

Coventry Health Care of Iowa, Inc.

<http://www.chciowa.com>

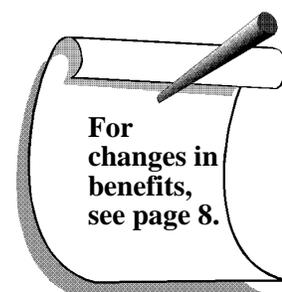


2007

A Health Maintenance Organization (high option), and a high deductible health plan

Serving: *Central, Eastern and Western Iowa*

Enrollment in this plan is limited. You must live or work in our Geographic service area to enroll. See page 7 for requirements.



This Plan has an Excellent Accreditation from the National Committee for Quality Assurance (NCQA), an independent, non-profit organization dedicated to improving health care quality and service. See the 2006 guide for more information on accreditation.

Enrollment codes for this Plan:

- SV1 High Option – Self Only**
- SV2 High Option – Self and Family**
- SV4 HDHP Option – Self Only**
- SV5 HDHP Option – Self and Family**



Authorized for distribution by the:



**United States
Office of Personnel Management**
Center for
Retirement and Insurance Services
<http://www.opm.gov/insure>

Important Notice from Coventry Health Care of Iowa About

Our Prescription Drug Coverage and Medicare

OPM has determined that the Coventry Health Care of Iowa prescription drug coverage is, on average, comparable to Medicare Part D prescription drug coverage; thus you do not need to enroll in Medicare Part D and pay extra for prescription drug benefits. 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 will coordinate benefits with Medicare.

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

Please be advised

If you lose or drop your FEHB coverage, you will have to pay a higher Part D premium if you go without equivalent prescription drug coverage for a period of 63 days or longer. If you enroll in Medicare Part D at a later date, your premium will increase 1 percent per month for each month you did not have equivalent prescription drug 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 most other people pay. You may also have to wait until the next open enrollment period 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 users should call 1-877-486-2048.

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Introduction

This brochure describes the benefits of Coventry Health Care of Iowa, Inc. under our contract (CS 2902) with the United States Office of Personnel Management, as authorized by the Federal Employees Health Benefits law. The address for the Coventry Health Care of Iowa administrative offices is:

Coventry Health Care of Iowa, Inc.

4320 NW 114th St .

Urbandale , Iowa50322

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, 2007, unless those benefits are also shown in this brochure.

OPM negotiates benefits and rates with each plan annually. Benefit changes are effective January 1, 2007, and changes are summarized on page 11.

Plain Language

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

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

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

Stop Health Care Fraud!

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

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

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

- Be wary of giving your plan identification (ID) number over the telephone or to people you do not know, except to your doctor, other provider, or authorized plan or OPM representative.
- Let only the appropriate medical professionals review your medical record or recommend services.
- Avoid using health care providers who say that an item or service is not usually covered, but they know how to bill us to get it paid.
- Carefully review explanations of benefits (EOBs) that you receive from us.

- Do not ask your doctor to make false entries on certificates, bills or records in order to get us to pay for an item or service.
- If you suspect that a provider has charged you for services you did not receive, billed you twice for the same service, or misrepresented any information, do the following:
 - Call the provider and ask for an explanation. There may be an error.
 - If the provider does not resolve the matter, call us at xxx/xxx-xxxx and explain the situation.
 - If we do not resolve the issue:

CALL - THE HEALTH CARE FRAUD HOTLINE

202-418-3300

OR WRITE TO:

United States Office of Personnel Management

Office of the Inspector General Fraud Hotline

1900 E Street NW Room 6400

Washington, DC20415-1100

- 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); o
 - Your child over age 22 (unless he/she is disabled and incapable of self support).
- If you have any questions about the eligibility of a dependent, check with your personnel office if you are employed, 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.
- You can be prosecuted for fraud and your agency may take action against you if you falsify a claim to obtain FEHB benefits or try to obtain services for someone who is not an eligible family member or who is no longer enrolled in the Plan.

Preventing medical mistakes

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

1. Ask questions if you have doubts or concerns.

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

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

- Bring the actual medicines or give your doctor and pharmacist a list of all the medicines that you take, including non-prescription (over-the-counter) medicines.
- Tell them about any drug allergies you have.
- 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.

3. Get the results of any test or procedure.

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

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

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

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

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

Want more information on patient safety?

Ø www.ahrq.gov/consumer/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.

Ø www.npsf.org. The National Patient Safety Foundation has information on how to ensure safer health care for you and your family.

Ø www.talkaboutrx.org The National Council on Patient Information and Education is dedicated to improving communication about the safe, appropriate use of medicines.

Ø www.leapfroggroup.org. The Leapfrog Group is active in promoting safe practices in hospital care.

Ø www.ahqa.org. The American Health Quality Association represents organizations and health care professionals working to improve patient safety.

Ø www.quic.gov/report. Find out what federal agencies are doing to identify threats to patient safety and help prevent mistakes in the nation's health care delivery system.

Section 1 Facts about this plan

The High Option 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 current provider directory. We give you a choice of enrollment in a High Option, or High Deductible Health Plan (HDHP).

HMO's 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/or 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.

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

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

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

General features of our High Deductible Health Plan:

HDHPs have higher annual deductibles and annual out-of-pocket maximum limits than other types of FEHB plans.

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.

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

You are eligible for a Health Savings Account (HSA) if you are enrolled in an HDHP, not covered by any other health plan that is not an HDHP (including a spouse's health plan, but does not include specific injury insurance and accident, disability, dental care, vision care, or long-term care coverage), not eligible for Medicare, 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 10% 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. In addition, 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.

- 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.

- 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, are limited to \$5,000 for Self-Only enrollment, or \$10,000 for family coverage.

We have network providers

Our HMO and HDHP plans offer services through a network. When you use our network providers, you will receive covered services at reduced cost. Coventry Health Care of Iowa, Inc. is solely responsible for the selection of network providers in your area. Contact us for the names of network providers and to verify their continued participation. You can also go to our Web page, which you can reach through the FEHB Web site, www.opm.gov/insure. Contact Coventry Health Care of Iowa, Inc. to request a network provider directory.

In-network benefits apply only when you use a network provider. Provider networks may be more extensive in some areas than others. We cannot guarantee the availability of every specialty in all areas.

How we pay providers

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

Your rights

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

Coventry Health Care of Iowa, Inc. has been in existence from January 1, 2000.

Coventry Health Care of Iowa, Inc. is a for-profit company.

If you want more information about us, call 800-257-4692, or write to 4320 NW 114th St., Urbandale, IA 50322. You may also contact us by fax at 302-283-6786 or visit our Web site at www.chciowa.com.

Service Area

To enroll in this Plan, you must live or work in our Service Area. This is where our network providers practice.

Our Service Area is: Adair, Appanoose, Benton, Black Hawk, Boone, Bremer, Butler, Calhoun, Carroll, Cedar, Cerro Gordo, Chickasaw, Clark, Dallas, Davis, Decatur, Franklin, Greene, Grundy, Guthrie, Hancock, Howard, Iowa, Jasper, Jones, Keokuk, Kossuth, Linn, Lucas, Madison, Marion, Mitchell, Palo Alto, Plymouth, Pocahontas, Polk, Sac, Scott, Story, Sioux, Union, Wayne, Webster, Winnebago, Woodbury, Worth, Warren and Wright counties.

You may also enroll with us if you live in the following counties: Hamilton, Mahaska, Marshall, and Poweshiek.

If you or a covered family member move outside of our service area, you can enroll in another plan. If a dependent lives 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 another plan that has agreements with affiliates in other areas. If you or a family member move, you do not have to wait until Open Season to change plans - contact your employing or retirement office.

