - continued on next page

Benefits Description	You pay
Organ/tissue transplants (cont.)	
- 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	After deductible, 20% coinsurance
Coventry Transplant Network (CTN) - NOTE: We cover related medical and hospital expenses of the donor when we cover the recipient. We cover donor screening tests and donor search expenses for the actual solid organ or up to four bone marrow/stem cell transplant donors in addition to the testing of family members.	
Not covered: • *Donor screening tests and donor search expenses, except as those shown above* • *Donor expenses related to donating organs or tissue to a non-member recipient* • *Implants of artificial organs* • *Transplants not specifically listed as covered*	*All charges*
Anesthesia	
Professional services provided in – • Hospital (inpatient) • Hospital outpatient department • Skilled nursing facility	After deductible, 20% coinsurance
Professional services provided in - • Office	After deductible, $50 copay

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 coinsurance amounts or 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.
- 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
Inpatient hospital	
Room and board, such as • Ward, semiprivate, or intensive care accommodations; • General nursing care • Meals and special diets Note: If you want a private room when it is not medically necessary, you pay the additional charge above the semiprivate room rate.	After deductible, 20% coinsurance
Other hospital services and supplies, such as: • Operating, recovery, maternity, and other treatment rooms • Prescribed drugs and medicines • Diagnostic laboratory tests and X-rays • Blood or blood plasma, if not donated or replaced • Dressings , splints , casts , and sterile tray services • Medical supplies and equipment, including oxygen • Anesthetics, including nurse anesthetist services • Take-home items • Medical supplies, appliances, medical equipment, and any covered items billed by a hospital for use at home (Note: calendar year deductible applies.)	After deductible, 20% coinsurance
Not covered: • *Custodial care* • *Non-covered facilities, such as nursing homes, schools*	*All charges*

Inpatient hospital - continued on next page

Benefit Description	You pay
Inpatient hospital (cont.)	
• *Personal comfort items, such as telephone, television, barber services, guest meals and beds* • *Private nursing care*	*All charges*
Outpatient hospital or ambulatory surgical center	
• Operating, recovery, and other treatment rooms • Prescribed drugs and medicines • Diagnostic laboratory tests, X-rays , and pathology services • Administration of blood, blood plasma, and other biologicals • 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.	At hospital: After deductible, 20% coinsurance At ambulatory surgical center: After deductible, $50 copay
Not covered: Blood and blood derivatives not replaced by the member	*All charges*
Extended care benefits/Skilled nursing care facility benefits	
The plan provides a comprehensive range of benefits for up to 100 days per calendar year when you are hospitalized under the care of a Plan physician. All medically necessary services are covered. • Bed, board and general nursing care • Drugs, biological, supplies and equipment ordinarily provided or arranged by the skilled nursing facility when prescribed by a Plan physician.	After deductible, 20% coinsurance
Not covered: Custodial care	*All charges*
Hospice care	
Hospice care: up to 210 days per lifetime The Plan covers supportive and palliative care for a terminally ill member. Coverage is provided in the home or a hospice facility. Services include inpatient, outpatient care and family counseling; these services are provided under the direction of a Plan physician who certifies that the patient is in terminal stages of illness, with a life expectancy of approximately six months or less.	After deductible, 20% coinsurance
Not covered: Independent nursing, homemaker services	*All charges*
Ambulance	
• Local professional ambulance service when medically appropriate • Air Ambulance limited to situation where ground transportation is not medically appropriate – prior plan authorization required. Note: See 5(d) for non-emergency service.	After deductible, no copay

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 coinsurance amounts 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.

What is a medical emergency?

A medical emergency is the sudden and unexpected onset of a condition or an injury that you believe endangers your life or could result in serious injury or disability, and requires immediate medical or surgical care. 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:

If you are in an emergency situation, please call your primary doctor. In extreme emergencies, if you are unable to contact your doctor, contact the local emergency system (e.g., the 911 telephone system) or go to the nearest hospital emergency room. Be sure to tell the emergency room personnel that you are a Plan member so they can notify the Plan. You or a family member should notify the Plan within 48 hours unless it is not reasonably possible to do so. It is your responsibility to ensure that the Plan has been notified timely.

If you need to be hospitalized, the Plan must be notified within 48 hours or the first working day following your admission, unless it is not reasonably possible to notify the Plan in that time. If you are hospitalized in non-Plan facilities and Plan doctors believe care can be better provided in a Plan hospital, you will be transferred when medically feasible with ambulance charges covered in full.

Emergencies within our service area: Benefits are available for care from non-Plan provider in a medical emergency only if delay in reaching a Plan provider would result in death, disability or significant jeopardy to your condition.