Section 2 How we changed for 2007

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

Changes to this Plan

Changes to All Options (HMO and HDHP)

- **We have expanded our service area to include the following Iowa counties:**

Cerro Gordo, Chickasaw, Franklin, Hancock, Howard, Kossuth, Mitchell, Palo Alto, Sioux, Union, Winnebago, Worth, and Wright

Changes to the High Option

- Your share of the non-Postal premium will increase by 8.5% for Self Only and 19.1% for Self and Family.
- Retail prescription drug copayments for up to a 31-day supply are now \$10 per formulary generic drug and brand name insulin; \$20 per formulary brand name drug; and \$45 per non-formulary drug. Previously, the copayments were \$5 per formulary generic drug and brand name insulin; \$15 per formulary brand name drug; and \$30 per non-formulary drug.
- Mail order prescription drug copayments for up to a 93-day supply are now \$20 per formulary generic drug and brand name insulin; \$40 per formulary brand name drug; and \$90 per non-formulary drug. Previously, the copayments were \$10 per formulary generic drug and brand name insulin; \$30 per formulary brand name drug; and \$60 per non-formulary drug.

Changes to the High Deductible Health Plan (HDHP).

Your share of the non-Postal premium will increase by 9.5% for Self Only and increase by 9.7% for Self and Family.

- We have no benefit changes or clarifications.

Section 3 How you get care

Identification cards

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

If you do not receive your ID card within 30 days after the effective date of your enrollment, or if you need replacement cards, call us at 800-257-4692 or write to us at 4320 114th St., Urbandale, Iowa 50322. You may also request replacement cards through our Web site: www.chciowa.com.

Where you get covered care

You get care from “Plan providers” and “Plan facilities.” You will only pay copayments, deductibles, and/or coinsurance, and you will not have to file claims if you are on the HMO plan. If you are on the HDHP, you may have to file claims if you receive services from a non-plan provider. You will also have to pay the entire amount for the services.

- **Network providers and facilities**

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.

What you must do to get covered care

- **Primary care**

You and each family member do not need to choose a Primary Care Physician to arrange your health care services. However, you must always seek care through our participating network physicians, unless you have plan approval.

- **Specialty care**

Here are some things you should know about specialty care:

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, 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 FEHP 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, contract 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 90 days.

- **Hospital care**

If you are hospitalized when your enrollment begins.

Your Plan 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 in the hospital when your enrollment in our Plan begins, call our customer service department immediately at 800-257-4692. If you are new to the FEHB Program, we will arrange for you to receive care and reimburse you for your covered expenses 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; or
- The day your benefits from your former plan runs out; or
- The 92nd day after you become a member of this Plan, whichever happens first.

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

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.

- **Services requiring our prior approval**

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

We call this review the prior approval process. Your physician must obtain prior approval for the following services: Hospital Inpatient Admissions, Outpatient Surgeries, Home Health Care, Home Infusion Services, Durable Medical Equipment, Outpatient Therapies (Physical, Occupational, and Speech), Growth Hormone Therapy, and any Out of Network Services.

Section 4 Your costs for covered services

You must share the costs of some services. You are responsible for:

Copayments

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

HMO Option:

Example: When you see your physician you pay a copayment of \$15 per visit and when you go in the hospital, you pay \$100 per day, \$300 maximum per admission.

HDHP Option:

Example: When you see a physician for preventive services you pay a copayment of \$20 per visit.

Deductible

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

HMO Option: We have no deductible on our HMO option.

HDHP Option: The calendar year deductible is \$1,100 per person. Under a family enrollment, the deductible is considered satisfied and benefits are payable for all family members when the combined covered expenses applied to the calendar year deductible for family members reach \$2,200.

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

And, 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.

HMO Option: Example: You pay 50% of our allowance for infertility services.

HDHP Option: Example: You pay 50% of our allowance for infertility services.

Note: If your provider routinely waives (does not require you to pay) your copayments, deductibles, or coinsurance, the provider is misstating the fee and may be violating the law. In this case, when we calculate our share, we will reduce the provider's fee by the amount waived.

For example, if your physician ordinarily charges \$100 for a service but routinely waives your 10% coinsurance, the actual charge is \$90. We will pay \$81 (90% of the actual charge of \$90).

Your catastrophic protection out-of-pocket maximum

HMO Option: After your coinsurance total \$750 per person or \$1,500 per family enrollment in any calendar year, you do not have to pay any more for covered services. However, copayments for the following services do not count toward your catastrophic protection out-of-pocket maximum, and you must continue to pay copayments for these services:

- Pharmacy Benefits
- Office Visits
- Inpatient Copayments

HDHP Option: After your deductible and coinsurance 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.

Be sure to keep accurate records of your coinsurance and/or deductible amounts as you are responsible for informing us when you reach the maximum.

Differences between our allowance and the bill

HDHP Option: In-network providers agree to limit what they will bill you. Because of that, when you use a network provider, your share of covered charges consists only of your deductible and coinsurance or copayment. Here is an example about coinsurance: You see a network physician who charges \$150, but our allowance is \$100. If you have met your deductible, you are only responsible for your coinsurance. That is, you pay just – \$10 of our \$100 allowance. Because of the agreement, your network physician will not bill you for the \$50 difference between our allowance and his bill.

EXAMPLE	In-network physician	Out-of-network physician
Physician's charge	\$150	N/A
Our allowance	We set it at: 100	N/A
We pay	90% of our allowance: 90	N/A
You owe: Coinsurance	10% of our allowance: 10	N/A
+Difference up to charge?	No: 0	N/A
TOTAL YOU PAY	\$10	N/A

HDHP Option: Out-of-network providers – we have no out of network benefit.

Section 5 High Option Benefits

Note: This benefits section is divided into subsections. Please read the important things you should keep in mind at the beginning of each subsection. Also read the General Exclusions in Section 7; they apply to the benefits in the following subsections. To obtain claim forms, claims filing advice, or more information about our benefits, contact us at 800-257-4692 or at our Web site at www.chciowa.com.

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

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan physicians must provide or arrange your care.
- A facility copay applies to services that appear in this section but are performed in an ambulatory surgical center or the outpatient department of a hospital.
- We have no calendar year deductible.
- 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 <ul style="list-style-type: none"> • In physician’s office • Office medical consultations 	\$15 per office visit
Professional services of physicians <ul style="list-style-type: none"> • In an urgent care center • During a hospital stay • In a skilled nursing facility • Second surgical opinion 	Nothing
At home	\$15 per House Call by a Physician
Lab, X-ray and other diagnostic tests	
Tests, such as: <ul style="list-style-type: none"> • Blood tests • Urinalysis • Non-routine Pap tests • Pathology • X-rays • Non-routine mammograms • CAT Scans/MRI • Ultrasound • Electrocardiogram and EEG 	Nothing if you receive these services during your office visit; otherwise, \$15 per office visit

Benefit Description	You pay
Preventive care, adult	
Routine screenings, such as: <ul style="list-style-type: none"> • Total Blood Cholesterol • Colorectal Cancer Screening, including • Fecal occult blood test • Sigmoidoscopy, screening – every five years starting at age 50 • Double contrast barium enema – every five years starting at age 50 • Colonoscopy screening – every ten years starting at age 50 	\$15 per office visit
Routine Prostate Specific Antigen (PSA) test – one annually for men age 40 and older	\$15 per office visit
Routine Pap test Note: The office visit is covered if pap test is received on the same day; see <i>Diagnosis and Treatment</i> , above.	\$15 per office visit
Routine mammogram – covered for women age 35 and older, as follows: <ul style="list-style-type: none"> • 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 	\$15 per office visit
Routine immunizations, limited to: <ul style="list-style-type: none"> • Tetanus-diphtheria (Td) booster – once every 10 years, ages 19 and over (except as provided for under Childhood immunizations) • Influenza vaccine, annually • Pneumococcal vaccine, age 65 and older 	\$15 per office visit
<i>Not covered: Physical exams required for obtaining or continuing employment or insurance, attending schools or camp, or travel.</i>	<i>All charges.</i>
Preventive care, children	
<ul style="list-style-type: none"> • Childhood immunizations recommended by the American Academy of Pediatrics 	\$15 per office visit
<ul style="list-style-type: none"> • Well-child care charges for routine examinations, immunizations and care (up to age 22) • Examinations, such as: <ul style="list-style-type: none"> - Eye exams through age 17 to determine the need for vision correction - Ear exams through age 17 to determine the need for hearing correction 	\$15 per office visit

Preventive care, children - continued on next page

Benefit Description	You pay
Preventive care, children (cont.)	
<ul style="list-style-type: none"> - Examinations done on the day of immunizations (up to age 22) 	\$15 per office visit
Maternity care	
<p>Complete maternity (obstetrical) care, such as:</p> <ul style="list-style-type: none"> • Prenatal care • Delivery • Postnatal care <p>Note: Here are some things to keep in mind:</p> <ul style="list-style-type: none"> • You do not need to precertify your normal delivery; see page 13 for other circumstances, such as extended stays for you or your baby. • You may remain in the hospital up to 48 hours after a regular delivery and 96 hours after a cesarean delivery. We will extend your inpatient stay if medically necessary. • We cover routine nursery care of the newborn child during the covered portion of the mother’s maternity stay. We will cover other care of an infant who requires non-routine treatment only if we cover the infant under a Self and Family enrollment. • We pay hospitalization and surgeon services (delivery) the same as for illness and injury. See Hospital benefits (Section 5c) and Surgery benefits (Section 5b). 	\$50 at the time of delivery; nothing there after
<i>Not covered: Routine sonograms to determine fetal age, size or sex.</i>	<i>All charges.</i>
Family planning	
<p>A range of voluntary family planning services, limited to:</p> <ul style="list-style-type: none"> • Voluntary sterilization (See Surgical procedures Section 5 (b)) • Surgically implanted contraceptives • Injectable contraceptive drugs (such as Depo provera) • Intrauterine devices (IUDs) • Diaphragms <p>Note: We cover oral contraceptives under the prescription drug benefit.</p>	\$15 per office visit
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Reversal of voluntary surgical sterilization</i> • <i>Genetic counseling</i> 	<i>All charges.</i>

Benefit Description	You pay
Infertility services	
<p>Diagnosis and treatment of infertility such as:</p> <ul style="list-style-type: none"> • Artificial insemination: • intravaginal insemination (IVI) • intracervical insemination (ICI) • intrauterine insemination (IUI) • Injectable Fertility drugs <p>Note: We cover injectable fertility drugs under medical benefits and oral fertility drugs under the prescription drug benefit.</p>	50% of allowable charges
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Assisted reproductive technology (ART) procedures, such as:</i> • <i>in vitro fertilization</i> • <i>embryo transfer, gamete intra-fallopian transfer (GIFT) and zygote intra-fallopian transfer (ZIFT)</i> • <i>Services and supplies related to ART procedures</i> • <i>Cost of donor sperm</i> • <i>Cost of donor egg.</i> 	<i>All charges.</i>
Allergy care	
<ul style="list-style-type: none"> • Testing and treatment • Allergy injections 	\$15 per office visit
Allergy Serum	Nothing
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Provocative food testing</i> • <i>Sublingual allergy desensitization</i> 	<i>All charges.</i>
Treatment therapies	
<ul style="list-style-type: none"> • Chemotherapy and radiation therapy <p>Note: High dose chemotherapy in association with autologous bone marrow transplants is limited to those transplants listed under Organ/Tissue Transplants on page 28.</p> <ul style="list-style-type: none"> • Respiratory and inhalation therapy • Dialysis – hemodialysis and peritoneal dialysis • Intravenous (IV)/Infusion Therapy – Home IV and antibiotic therapy • Growth hormone therapy (GHT) <p>Note: Growth hormone is covered under the prescription drug benefit.</p>	\$15 per office visit

Treatment therapies - continued on next page

Benefit Description	You pay
Treatment therapies (cont.)	
<p>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; otherwise, we will only cover GHT services from the date you submit the information. If you do not ask or if we determine GHT is not medically necessary, we will not cover the GHT or related services and supplies. See <i>Services requiring our prior approval</i> in Section 3.</p>	\$15 per office visit
Physical and occupational therapies	
<p>60 days per condition for the services of the following:</p> <ul style="list-style-type: none"> • qualified physical therapists and • occupational therapists <p>Note: These services are covered when determined by the plan to be medically necessary.</p> <p>Cardiac rehabilitation following a heart transplant, bypass surgery or a myocardial infarction is provided for up to 60 days.</p>	<p>\$15 per visit</p> <p>Nothing per visit during covered inpatient admission</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Long-term rehabilitative therapy</i> • <i>Exercise programs</i> 	<i>All charges.</i>
Speech therapy	
<p>60 days per condition</p> <p>Note: These services are covered when determined by the plan to be medically necessary.</p>	<p>\$15 per visit</p> <p>Nothing per visit during covered inpatient admission.</p>
Hearing services (testing, treatment, and supplies)	
<ul style="list-style-type: none"> • First hearing aid and testing only when necessitated by accidental injury • Hearing testing for children through age 17, which include; (see <i>Preventive care, children</i>) 	\$15 per office visit
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>All other hearing testing</i> • <i>Hearing aids, testing and examinations for them</i> • <i>Cochlear implants</i> 	<i>All charges.</i>

Benefit Description	You pay
Vision services (testing, treatment, and supplies)	
<p>Annual eye refraction (which includes the written lens prescription) may be obtained from Plan Providers.</p> <ul style="list-style-type: none"> • Eye exam to determine the need for vision correction • Annual eye refractions <p>Note: See <i>Preventive care, children</i> for eye exams for children.</p>	<p>Nothing to Optometrist; \$15 per office visit to and Ophthalmologist</p>
<p>First pair of corrective lenses when medically necessary following an impairment directly caused by accidental ocular injury or intraocular surgery (such as cataracts).</p>	<p>20% of allowable charges</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Eyeglasses or contact lenses, except as shown above</i> • <i>Eye exercises and orthoptics</i> • <i>Radial keratotomy and other refractive surgery</i> 	<p><i>All charges.</i></p>
Foot care	
<p>Routine foot care when you are under active treatment for a metabolic or peripheral vascular disease, such as diabetes.</p> <p>Note: See Orthopedic and prosthetic devices for information on podiatric shoe inserts.</p>	<p>\$15 per office visit</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>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</i> • <i>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)</i> 	<p><i>All charges.</i></p>
Orthopedic and prosthetic devices	
<ul style="list-style-type: none"> • Artificial limbs and eyes; stump hose • Externally worn breast prostheses and surgical bras, including necessary replacements following a mastectomy • Internal prosthetic devices , such as artificial joints, pacemakers, cochlear implants, and surgically implanted breast implant following mastectomy. <p>Note: See 5(b) for coverage of the surgery to insert the device.</p>	<p>20% of allowable charges</p>

Orthopedic and prosthetic devices - continued on next page

Benefit Description	You pay
Orthopedic and prosthetic devices (cont.)	
<ul style="list-style-type: none"> Internal prosthetic devices, such as artificial joints, pacemakers, cochlear implants, and surgically implanted breast implant following mastectomy. Note: Internal prosthetic devices are paid as hospital benefits; see Section 5(c) for payment information. Insertion of the device is paid as surgery; see Section 5(b) for coverage of the surgery to insert the device. Corrective orthopedic appliances for non-dental treatment of temporomandibular joint (TMJ) pain dysfunction syndrome. 	20% of allowable charges
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <i>Orthopedic and corrective shoes</i> <i>Arch supports</i> <i>Foot orthotics</i> <i>Heel pads and heel cups</i> <i>Lumbosacral supports</i> <i>Corsets, trusses, elastic stockings, support hose, and other supportive devices</i> <i>Prosthetic replacements provided less than 3 years after the last one we covered</i> 	<i>All charges</i>
Durable medical equipment (DME)	
<p>We cover rental or purchase of durable medical equipment, at our option, including repair and adjustment. Covered items include:</p> <ul style="list-style-type: none"> Oxygen; Dialysis equipment; Manual Hospital beds; Manual Wheelchairs; Crutches; Walkers; Blood glucose monitors; and Insulin pumps. 	20% of allowable charges
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <i>Motorized wheelchairs</i> <i>Convenience items or exercise equipment</i> 	<i>All charges.</i>