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

Emergencies outside our service area: Benefits are available for any medically necessary service that is immediately required because of injury or unforeseen illness.

If you need to be hospitalized, the Plan must be notified within 48 or on the first working day following your admission, unless it was not reasonably possible to notify the Plan in that time. If you are hospitalized in non-Plan facilities and Plan doctors believe care can be better provided in a Plan hospital, you will be transferred when medically feasible with any ambulance charges covered in full.

Benefit Description	You pay
Emergency within our service area	
• Emergency care at a doctor's office	After deductible, $10 per office visit to your primary care physician or $25 per office visit to a specialist
• Emergency care at an urgent care center	After deductible, $25 copay
• Emergency care as an outpatient in a hospital, including doctors' services Note: We waive the ER copay if you are admitted to the hospital	After deductible, $50 copay
Not covered: Elective care or non-emergency care	*All charges*
Emergency outside our service area	
• Emergency care at a doctor's office	After deductible, $10 per office visit to your primary care physician or $25 per office visit to a specialist
• Emergency care at an urgent care center	After deductible, $25 copay
• Emergency care as an outpatient in a hospital, including doctors' services Note: We waive the ER copay if you are admitted to the hospital.	After deductible, $50 copay
Not covered: • *Elective care or non-emergency care and follow-up care recommended by non-Plan providers that has not been approved by the Plan or provided by Plan providers* • *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	
• Professional ambulance service when medically appropriate. • Air Ambulance limited to situation where ground transportation is not medically appropriate – prior plan authorization required. Note: See 5(d) for non-emergency service.	After deductible, no copay

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

You need to get Plan approval (preauthorization) for services and follow a treatment plan we approve in order to get benefits. When you receive services as part of an approved treatment plan, cost-sharing and limitations for Plan mental health and substance abuse benefits are no greater than for similar benefits for other illnesses and conditions.

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 calendar year deductible or, for facility care, the inpatient deductible applies to almost all benefits in this Section. We added "(No deductible)" to show when a 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:
- We will provide medical review criteria or reasons for treatment plan denials to enrollees, members 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
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 • Professional charges for intensive outpatient treatment in a provider's office or other professional setting • Electroconvulsive therapy	After deductible, $25 copay

Benefit Description	You pay
Diagnostics	
• Outpatient diagnostic tests provided 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	After deductible, $25 copay
Inpatient hospital or other covered facility	
Inpatient services provided and billed by a hospital or other covered facility • Room and board, such as semiprivate or intensive accommodations, general nursing care, meals and special diets, and other hospital services	After deductible, 20% coinsurance
Not covered	
Services that are not part of a preauthorized approved treatment plan. *Note: OPM will base its review of disputes about treatment plans on the treatment plan's clinical appropriateness. OPM will generally not order us to pay or provide one clinically appropriate treatment plan in favor of another.*	*All charges*

Preauthorization

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

Prior to seeking mental health and substance abuse treatment, you must call Psych/Care at 1-800-221-5487. Psych/Care is a managed behavioral health care firm with over 500 providers in our service area. You do not need a referral from your primary care physician or authorization from us. A Psych/Care provider will evaluate you and develop a treatment plan.

Once the treatment plan has been approved, you must follow it. If you need inpatient care, your Psych/Care provider will arrange it for you. Call Psych/Care for a list of participating providers in your area.

Limitation

We may limit your benefits if you do not obtain a 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.
- 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 plan physician or licensed dentist must write the prescription.
- **Where you can obtain them.** You may fill the prescription at a participating pharmacy. Please see the complete listing of participating pharmacies in our provider directory.
- **We use a formulary.** The formulary is a list of medications, both brand and generic, that we approve as covered medication. Plan pharmacies dispense prescription medication to our members based on our formulary list. However, we cover non-formulary drugs prescribed by a Plan doctor. You must pay a higher copay for non-formulary drugs. Our formulary has 4 tiers of prescription drug coverage. Tier 1 includes low cost generic formulary drugs. Tier 2 includes brand name formulary drugs. Tier 3 includes high cost, mostly brand name non-formulary drugs that usually have generic or brand name alternatives in Tiers 1 or 2. Tier 4 includes high technology and self-administered drugs, including growth hormone. Tier 4 drugs require our prior authorization. If you'd like a copy of our formulary, please call us at 1-866-575-1882.
- **These are the dispensing limitations.** You may obtain a 30-day supply at a Plan pharmacy or a 90-day supply via mail order. Mail order is available for maintenance medications only. A 90-day vacation supply may also be obtained from a Plan pharmacy once a year. Plan pharmacies will not dispense refills in excess of the number specified by the physician or refill medication more than 12 months after the original date of the prescription. You may obtain a refill up to 6 days before your prescription runs out. A generic equivalent will be dispensed if it is available, unless your physician specifically requires a name brand drug. When your physician requires a name brand drug, the physician must specify "Dispense as Written" on the prescription or you will have to pay the difference in cost between the name brand drug and the generic.
- **Prior authorization process for medication other than self-injectable drugs.** Our prescription drug formulary is based on the principles of providing and promoting safe, efficacious and cost-effective medications for our members. In order to monitor drug therapy duplication, abuse, misuse, and interactions, we administer a prior authorization (PA) requirement for certain drugs. Our prior authorization program operates in the following manner.