Benefit Description	You pay
Home health services	
<ul style="list-style-type: none"> • 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.), licensed vocational nurse (L.V.N.), or home health aide. • Services include oxygen therapy, intravenous therapy and medications. <p>Note: We cover self-administered injectables under the prescription drug benefit.</p>	Nothing
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Nursing care requested by, or for the convenience of, the patient or the patient's family;</i> • <i>Home care primarily for personal assistance that does not include a medical component and is not diagnostic, therapeutic, or rehabilitative.</i> 	<i>All charges.</i>
Chiropractic	
<p>20 visits per year</p> <ul style="list-style-type: none"> • Manipulation of the spine and extremities • Adjunctive procedures such as ultrasound, electrical muscle stimulation, vibratory therapy, and cold pack application 	\$15 per office visit
Alternative treatments	
<i>No benefit</i>	<i>All charges.</i>
Educational classes and programs	
<p>Coverage is limited to:</p> <ul style="list-style-type: none"> • Smoking cessation - Up to \$100 for one smoking cessation program per member per lifetime, including related expenses such as some drugs (over-the-counter products excluded). • Diabetes self management 	Varying cost; call us at 800-257-4692 for benefit cost, restrictions and guidelines.

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.
- We have no calendar year deductible.
- 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 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 OF 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
Surgical procedures	
<p>A comprehensive range of services, such as:</p> <ul style="list-style-type: none"> • 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 <i>Reconstructive surgery</i>) • Surgical treatment of morbid obesity (bariatric surgery) – -The patient is an adult (≥ 18 years of age) with morbid obesity that has persisted for at least 3 years, and for which there is no treatable metabolic cause for the obesity; • There is presence of morbid obesity, defined as a body mass index (BMI) exceeding 40, or greater than 35 with documented co-morbid conditions (cardiopulmonary problems e.g., severe apnea, Pickwickian Syndrome, and obesity-related cardiomyopathy, severe diabetes mellitus, hypertension, or arthritis). (BMI is calculated by dividing a patient’s weight (in kilograms) by height (in meters) squared. To convert pounds to kilograms, multiply pounds by 0.45. To convert inches to multiply inches by .0254); 	<p>\$15 per office visit; nothing as an inpatient</p>

Surgical procedures - continued on next page

Benefit Description	You pay
Surgical procedures (cont.)	
<ul style="list-style-type: none"> • The patient has failed to lose weight (approximately 10% from baseline) or has regained weight • meters, multiply inches by .0254); • The patient has failed to lose weight (approximately 10% from baseline) or has regained weight despite participation in a three month physician-supervised multidisciplinary program within the past six months that included dietary therapy, physical activity and behavior therapy and support; • The patient has been evaluated for restrictive lung disease and received surgical clearance by a pulmonologist, if clinically indicated; has received cardiac clearance by a cardiologist if there is a history of prior phen-fen or redux use, and the patient has agreed, following surgery, to participate in a multidisciplinary program that will provide guidance on diet, physical activity and social support; and, • The patient has completed a psychological evaluation and has been recommended for bariatric surgery by a licensed mental health professional (this must be documented in the patient’s medical record) and the patient’s medical record reflects documentation by the treating psychotherapist that all psychosocial issues have been identified and addressed; and the psychotherapist indicates that the patient is likely to be compliant with the post-operative diet restrictions; • Voluntary sterilization (e.g., Tubal ligation, Vasectomy) • Treatment of burns 	<p>\$15 per office visit; nothing as an inpatient</p>
<p>Insertion of internal prosthetic devices. See 5(a) – Orthopedic and prosthetic devices for device coverage information</p> <p>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.</p>	<p>40% of allowable charges</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Reversal of voluntary sterilization</i> • <i>Routine treatment of conditions of the foot; see Foot care</i> 	<p><i>All Charges.</i></p>

Benefit Description	You pay
Reconstructive surgery	
<ul style="list-style-type: none"> • Surgery to correct a functional defect • Surgery to correct a condition caused by injury or illness if <ul style="list-style-type: none"> - the condition produced a major effect on the member's appearance and - the condition can reasonably be expected to be corrected by such surgery • Surgery to correct a condition that existed at or from birth and is a significant deviation from the common form or norm. Examples of congenital anomalies are: protruding ear deformities; cleft lip; cleft palate; birth marks; webbed fingers; and webbed toes. • All stages of breast reconstruction surgery following a mastectomy, such as: <ul style="list-style-type: none"> - 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) <p>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.</p>	<p>\$15 per office visit; nothing as an inpatient</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>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</i> • <i>Surgeries related to sex transformation</i> 	<p><i>All Charges.</i></p>
Oral and maxillofacial surgery	
<p>Oral surgical procedures, limited to:</p> <ul style="list-style-type: none"> • 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. 	<p>\$15 per office visit</p>

Oral and maxillofacial surgery - continued on next page

Benefit Description	You pay
Oral and maxillofacial surgery (cont.)	
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • Oral implants and transplants • Procedures that involve the teeth or their supporting structures (such as the periodontal membrane, gingiva, and alveolar bone) 	<p><i>All charges.</i></p>
Organ/tissue transplants	
<p>Solid organ transplants limited to:</p> <ul style="list-style-type: none"> • Cornea • Heart • Heart/lung • Single, double or lobar lung • Kidney • Liver • Pancreas • <u>Autologous pancreas islet cell transplant (as an adjunct to total or near total pancreatectomy) only for patients with chronic pancreatitis</u> • Intestinal transplants <ul style="list-style-type: none"> - Small intestine - Small intestine with the liver - Small intestine with multiple organs, such as the liver, stomach, and pancreas 	<p>Nothing</p>
<p>Blood or marrow stem cell transplants limited to the stages of the following diagnoses: (the medical necessity limitation is considered satisfied if the patient meets the staging description.)</p> <p>Allogeneic transplants for</p> <ul style="list-style-type: none"> • Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia • Advanced Hodgkin’s lymphoma • Advanced non-Hodgkin’s lymphoma • Chronic myelogenous leukemia • Severe combined immunodeficiency • Severe or very severe aplastic anemia <p>Autologous transplant for</p> <ul style="list-style-type: none"> • Acute lymphocytic or nonlymphocytic (i.e., myelogenous) leukemia • Advanced Hodgkin’s lymphoma • Advanced non-Hodgkin’s lymphoma • Advanced neuroblastoma 	<p>Nothing</p>

Organ/tissue transplants - continued on next page

Benefit Description	You pay
Organ/tissue transplants (cont.)	
<p>Autologous tandem transplants for recurrent germ cell tumors (including testicular cancer)</p> <p>Blood or marrow stem cell transplants limited to the staages of the following diagnoses: (The medical necessity limitation is considered satisfied if the patient meets the staging description.)</p> <p>Allogeneic transplants for</p> <ul style="list-style-type: none"> • <u>Phagocytic deficiency diseases (e.g., Wiskott-Aldrich syndrome)</u> <p>Autologous transplants for</p> <ul style="list-style-type: none"> • Multiple myeloma • Testicular, mediastinal, retroperitoneal, and ovarian germ cell tumors • Breast cancer- may be limited to clinical trials • Epithelial ovarian cancer-may be limited to clinical trails 	<p>Nothing</p>
<p>Blood or marrow stem cell transplants covered only in a National Cancer Institute or National Institute of Health approved clinical trial or a Plan-designed center of excellence and if approved by the Plan's medical director in accordance with the Plan's protocols for:</p> <ul style="list-style-type: none"> • Allogeneic transplants for: • Chronic lymphocytic leukemia • Early statge (indolent or non-advanced) small cell lymphocytic lymphoma • Multiple myeloma • Nonmyeloablative allogeneic transplants for • Acute lymphocytic or non-lymphocytic (i.e. myelogeneous) leukemia • Advanced Hodgkin's lymphoma • Advanced non-Hodgkin's lymphoma • Chronic lymphocytic leukemia • Chronic myelogeneous leukemia • Early stage (indolent or non-advanced) small cell lymphocytic lymphoma • Autologous transplants for: • Chronic lymphocytic leukemia • Chronic myelogenous leukemia • Early stage (indolent or non advanced) small cell lymphocytic lymphoma 	<p>Nothing</p>

Organ/tissue transplants - continued on next page

Benefit Description	You pay
Organ/tissue transplants (cont.)	
<p>Note: We cover related medical and hospital expenses of the donor when we cover the recipient.</p> <p>Note: If the recipient resides more than 150 miles from the transplant facility: Reimbursement for travel may be authorized.</p> <p>Lodging for one family member or one responsible adult may be authorized.</p> <p>Lifetime limitation for travel and lodging as determined by Coventry Health Care of Iowa, Inc. and reviewed annually.</p>	Nothing
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Donor screening tests and donor search expenses, except those performed for the actual donor</i> • <i>Implants of artificial organs</i> • <i>Transplants not listed as covered</i> 	<i>All Charges</i>
Anesthesia	
<p>Professional services provided in –</p> <ul style="list-style-type: none"> • Hospital (inpatient) 	Nothing
<p>Professional services provided in –</p> <ul style="list-style-type: none"> • Hospital outpatient department • Skilled nursing facility • Ambulatory surgical center • Office 	Nothing

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.
- We have no calendar year deductible.
- 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 OF 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 <ul style="list-style-type: none"> • Ward, semiprivate, or intensive care accommodations; • General nursing care; and • 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.	\$100 per day up to a \$300 maximum per admission
Other hospital services and supplies, such as: <ul style="list-style-type: none"> • 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 	\$100 per day up to a \$300 maximum per admission
<ul style="list-style-type: none"> • Anesthetics, including nurse anesthetist services • Take-home items Note: We cover hospital services and supplies related to dental procedures when necessitated by non-dental physical impairment. We do not cover the dental procedure.	\$100 per day up to a \$300 maximum per admission
Not covered: <ul style="list-style-type: none"> • 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.)	
<ul style="list-style-type: none"> • <i>Personal comfort items, such as telephone, television, barber services, guest meals and beds</i> • <i>Private nursing care</i> 	<i>All Charges</i>
Outpatient hospital or ambulatory surgical center	
<ul style="list-style-type: none"> • 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 <p>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.</p>	Nothing
<i>Not covered: Blood and blood derivatives not replaced by the member</i>	<i>All charges.</i>
Extended care benefits/Skilled nursing care facility benefits	
<p>Extended care benefit: We cover a comprehensive range of benefits up to 62 days per calendar year when full-time skilled nursing is necessary and confinement in a skilled nursing facility is medically appropriate as determined by a plan doctor and approved by the plan.</p>	Nothing
Hospice care	
<p>Supportive and palliative care for a terminally ill member is covered in the home or hospice facility. Services include inpatient and outpatient care and family counseling; these services are provided under the direction of the plan doctor who certifies that the patient is in the terminal stages of illness, with a life expectancy of approximately six months or less.</p>	Nothing
<i>Not covered: Independent nursing, homemaker services</i>	<i>All Charges</i>

Benefit Description	You pay
Ambulance	
Local professional ambulance service when medically appropriate	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 have no calendar year deductible.

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:

Emergencies within our service area: If you are in an emergency situation, please contact your doctor. In extreme emergencies, if you are unable to contact your doctor, 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 must notify your doctor as soon as possible and/or contact the Plan within 48 hours of the emergency room visit. It is your responsibility to ensure that the Plan has been timely notified.

If you need to be hospitalized, the plan must be notified within 48 hours or on the first working day following your admission, unless it is not reasonably possible to notify the Plan within 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 and any ambulance charges are covered in full.

Benefits are available for care from non-Plan providers 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, a follow-up care recommended by non-Plan providers must be approved by the Plan.

The Plan pays reasonable charges for emergency services to the extent the services would have been covered if received from Plan providers. You pay \$50 copayment or 50% of the covered charges, whichever is less, per hospital emergency room visit or \$30 copayment per urgent care center visit for emergency services which are covered benefits of this Plan. The copayment or coinsurance will be waived if you are admitted as a result of your condition.

Emergencies outside our service area: Benefits are available for any medically necessary health service that is immediately required because of injury or unforeseen illness. **If you need to be hospitalized, you or a family member must notify the Plan within 48 hours or on the first working day following your admission, unless it was not reasonably possible to notify the Plan within that time.** If a Plan doctor believes that care can be better provided in a Plan hospital, you will be transferred when medically feasible with any ambulance charges covered in full.

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

The Plan pays reasonable charges for emergency services to the extent the services would have been covered if received from Plan providers. You pay a \$50 copayment or 50% of covered charges, whichever is less, per hospital emergency room visit for emergency services received at a non-Plan facility or doctor’s office or urgent care center. The copayment or coinsurance will be waived if you are admitted to the hospital as a result of your condition.

Benefit Description	You pay After the calendar year deductible...
Emergency within our service area	
Emergency care at a doctor's office	\$15 per office visit
Emergency care at an urgent care center	\$30 per Urgent care visit
Emergency care as an outpatient at a hospital , including doctors' services	\$50 per visit or 50% of allowable charges, whichever is less
<i>Not covered: Elective care or non-emergency care</i>	<i>All Charges.</i>
Emergency outside our service area	
<ul style="list-style-type: none"> • Emergency care at a doctor's office • Emergency care at an urgent care center • Emergency care as an outpatient at a hospital, including doctors' services 	\$50 per visit or 50% of allowable charges, whichever is less
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Elective care or non-emergency care</i> • <i>Emergency care provided outside the service area if the need for care could have been foreseen before leaving the service area</i> • <i>Medical and hospital costs resulting from a normal full-term delivery of a baby outside the service area</i> 	<i>All Charges.</i>
Ambulance	
<p>Professional ambulance service when medically appropriate.</p> <p>Note: Air ambulance covered only when medically necessary.</p> <p>Note: For non-emergency service refer to that section.</p>	Nothing

Section 5(e) Mental health and substance abuse benefits

When you get our approval for services and follow a treatment plan we approve, cost-sharing and limitations for Plan mental health and substance abuse benefits will be 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.
- We have no calendar year deductible.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

YOU MUST GET PREAUTHORIZATION OF THESE SERVICES. See the instructions after the benefits description below.

Benefit Description	You pay
Mental health and substance abuse benefits	
<p>All diagnostic and treatment services recommended by a Plan provider and contained in a treatment plan that we approve. The treatment plan may include services, drugs, and supplies described elsewhere in this brochure.</p> <p>Note: Plan 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.</p>	<p>Your cost sharing responsibilities are no greater than for other illnesses or conditions.</p>
<ul style="list-style-type: none"> • Professional services, including individual or group therapy by providers such as psychiatrists, psychologists, or clinical social workers • Medication management 	<p>\$15 per visit</p>
<p>Diagnostic test</p> <ul style="list-style-type: none"> • Services provided by a hospital or other facility • Services in approved alternative care settings such as partial hospitalization, half-way house, residential treatment, full-day hospitalization, facility based intensive outpatient treatment 	<p>Nothing, if you receive these services during your office visit; otherwise \$15 per office visit.</p>
<p><i>Not covered: Services we have not approved.</i></p> <p><i>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.</i></p>	<p><i>All Charges.</i></p>

Preauthorization

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

All mental conditions/substance abuse services are coordinated by American Psych Systems (APS). To access your mental conditions/substance abuse benefits, call APS directly at 800-752-7242.