We provide our participating physicians with a list of medications that require our prior authorization before they can be dispensed by a Plan pharmacy. Your Plan physician must complete and submit a PA form to Coventry Health Care of Florida (Coventry) to begin the authorization process. If you try to fill the prescription at a pharmacy and we have not authorized the medication, the pharmacist will advise you that your physician must obtain prior authorization for the medication before it can be dispensed. Your physician should call 1-866-847-8279 to obtain a PA form and must complete and fax it to 954-858-3386. If PA is urgent and you need the medication immediately, the physician can call the Rx phone number and speak to a Coventry's clinical pharmacist during office hours. After office hours, pharmacies can call Coventry's round-the-clock Pharmacy Benefit Manager at 1-800-922-1557 to obtain an authorization for a one-time 7-day supply of a non-formulary medication.

- **Prior authorization process for self-injectable drugs.** The prior approval process for requesting self-injectable medication is very similar to PA for other medication. The only difference is that the prescription must be filled by a Specialty Pharmacy. The physician completes a request form and faxes it to the Specialty Pharmacy and the specialty pharmacy forwards it to Coventry's Pharmacy Department for approval. If you have any questions about the prior authorization process, please contact 1-866-575-1882.
- **Why use generic drugs?** Generic drugs offer a safe and economic way to meet your prescription drug needs. The generic name of a drug is its chemical name; the name brand is the name under which the manufacturer advertises and sells a drug. Under federal law, generic and name brand drugs must meet the same standards for safety, purity, strength, and effectiveness. A generic prescription costs you – and us – less than a name brand prescription.
- **When you do have to file a claim.** There are no claims to file when you use a Plan pharmacy or our mail order program. If you have an emergency while outside our service area, and you fill a prescription at a non-Plan pharmacy, you must submit a claim for reimbursement. We will reimburse up to the amount we would have paid if you had used a plan pharmacy.
- **If you are a military reservist called to active duty or are a member requiring a supply of medication during a national emergency,** call us at 1-866-847-8279 for assistance with obtaining your medication.

Benefit Description	You pay
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 • Disposable needles and syringes for the administration of covered medications • Drugs for sexual dysfunction Note: Drugs for sexual dysfunctions have special dispensing limits and guidelines. Please contact us for details. These drugs are not available under our mail-order program. Note: Tier 4 includes: High technology and select self-injectable specialty pharmacy medications. These drugs are not available under our mail-order program. Tier 4 drugs require our prior authorization. We periodically review and update the list of medications. Please contact us to verify if your drug is on Tier 4. These drugs have specific characteristics such as: usually injectable, high in cost; and require special handling and special training to use.	**Retail Pharmacy** (up to 30-day supply per prescription unit or refill): • Tier 1 - After deductible - $5; select generic formulary • Tier 2 - After deductible - $35; name brand formulary • Tier 3 - After deductible - $50; non-formulary • Tier 4 - After deductible - 20% of negotiated rate up to $100 per month out-of-pocket limit to a maximum of $1,200 per calendar year (except for diabetic supplies). Tier 4 drugs require prior authorization. Note: If there is no generic equivalent available, you will still have to pay the brand name or non-formulary copay. **Mail-Order Pharmacy** (up to a 90-day supply of maintenance medication): • Tier 1 - After deductible - $15; select generic formulary • Tier 2 - After deductible - $105; name brand formulary • Tier 3 - After deductible - $150; non-formulary Note: We have no Tier 4 under mail-order. Therefore, high technology and self-injectable specialty pharmacy medications are available through Tier 4 retail. Note: If there is no generic equivalent available, you will still have to pay the name brand copay.
Women's contraceptive drugs and devices	Nothing
Note: Over-the-counter and prescription drugs approved by the FDA to treat tobacco dependence are covered under the Tobacco cessation benefit and require a written prescription by an approved physician. (See page 91).	• Drugs for smoking cessation (combined with all Tobacco cessation services) including "Over the Counter" (OTC) products require a script to obtain with no charge. Should the drug be indicated for multiple purposes, members are required to ask their doctor to submit a Prior Authorization Form with supporting documentation as to the indicated use of the medicine/product.