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.
- 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 have no calendar year deductible.

Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works. Also read Section 10 about coordinating benefits with other coverage, including with Medicare.

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

- **Who can write your prescription.** A licensed physician must write the prescription .
- **Where you can obtain them.** You may fill the prescription at a Plan pharmacy, or by mail for a maintenance medication
- **We have an open formulary.** If your physician believes a name brand product is necessary or there is no generic available, your physician may prescribe a name brand drug from a formulary list. This list of name brand drugs is a preferred list of drugs that we selected to meet patient needs at a lower cost. To order a prescription drug brochure, call 800-257-4692
- **Prior Authorizations.** Some drugs require Prior Authorization in order for them to be a Covered Service. These prescriptions include, but are no limited to, those that are not suggested for first-line therapy, may require special tests before starting them, or have limited approval for use. These drugs requiring prior authorization are identified in our formulary with a "PA" next to the name. The list of the drugs are posted on the website, www.chciowa.com. Before you can fill a prescription order or refill for a drug requiring Prior Authoirzation the member must obtain approval from us.
- **These are the dispensing limitations.**One copayment is due each time a prescription is filled or refilled up to a thirty-one (31) day supply. Maintenance drugs obtained through a mail order pharmacy designated by the Plan, may be dispensed with two (2) copayments for up to a ninety-three (93) day supply. Drugs that are not listed on the maintenance listing are not eligible for the mail order program
- **A generic equivalent will be dispensed if it is available,** unless your physician specifically requires a name brand. If you receive a name brand drug when a Federally-approved generic drug is available, and your physician has not specified Dispense as Written for the name brand drug, you have to pay the difference in cost between the name brand drug and the generic.

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 cost you – and us – less than a name brand prescription.

When you do have to file a claim. Plan pharmacies will submit you claim for you

Benefit Description	You pay
Covered medications and supplies	
<p>We cover the following medications and supplies prescribed by a Plan physician and obtained from a Plan pharmacy or through our mail order program:</p> <ul style="list-style-type: none"> • Drugs and medicines that by Federal law of the United States require a physician’s prescription for their purchase, except those listed as <i>Not covered</i>. • Insulin - One copayment per vial • Disposable needles and syringes for the administration of covered medications • Maintenance Drugs • Drugs for sexual dysfunction are limited to four tablets per month. Prior approval is required by the Plan (See Prior Authoirzation) • Contraceptive drugs and devices • Medication used for maintenance of Mutiple Sclerosis require prior authroization • Growth hormone 	<p>Retail Pharmacy (31-day supply)</p> <p>\$10 per formulary generic drug and brand name insulin</p> <p>\$20 per formulary brand name drug</p> <p>\$45 per non-formulary drug</p> <p>Mial Order maintenance medications only (93-day supply)</p> <p>\$20 per formulary generic drug and brand name insulin</p> <p>\$40 per formulary brand name drug</p> <p>\$90 per non-formulary drug</p> <p>Note: If there is no generic equivalent available, you will still have to pay the brand name copay</p>
<ul style="list-style-type: none"> • Oral fertility drugs- See page for coverage of Norplant implementation and removal • Self administered injectables 	<p>50% of charges</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Drugs and supplies for cosmetic purposes</i> • <i>Drugs to enhance athletic performance</i> • <i>Drugs obtained at a non-Plan pharmacy; except for out-of-area emergencies</i> • <i>Vitamins, nutrients and food supplements even if a physician prescribes or administers them</i> • <i>Nonprescription medicines</i> 	<p><i>All Charges.</i></p>

Section 5(g) Special features

Feature	Description
Flexible benefits option	<p>Under the flexible benefits option, we determine the most effective way to provide services.</p> <ul style="list-style-type: none"> • We may identify medically appropriate alternatives to traditional care and coordinate other benefits as a less costly alternative benefit. • Alternative benefits are subject to our ongoing review. • By approving an alternative benefit, we cannot guarantee you will get it in the future. • The decision to offer an alternative benefit is solely ours, and we may withdraw it at any time and resume regular contract benefits. • Our decision to offer or withdraw alternative benefits is not subject to OPM review under the disputed claims process.
Services for deaf and hearing impaired	877-843-1942, Extension 6979
High risk pregnancies	Members identified as having high risk pregnancies will be assigned to a nurse within our organization who will work with them to monitor their care.
Centers of Excellence	Coventry Health Care of Iowa, Inc utilizes a network of centers of excellence for transplant care.
Travel benefit/services overseas	Anytime you are outside of the service area, you and your covered dependents are always covered for true emergency situations.

Section 5(h) 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
- Plan dentists must provide or arrange your care.
- We have no calendar year deductible.
- 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 10 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.	20% of allowable charges
Dental benefits	
We have no other dental benefits.	<i>All charges.</i>

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Summary of benefits for the HDHP Option - 200792

Section 6(a) Preventive care

Important things you should keep in mind about these preventive care benefits:

- The Plan pays 100% for the preventive care services listed in this Section after you pay \$20 copay for primary care doctor visit or \$30 copayment for specialist visit.
- For all other covered expenses, please see Traditional Medical Coverage.
- 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.

Benefit Description	You pay
Preventive care, adult	
Professional services, such as: <ul style="list-style-type: none"> • Routine physicals • Routine screenings • Routine immunizations 	\$20 per primary care physicans office; \$30 per specialist office visit
<i>Not covered:</i> <ul style="list-style-type: none"> • <i>Physical exams required for obtaining or continuing employment or insurance, attending schools or camp, athletic exams or travel.</i> • Immunizations, boosters, and medications for travel or work-related exposure. 	<i>All Charges.</i>
Preventive care, children	
<ul style="list-style-type: none"> • Professional services, such as: • Well-child visits for routine examinations, immunizations and care (up to age 22) • 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 	\$20 per primary care physicians office; \$30 per specialists office visit
<i>Not covered:</i> <ul style="list-style-type: none"> • <i>Physical exams required for obtaining or continuing employment or insurance, attending schools or camp, or travel.</i> • <i>Immunizations, boosters, and medications for travel.</i> 	<i>All Charges.</i>

Section 6(b) 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% after you pay \$20 per primary doctor's office visit or \$30 per specialist's office visit and is not subject to the calendar year deductible.
- We have no out-of-network benefits
- The deductible is \$1,100 per person or \$2,200 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.
- 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 \$5000 per person or \$10000 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).
- Be sure to read Section 4, Your costs for covered services, for valuable information about how cost sharing works. Also read Section 10 about coordinating benefits with other coverage, including with Medicare.