Covered medications and supplies - continued on next page

Benefit Description	You pay
Covered medications and supplies (cont.)	
	• All of the OTC Tobacco cessation products are approved for OTC use in adults 18 years of age or older. • Users under 18 years of age are to consult with their doctor prior to use. • Individuals who continue to smoke, chew tobacco, use snuff or use a nicotine patch or other nicotine containing products should not use. • All OTC products have the same indication.
Not covered: • *Drugs and supplies for cosmetic purposes* • *Drugs to enhance athletic performance* • *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* • *Nonprescription medicines* • *Drugs given to you while you are a patient in a hospital, skilled nursing facility, convalescent hospital, hospice or other facility where drugs are ordinarily provided by the facility to its patients.* • *Refills in excess of the number specified by the physician or refills dispensed more than 12 months after the original date of the prescription.* • *Drugs provided to you by this plan, but which are lost, stolen or destroyed.* • *Drugs for the treatment of obesity, unless medically necessary for the treatment or morbid obesity.*	*All charges*

Section 5(g). Dental benefits

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- If you are enrolled in a Federal Employees Dental/Vision Insurance Program (FEDVIP) Dental Plan, your FEHB Plan will be First/Primary payor of any Benefit payments and your FEDVIP Plan is secondary to your FEHB Plan. See Section 9 Coordinating benefits with other coverage.
- Plan dentists must provide or arrange your care.
- Under your Traditional medical coverage, you will be responsible for your coinsurance amounts and copayments for eligible medical expenses and prescriptions.
- We cover hospitalization for dental procedures only when a non-dental physical impairment exists which makes hospitalization necessary to safeguard the health of the patient. See Section 5(c) for inpatient hospital benefits. We do not cover the dental procedure unless it is described below.
- 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
Accidental injury benefit	
We cover restorative services and supplies necessary to promptly repair (but not replace) sound natural teeth. The need for these services must result from an accidental injury.	After deductible, $25 copay

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 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).
Services for deaf and hearing impaired	If you are hearing or speech impaired and use a telephone device for the deaf, you may call 1-888-444-7352 Monday through Friday from 8 a.m. to 6 p.m.
High risk pregnancies	Coventry Health Care of Florida offers a dedicated OB Case Management unit, coordinating and monitoring all phases of care through the member's pregnancy.
Centers of excellence	Coventry Health Care of Florida utilizes Centers of Excellence for transplant services. Please call us at 1-866-575-1882 for more information.
Travel benefit/services overseas	Limited to ER services world-wide must submit translated documents. (E.R. notes, receipts of paid services)

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

Special Features	Description
Health education resources	We publish an e-newsletter to keep you informed on a variety of issues related to your good health. Visit our Web site at feds.chcflorida.com for the Visit our on our Web site at feds.chcflorida.com for information on: • General health topics • Links to health care news • Cancer and other specific diseases • Drugs/medication interactions • Kids' health • Patient safety information • Several helpful web site links
Account management tools	For each HSA and HRA account holder, we maintain a complete claims payment history online through feds.chcflorida.com. Your balance will also be shown on your explanation of benefits (EOB) form. You will receive an EOB after every claim. If you have an **HSA**: • You will receive a outlining your account balance and activity for the month. • You may also access your account on-line at feds.chcflorida.com. If you have an **HRA**: • Your HRA balance will be available online through feds.chcflorida.com. Your balance will also be shown on your EOB form.
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. Directories are available online at feds.chcflorida.com. Pricing information for medical care is available at feds.chcflorida.com. Pricing information for prescription drugs is available at feds.chcflorida.com. Link to online pharmacy through feds.chcflorida.com. Educational materials on the topics of HSAs, HRAs and HDHPs are available at feds.chcflorida.com
Care support	Patient safety information is available online at feds.chcflorida.com. Case Managers

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. Fees you pay for these services do not count toward FEHB deductibles or catastrophic protection out-of-pocket maximums. These programs and materials are the responsibility of the Plan, and all appeals must follow their guidelines. For additional information contact the Plan at, 866-575-1882 or visit their website at feds.chcflorida.com.

Over-the-Counter Value Added Benefit

- $120 on over-the-counter products, a $10 value per subscriber per month. Mail order available.

Coventry WellBeing Program

- **Free Fitness Club Membership -** receive a basic gym membership at participating fitness centers.
- **Tobacco Cessation Program-** an online behavioral support program to help people quit smoking.
- **Online Wellness Program -** an online program that promotes healthy eating and fitness management.
- **Coventry WellBeing CAM Program -** receive discounts of up to 30% for various alternative therapies through American WholeHealth Network (AWHN) of practitioners.

Disease Management and Wellness Incentives

- Members enrolled in a Disease Management program receive a $50 Wellness Incentive if they complete the at-home biometric screening and online HRA. Disease Management programs are available to members diagnosed with asthma, diabetes and/or congestive heart failure, hypertension and chronic kidney disease.

Weight Loss Plan Discounts

- Members have access to discounts at Jenny Craig and Weight Watchers for weight loss programs.

HEARx Discounts

- Through HEARx convenient store locations, Coventry members including children and newborns are offered up to a 20% discount with a 30-day satisfaction guarantee return policy and a limited warranty on all purchases.

LASIK Surgery services at Preferred Rates

- Direct access to affordable vision correction for members who are nearsighted or have astigmatism and wear glasses or contacts.

Medicare Advantage

- Coventry Health Care of Florida offers Medicare Advantage plans to individuals who live in Miami-Dade, Broward, Martin, Palm Beach and St. Lucie counties and are entitled to Medicare Part A and enrolled in Medicare Part B. For more information call 1-800-826-1013, Monday through Friday from 9:00 a.m to 5:00 p.m. or TDD 1-888-444-7352 if you are hearing or speech impaired.

Individual Products

- Coventry Health Care of Florida offers Individual HMO and PPO plans to individuals who live in Miami-Dade, Broward, Martin, Palm Beach and St. Lucie counties. For more information call 1-888-275-2700, Monday through Friday from 8:30 a.m. to 5:00 p.m.

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 approval 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 that are not medically necessary
- Services, drugs, or supplies not required according to accepted standards of medical, dental, or psychiatric practice
- Experimental or investigational procedures, treatments, drugs or devices
- Services, drugs, or supplies related to abortions, except when the life of the mother would be endangered if the fetus were carried to term or when the pregnancy is the result of an act of rape or incest
- Services, drugs, or supplies related to sex transformations
- Services, drugs, or supplies you receive from a provider or facility barred from the FEHB Program
- Services, drugs, or supplies you receive without charge while in active military service
- Services provided to you without charge or that would normally be provided without charge if you were not covered under this Plan or under any other insurance, and care rendered by your immediate family members.
- 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. This plan does not cover these costs.

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 copay, 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 1-866-575-1882, or at our Web site at feds.chcflorida.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 substitutes for itemized bills.

Submit your claims to:

Coventry Health Care of Florida, Inc.
Attn: FEHB Claims Department
P.O. Box 7807
London, KY 40742

Prescription drugs

You do not file claims when you use Plan pharmacies or the plan's mail order service to fill your prescriptions. You use your identification card and pay the appropriate copay. If you fill a prescription at a non-Plan pharmacy in an emergency, you must submit a Pharmacy Reimbursement Form for reimbursement. Include your itemized prescription receipt from the pharmacy along with your cash register receipt showing the amount you paid and explain why you filled the prescription at a non-Plan pharmacy. Pharmacy Reimbursement forms may be obtained by calling our Customer Service Department at 1-866-575-1882.

Submit your reimbursement form to:

Coventry Health Care of Florida, Inc.
PO Box 459011
Sunrise, FL 33345-9011

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, we may take up to an additional 15 days for review and we will notify you before the expiration of the original 30-day period. Our notice will include the circumstances underlying the request for the extension and the date when a decision is expected.

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

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

Authorized Representative

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

Notice Requirements

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 directly to the Office of Personnel Management (OPM) if we do not follow required claims processes. For more information about situations in which you are entitled to immediately appeal to OPM, including additional requirements not listed in Sections 3, 7 and 8 of this brochure, please visit feds.chcflorida.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 Florida, 1340 Concord Terrace, Sunrise, FL 33323 or calling (866) 575-1882.

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, medical 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 representative who is neither the individual who made the initial decision that is 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 claim 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.

1 Ask us in writing to reconsider our initial decision. You must:

a) Write to us within 6 months from the date of our decision; and

b) Send your request to us at:
Coventry Health Care of Florida
Grievance and Appeal
1340 Concord Terrace
Sunrise, Florida 33323

c) Include a statement about why you believe our initial decision was wrong, based on specific benefit provisions in this brochure; and

d) Include copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms.

e) Include your email address (optional for member), if you would like to receive our decision via email. Please note that by giving us your email, we may be able to provide our decision more quickly.

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

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

a) Pay the claim 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 Personnel Management, Insurance Operations, Health Insurance 3, 1900 E Street, NW, Washington, DC 20415.

Send OPM the following information:

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

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

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

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

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 within 60 days. There are no other administrative appeals.