Benefit Description	You pay After the calendar year deductible...
Deductible before Traditional medical coverage begins	
The deductible applies to almost all benefits in this Section. In the You pay column, we say "No deductible" when it does not apply. When you receive covered services from network providers, you are responsible for paying the allowable charges until you meet the deductible.	100% of allowable charges until you meet the deductible of \$1,100 per person or \$2,200 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 6(c) 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 \$1100 for Self Only enrollment and \$2200 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 copayments for eligible medical expenses and prescriptions.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

Benefit Description	You pay After the calendar year deductible...
Diagnostic and treatment services	
Professional services of physicians <ul style="list-style-type: none"> • In physician’s office • In an urgent care center • During a hospital stay • In a skilled nursing facility 	\$20 per primary care physicians office; \$30 per specialist office visit
Lab, X-ray and other diagnostic tests	
Tests, such as: <ul style="list-style-type: none"> • Blood tests • Urinalysis • Pathology • X-rays • Non-routine mammograms • CAT Scans/MRI • Ultrasound • Electrocardiogram and EEG 	\$20 per primary care physicians office; \$30 per specialists office visit
Maternity care	
Complete maternity (obstetrical) care, such as: <ul style="list-style-type: none"> • Prenatal care • Delivery • Postnatal care <p>Note: Here are some things to keep in mind:</p>	10% of the Plan allowance

Maternity care - continued on next page

Benefit Description	You pay After the calendar year deductible...
Maternity care (cont.)	
<ul style="list-style-type: none"> You do not need to precertify your normal delivery; see page xx for other circumstances, such as extended stays for you or your baby. You may remain in the hospital up to 48 hours after a regular delivery and 96 hours after a cesarean delivery. We will cover an extended inpatient stay if medically necessary but you, your representatives, your doctor, or your hospital must recertify the extended stay. We cover routine nursery care of the newborn child during the covered portion of the mother’s maternity stay. We will cover other care of an infant who requires non-routine treatment only if we cover the infant under a Self and Family enrollment. Surgical benefits, not maternity benefits, apply to circumcision. We pay hospitalization and surgeon services (delivery) the same as for illness and injury. See <i>Hospital benefits</i> (Section 5c) and <i>Surgery benefits</i> (Section 5b). 	10% of the Plan allowance
<p>Not covered: Routine sonograms to determine fetal age, size, or sex.</p>	All charges
Family planning	
<p>A range of voluntary family planning services, limited to:</p> <ul style="list-style-type: none"> Voluntary sterilization (See Surgical procedures Section 5 (b)) Surgically implanted contraceptive s Injectable contraceptive drugs (such as Depo provera) Intrauterine devices (IUDs) Diaphragms <p>Note: We cover oral contraceptives under the prescription drug benefit.</p>	50% of the Plan allowance
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <i>Reversal of voluntary surgical sterilization</i> <i>Genetic counseling.</i> 	<i>All Charges.</i>

Benefit Description	You pay After the calendar year deductible...
Infertility services	
<p>Diagnosis and treatment of infertility such as:</p> <ul style="list-style-type: none"> • Artificial insemination: <ul style="list-style-type: none"> - intravaginal insemination (IVI) - intracervical insemination (ICI) - intrauterine insemination (IUI) • Injectable Fertility drugs <p>Note: We cover injectable fertility drugs under medical benefits and oral fertility drugs under the prescription drug benefit.</p>	50% of the Plan allowance
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Infertility services after voluntary sterilization</i> • <i>Assisted reproductive technology (ART) procedures, such as:</i> <ul style="list-style-type: none"> - <i>in vitro fertilization</i> - <i>embryo transfer, gamete intra-fallopian transfer (GIFT) and zygote intra-fallopian transfer (ZIFT)</i> • <i>Services and supplies related to ART procedures</i> • <i>Cost of donor sperm</i> • <i>Cost of donor egg.</i> 	<i>All Charges.</i>
Allergy care	
<ul style="list-style-type: none"> • Testing and treatment • Allergy injections 	\$20 per primary care physician office visit; \$30 per specialist office visit.
Allergy serum	Nothing
<i>Not covered: Proactive food testing and sublingual allergy desensitization</i>	<i>All Charges.</i>
Treatment therapies	
<ul style="list-style-type: none"> • Chemotherapy and radiation therapy <p>Note: High dose chemotherapy in association with autologous bone marrow transplants is limited to those transplants listed under Organ/Tissue Transplants on page 57.</p> <ul style="list-style-type: none"> • Respiratory and inhalation therapy • Dialysis – hemodialysis and peritoneal dialysis • Intravenous (IV)/Infusion Therapy – Home IV and antibiotic therapy • Growth hormone therapy (GHT) 	In-network: \$20 per visit at a primary care physicians office, and \$30 copayment per visit at a specialists office.

Treatment therapies - continued on next page

Benefit Description	You pay After the calendar year deductible...
Treatment therapies (cont.)	
<p>Note: – We only cover GHT for medically necessary conditions when we preauthorized the treatment. Such authorizations must be obtained by having your physician contact our Health Service Department at 1-800-470-6352. See services requiring our prior approval in section 3.</p>	<p>In-network: \$20 per visit at a primary care physicians office, and \$30 copayment per visit at a specialists office.</p>
Physical and occupational therapies	
<p>60 days per condition for the following services:</p> <ul style="list-style-type: none"> • qualified physical therapists and • occupational therapists <p>Note: These services are covered when determined by the plan to be medically necessary.</p>	<p>10% of the Plan allowance</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Long-term rehabilitative therapy</i> • <i>Exercise programs</i> 	<p><i>All Charges.</i></p>
Speech therapy	
<p>60 days per condition</p> <p>Note: These services are covered when determined by the plan to be medically necessary.</p>	<p>10% of the Plan allowance</p>
Pulmonary and cardiac rehabilitation	
<p>60 days per condition</p> <p>Note: These services are covered when determined by the plan to be medically necessary.</p>	<p>10% of the Plan allowance</p>
Hearing services (testing, treatment, and supplies)	
<ul style="list-style-type: none"> • First hearing aid and testing only when necessitated by accidental injury • Hearing exams for children through age 17 (see <i>Preventive care, children</i>) 	<p>10% of the Plan allowance</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>All other hearing testing</i> • <i>Hearing aids, testing and examinations for them</i> • <i>Cochlear implants</i> 	<p><i>All Charges.</i></p>

Benefit Description	You pay After the calendar year deductible...
Vision services (testing, treatment, and supplies)	
<ul style="list-style-type: none"> • First pair of eyeglasses or contact lenses to correct an impairment directly caused by accidental ocular injury or intraocular surgery (such as for cataracts) • Annual eye refractions <p>Note: See Preventative care, children for eye exams for children under age 17</p>	10% of the Plan allowance
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Eyeglasses or contact lenses, except as shown above</i> • <i>Eye exercises and orthoptics</i> • <i>Radial keratotomy and other refractive surgery</i> 	<i>All Charges.</i>
Foot care	
<p>Routine foot care when you are under active treatment for a metabolic or peripheral vascular disease, such as diabetes.</p>	10% of the Plan allowance
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>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</i> • <i>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)</i> 	<i>All Charges.</i>
Orthopedic and prosthetic devices	
<ul style="list-style-type: none"> • Artificial limbs and eyes; stump hose • Externally worn breast prostheses and surgical bras, including necessary replacements following a mastectomy • Internal prosthetic devices, such as artificial joints, pacemakers, cochlear implants, and surgically implanted breast implant following mastectomy. Note: See 5(b) for coverage of the surgery to insert the device. • Corrective orthopedic appliances for non-dental treatment of temporomandibular joint (TMJ) pain dysfunction syndrome 	10% of Plan allowance
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Orthopedic and corrective shoes</i> • <i>Arch supports</i> 	<i>All Charges.</i>

Orthopedic and prosthetic devices - continued on next page

Benefit Description	You pay After the calendar year deductible...
Orthopedic and prosthetic devices (cont.)	
<ul style="list-style-type: none"> • <i>Foot orthotics</i> • <i>Heel pads and heel cups</i> • <i>Lumbosacral supports</i> • <i>Corsets, trusses, elastic stockings, support hose, and other supportive devices</i> • <i>Prosthetic replacements provided less than {X} years after the last one we covered</i> 	<i>All Charges.</i>
Durable medical equipment (DME)	
<p>We cover rental or purchase of durable medical equipment, at our option, including repair and adjustment. Covered items include:</p> <ul style="list-style-type: none"> • Oxygen; • Dialysis equipment; • Manual Hospital beds; • Manual Wheelchairs; • Crutches; • Walkers; • Blood glucose monitors; and • Insulin pumps. <p>Note: All purchases over \$100 and rentals require prior authorization or payment is denied</p>	10% of the Plan allowance
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Motorized wheelchairs</i> • <i>Convenience items or exercise equipment</i> 	<i>All Charges.</i>
Home health services	
<ul style="list-style-type: none"> • 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. 	10% of the Plan allowance
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Nursing care requested by, or for the convenience of, the patient or the patient's family;</i> • <i>Home care primarily for personal assistance that does not include a medical component and is not diagnostic, therapeutic, or rehabilitative.</i> 	<i>All Charges.</i>