If you do not agree with OPM's decision, your only recourse is to sue. If you decide to sue, you must file the suit against OPM in Federal court by December 31 of the third year after the year in which you received the disputed services, drugs, or supplies or from the year in which you were denied 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 sue until you have completed the disputed claims process. Further, Federal law governs your lawsuit, benefits, and payment of benefits. The Federal court will base its review on the record that was before OPM when OPM decided to uphold or overturn our decision. You may recover only the amount of benefits in dispute.

Note: **If you have a serious or life threatening condition** (one that may cause permanent loss of bodily functions or death if not treated as soon as possible), and you did not indicate that your claim was a claim for urgent care, then call us at (866) 575-1882. We will hasten 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) 606-0755 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 is covered under this plan. You must raise eligibility issues with your Agency personnel/payroll office if you are an employee, your retirement system if you are an annuitant or the Office of Workers' Compensation Programs if you are receiving Workers' Compensation benefits.

Section 9. Coordinating benefits with Medicare 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 web site 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, up to our regular benefit. We will not pay more than our allowance.

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 or 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.

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 Employees Dental and Vision Insurance Plan (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 healthplan will provide related care as follows, if it is not provided by the clinical trial:

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

When you have Medicare

- **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. If you have limited savings and a low income, you may be eligible for Medicare's Low-Income Benefits. For people with limited income and resources, extra help in paying for a Medicare prescription drug plan is available. Information regarding this program is available through the Social Security Administration (SSA). For more information about this extra help, visit SSA online at www.socialsecurity.gov, or call them at 1-800-772-1213, (TTY 1-800-325-0778). 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. The notice will give you guidance on enrolling in Medicare Part D.

- **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 1-866-575-1882 or see our Web site at feds.chcflorida.com.

Coventry coordinates if the original Medicare plan is your primary payor and also liable for Medicare deductible and coinsurance.

Note: All plan deductible and penalties apply.

We do not waive any costs if the Original Medicare Plan is your primary payor.

You can find more information about how our plan coordinates benefits with Medicare at www.summithealthplan.com.

- **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 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:

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), but 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)**

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

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

Primary Payor Chart		
A. When you - or your covered spouse - are age 65 or over and have Medicare and you...	**The primary payor for the individual with Medicare is...**	
	Medicare	**This Plan**
1) Have FEHB coverage on your own as an active employee		✓
2) Have FEHB coverage on your own as an annuitant or through your spouse who is an annuitant	✓	
3) Have FEHB through your spouse who is an active employee		✓
4) Are a reemployed annuitant with the Federal government and your position is excluded from the FEHB (your employing office will know if this is the case) and you are not covered under FEHB through your spouse under #3 above	✓	
5) Are a reemployed annuitant with the Federal government and your position is not excluded from the FEHB (your employing office will know if this is the case) and...		
• You have FEHB coverage on your own or through your spouse who is also an active employee		✓
• You have FEHB coverage through your spouse who is an annuitant	✓	
6) Are a Federal judge who retired under title 28, U.S.C., or a Tax Court judge who retired under Section 7447 of title 26, U.S.C. (or if your covered spouse is this type of judge) and you are not covered under FEHB through your spouse under #3 above	✓	
7) Are enrolled in Part B only, regardless of your employment status	✓ for Part B services	✓ for other services
8) Are a Federal employee receiving Workers' Compensation 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; or is a drug trial that is exempt from the requirement of an investigational new drug application.

- 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.

Coinsurance

Coinsurance is the percentage of our allowance that you must pay for your care. You may also be responsible for additional amounts. See page 21.

Contracting Medical Group (CMG)

A partnership, corporation, association, Independent Practice Association, medical group or other legal entity which has entered in a service arrangement (or arrangements), with licensed physicians or other health care providers, a majority or all of whom are licensed to practice medicine, and which has a written agreement with us to arrange for the provision of covered services to our members.

Copayment

A copayment is a fixed amount of money or a percentage of the negotiated rated that you pay when you receive covered services. See page 21.

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

Medically necessary medical, surgical, hospital, and other services or supplies rendered by Contracting Providers, and Emergency Services and Care and supplies provided by non-Contracting Providers, which are specified as being covered in this brochure.

Custodial care

Services to support and generally maintain the patient’s condition, provide for the patient’s comfort or ensure the manageability of the patient. Custodial care that lasts 90 days or more is sometimes known 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 page 18.

Experimental or investigational service

Services, supplies, drugs and procedures, which have not demonstrated to be safe, effective, medically appropriate for use in the treatment of illness or injury. Also include service supplies, drugs and procedures that are determined to be the subject of clinical trial.

Group health coverage

Services which are necessary and appropriate for the treatment of an illness or injury according to professionally recognized standards of practice and are consistent with Coventry Health Care of Florida, Inc. medical policies.

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 Services which are necessary and appropriate for the treatment of an illness or injury according to professionally recognized standards of practice and are consistent with Coventry Health Care of Florida, Inc. medical policies.

Negotiated Rate The rate of compensation for a particular covered service, payable on a fee-for-service or per diem basis, which Coventry Health Care of Florida pays to the Contracting Provider providing the covered service, or where the provider is paid by the CMG, the rate paid to the provider by the CMG.

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 referral results in a reduction of benefits.

Primary Care Physician (PCP) Any contracting physician who has the responsibility for providing initial and primary care to Members, maintaining the continuity of patient care, initiating referral for specialist care, and who is listed in the current Contracting Provider Directly for your area as a PCP.

Prior Authorization The requirement that a Member's attending physician requests approval of coverage from us prior to the member obtaining certain Covered Services.

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

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 judgement 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 866-575-1882. 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 Florida.

Usual and Customary The usual charge is that price normally charged, for a given service or supply, by a health care provider to the provider's private patients. A charge is customary when it is within the range of usual prices charged by health care providers of similar training and experience, for the same service or supply within the same specific and limited geographic area, as determined by us through a professional review process.

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. the result can be a discount of 20% to more than 40% on service/products you 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 a tax-favored benefit that allows you to set aside pre-tax money from your paychecks to pay for a variety of eligible expenses. **Annuitants are not eligible to enroll.**

There are three types of FSAs offered by FSAFEDS. Each type has a minimum annual election of $250. 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.

- **Health Care FSA (HCFSA)** –Reimburses you for eligible health care expenses (such as copayments, deductibles, insulin, products, **physician prescribed** over-the-counter drugs and medications, vision and dental expenses, and much more) for you and your tax dependents, including adult children (through the end of the calendar year in which they turn 26) which are not covered or reimbursed by FEHBP or FEDVIP coverage or any other insurance.

FSAFEDS offers paperless reimbursement for your HCFSA through a number of FEHB and FEDVIP plans. This means that when you or your provider files claims with your FEHB or FEDVIP plan, FSAFEDS will automatically reimburse your eligible out-of-pocket expenses based on the claim information it receives from your plan.

- **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 dental and vision care expenses for you and your tax dependents including adult children (through the end of the calendar year in which they turn 26) which are not covered or reimbursed, by FEHBP or FEDVIP coverage or any other insurance.
- **Dependent Care FSA (DCFSA)** – Reimburses you for **non medical** daycare expenses for your child(ren) under age 13 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 DCFSA.
- If you are a new or newly eligible employee, you have 60 days from your hire date to enroll in an 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 Empolyees 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, and was established by the Federal Employee Dental and Vision Benefits Enhancement Act of 2004. **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.Beginning in 2014, most FEDVIP dental plans cover adult orthodontia. 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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Summary of benefits for the High Option of Coventry Health Plan of Florida 2014

- **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.
- Below, an asterisk (*) means the item is subject to the $250 hospital deductible .

High Option Benefits	You pay	Page
Medical services provided by physicians:		
Diagnostic and treatment services provided in the office	Office visit copay: $15 primary care; $30 specialist	28
Services provided by a hospital:*		
• Inpatient	$150 per admission copay up to a maximum of $450 after $250 hospital deductible has been met.	48
• Outpatient	$50 copay per outpatient surgery when performed at a freestanding participating facility. $100 copay at a participating hospital after $250 hospital deductible has been met.	49
Emergency benefits: In-area or out-of-area	$40 per urgent care center visit or $150 per hospital emergency room visit	51
Mental health and substance abuse treatment:*	Regular cost-sharing	53
Prescription drugs:		55
• Retail pharmacy (up to a 30-day supply)	Tier 1A -$3 select generic formulary /Tier 1B -$20 generic formulary / Tier 2 - $40 brand name formulary / Tier 3 - $60 non-formulary / Tier 4 - 20% of negotiated price up to $100 per month specialty drugs.	56
• Mail order (up to a 90-day supply of maintenance medication)	Plan's Mail-Order Pharmacy: Tier 1A - $3 select generic formulary; Tier 1B - $60 generic formulary; Tier 2 - $120 name brand formulary; and Tier 3 - $180 non-formulary. We do not cover Tier 4 injectables and specialty drugs under our mail order program.	56
Dental care:	$30 to specialist	59
Vision care: Annual eye refraction and other vision care services	$19 copay for eye exam and various copays/discounts on frames and lenses at a participating optometrist	34
Special features: Flexible benefits option; Services for deaf and hearing impaired, High risk pregnancies, Centers of excellence for transplants, Case Management programs and Disease State Management programs		60
Protection against catastrophic costs (annual out-of-pocket maximum)**:** Some costs do not count toward this protection.	$1,500/Self Only enrollment or $3,000/Family enrollment for medical care and $1,200 per person for Tier 4 prescription medication	23

Summary of benefits for the Standard Option of Coventry Health Plan of Florida 2014

- **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.
- Below, an asterisk (*) means the item is subject to the $500 hospital deductible .

Standard Option Benefits	You pay	Page
Medical services provided by physicians:		
Diagnostic and treatment services provided in the office	Office visit copay: $20 primary care; $50 specialist	28
Services provided by a hospital: *		
• Inpatient	$150 per admission copay up to a maximum of $750 after $500 hospital deductible has been met.	48
• Outpatient	$150 copay per outpatient surgery when performed at a freestanding participating facility. $250 copay at a participating hospital after $500 hospital deductible has been met.	49
Emergency benefits: In-area or out-of-area	$50 per urgent care center visit or $150 per hospital emergency room visit	51
Mental health and substance abuse treatment:*	Regular cost-sharing	53
Prescription drugs:		55
• Retail pharmacy (up to a 30-day supply)	Tier 1A -$3 select generic formulary /Tier 1B -$10 generic formulary / Tier 2 - $50 brand name formulary / Tier 3 - $70 non-formulary / Tier 4 - 20% of negotiated price up to $100 per month specialty drugs.	56
• Mail order (up to a 90-day supply of maintenance medication)	Plan's Mail-Order Pharmacy: Tier 1A - $3 select generic formulary; Tier 1B - $10 generic formulary; Tier 2 - $100 name brand formulary; and Tier 3 - $210 non-formulary. We do not cover Tier 4 injectables and specialty drugs under our mail order program.	56
Dental care: Accidental injury coverage	$50 to specialist	59
Vision care: Annual eye refraction and other vision care services	$19 copay for eye exam and various copays/discounts on frames and lenses at a participating optometrist	34
Special features: Flexible benefits option; Services for deaf and hearing impaired, High risk pregnancies, Centers of excellence for transplants, Case Management programs and Disease State Management programs		60
Protection against catastrophic costs (out-of-pocket maximum):	$2,500/Self Only enrollment or $5,000/Family enrollment for medical care and $1,200 per person for Tier 4 prescription medication.	23

Summary of benefits for the HDHP for Coventry Health Plan of Florida 2014

- **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.
- Below, an asterisk (*) means the item is subject to the $2,500 hospital deductible .

HDHP Option Benefits	You pay	Page
In-network medical and dental preventive care	Nothing	
Medical services provided by physicians:		
Diagnostic and treatment services provided in the office	After deductible, $10 primary care; $25 specialist	75
Services provided by a hospital: *		
• Inpatient	After deductible, 20% coinsurance.	89
• Outpatient	At hospital: After deductible, 20% coinsurance; At ambulatory surgical center: After deductible, $50 copay.	90
Emergency benefits: In-area or out-of-area	After deductible, $25 per urgent care center visit or $50 per hospital emergency room visit	91
Mental health and substance abuse treatment:*	Regular cost-sharing	93
Prescription drugs:		95
• Retail pharmacy (up to a 30-day supply)	After deductible: Tier 1 -$5 generic formulary / Tier 2 - $35 brand name formulary / Tier 3 - $50 non-formulary / Tier 4 - 20% of negotiated price up to $100 per month specialty drugs.	96
• Mail order (up to a 90-day supply of maintenance medication)	After deductible: Plan's Mail-Order Pharmacy- Tier 1 - $15 generic formulary; Tier 2 - $105 name brand formulary; and Tier 3 - $150 non-formulary. We do not cover Tier 4 injectables and specialty drugs under our mail order program.	96
Dental care: Accidental injury	After deductible, $25 copay	98
Vision care: Annual eye refraction and other vision care services	$19 copay for eye exam and various copays/discounts on frames and lenses	79
Special features: Flexible benefits option; Services for deaf nd hearing impaired, High risk pregnancies, Centers of exellence for transplants, Case Management programs and Disease State Management programs		99
Protection against catastrophic costs (out-of-pocket maximum):	$5,000/ Self Only enrollment or $10,000/Family enrollment for medical care and $1,200 per person for Tier 4 prescription medication.	65

2014 Rate Information

For 2014 health premium information, please see:
http://www.opm.gov/healthcare-insurance/indian-tribes/health-insurance/#url=Premiums or contact your tribe's Human Resources department.