Benefit Description	You pay After the calendar year deductible...
Chiropractic	
20 visits per year <ul style="list-style-type: none"> • Manipulation of the spine and extremities • Adjunctive procedures such as ultrasound, electrical muscle stimulation, vibratory therapy, and cold pack application 	10% of the Plan allowance
Alternative treatments	
No benefit	<i>All charges</i>
Educational classes and programs	
Coverage is limited to: <ul style="list-style-type: none"> • Diabetes self management • Smoking cessation - Up to \$100 for one smoking cessation program per member per lifetime, including related expenses such as some drugs (over-the-counter products are excluded) <p>Note: Call us at 1-800-257-4692 for benefit restrictions and guidelines</p>	10% of the Plan allowance

Section 6(d) Surgical and anesthesia services provided by physicians and other health care professionals

YOUR PHYSICIAN MUST GET PRECERTIFICATION OF SOME SURGICAL PROCEDURES. Please refer to the precertification information shown in Section 3 to be sure which services require precertification and identify which surgeries require precertification.

Benefit Description	You pay After the calendar year deductible...
Surgical procedures	
<p>A comprehensive range of services, such as:</p> <ul style="list-style-type: none"> • 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 <i>Reconstructive surgery</i>) • Surgical treatment of morbid obesity (bariatric surgery) <p>The patient is an adult (≥ 18 years of age) with morbid obesity that has persisted for at least 3 years, and for which there is no treatable metabolic cause for the obesity;</p> <ul style="list-style-type: none"> • There is presence of morbid obesity, defined as a body mass index (BMI) exceeding 40, or greater than 35 with documented co-morbid conditions (cardiopulmonary problems e.g., severe apnea, Pickwickian Syndrome, and obesity-related cardiomyopathy, severe diabetes mellitus, hypertension, or arthritis). (BMI is calculated by dividing a patient’s weight (in kilograms) by height (in meters) squared. To convert pounds to kilograms, multiply pounds by 0.45. To convert inches to meters, multiply inches by .0254); • The patient has failed to lose weight (approximately 10% from baseline) or has regained weight despite participation in a three month physician-supervised multidisciplinary program within the past six months that included dietary therapy, physical activity and behavior therapy and support; 	<p>10% of the Plan allowance</p>

Surgical procedures - continued on next page

Benefit Description	You pay After the calendar year deductible...
Surgical procedures (cont.)	
<ul style="list-style-type: none"> • The patient has been evaluated for restrictive lung disease and received surgical clearance by a pulmonologist, if clinically indicated; has received cardiac clearance by a cardiologist if there is a history of prior phen-fen or redux use, and the patient has agreed, following surgery, to participate in a multidisciplinary program that will provide guidance on diet, physical activity and social support; and, • The patient has completed a psychological evaluation and has been recommended for bariatric surgery by a licensed mental health professional (this must be documented in the patient’s medical record) and the patient’s medical record reflects documentation by the treating psychotherapist that all psychosocial issues have been identified and addressed; and the psychotherapist indicates that the patient is likely to be compliant with the post-operative diet restrictions; • Insertion of internal prosthetic devices . See 5(a) <i>Orthopedic and prosthetic devices</i> for device coverage information • Voluntary sterilization (e.g., tubal ligation, vasectomy) • Treatment of burns <p>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.</p>	<p>10% of the Plan allowance</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Reversal of voluntary sterilization</i> • <i>Routine treatment of conditions of the foot; see Foot care</i> 	<p><i>All Charges.</i></p>
Reconstructive surgery	
<ul style="list-style-type: none"> • Surgery to correct a functional defect • Surgery to correct a condition caused by injury or illness if: <ul style="list-style-type: none"> - the condition produced a major effect on the member’s appearance and - the condition can reasonably be expected to be corrected by such surgery 	<p>10% of the Plan allowance</p>

Reconstructive surgery - continued on next page

Benefit Description	You pay After the calendar year deductible...
Reconstructive surgery (cont.)	
<ul style="list-style-type: none"> • Surgery to correct a condition that existed at or from birth and is a significant deviation from the common form or norm. Examples of congenital anomalies are: protruding ear deformities; cleft lip; cleft palate; birth marks; and webbed fingers and toes. • All stages of breast reconstruction surgery following a mastectomy, such as: <ul style="list-style-type: none"> - 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) <p>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.</p>	10% of the Plan allowance
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>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</i> • <i>Surgeries related to sex transformation</i> 	<i>All Charges.</i>
Oral and maxillofacial surgery	
<p>Oral surgical procedures, limited to:</p> <ul style="list-style-type: none"> • 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. • Surgical treatment of temporomandibular joint (TMJ) syndrome 	10% of the Plan allowance
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Oral implants and transplants</i> • <i>Procedures that involve the teeth or their supporting structures (such as the periodontal membrane, gingiva, and alveolar bone)</i> 	<i>All Charges.</i>

Benefit Description	You pay After the calendar year deductible...
Organ/tissue transplants	
<p>Solid organ transplants limited to:</p> <ul style="list-style-type: none"> • Cornea • Heart • Heart/lung • Single, double or lobar lung • Kidney • Liver • Pancreas • <u>Autologous pancreas islet cell transplant (as an adjunct to total or near total pancreatectomy) only for patients with chronic pancreatitis</u> • Intestinal transplants <ul style="list-style-type: none"> - Small intestine - Small intestine with the liver - Small intestine with multiple organs, such as the liver, stomach, and pancreas 	<p>10% of the Plan allowance</p>
<p>Blood or marrow stem cell transplants limited to the stages of the following diagnoses and are not subject to medical necessity or experimental/investigational review:</p> <ul style="list-style-type: none"> • Allogeneic transplants for <ul style="list-style-type: none"> - Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia - Advanced Hodgkin’s lymphoma - Advanced non-Hodgkin’s lymphoma - Chronic myelogenous leukemia - Severe combined immunodeficiency - Severe or very severe aplastic anemia • Allogeneic transplant for <ul style="list-style-type: none"> - Acute lymphocytic or nonlymphocytic (i.e., myelogenous) leukemia - Advanced Hodgkin’s lymphoma - Advanced non-Hodgkin’s lymphoma - Advanced neuroblastoma • Autologous tandem transplants for recurrent germ cell tumors (including testicular cancer) <p>Blood or marrow stem cell transplants for</p> <ul style="list-style-type: none"> • Allogeneic transplants for <ul style="list-style-type: none"> - <u>Phagocytic deficiency diseases (e.g., Wiskott-Aldrich syndrome)</u> 	<p>10% of Plan allowance</p>

Organ/tissue transplants - continued on next page

Benefit Description	You pay After the calendar year deductible...
Organ/tissue transplants (cont.)	
<p>Autologous transplants for</p> <ul style="list-style-type: none"> - Multiple myeloma - Testicular, mediastinal, retroperitoneal, and ovarian germ cell tumors - Breast cancer - Epithelial ovarian cancer 	10 of Plan allowance
<p>Blood or marrow stem cell transplants covered only in a National Cancer Institute or National Institutes of Health approved clinical trial at a Plan-designated center of excellence and if approved by the Plan's medical director in accordance with the Plan's protocols for:</p> <ul style="list-style-type: none"> • <u>Allogeneic transplants for</u> <ul style="list-style-type: none"> - <u>Chronic lymphocytic leukemia</u> - <u>Early stage (indolent or non-advanced) small cell lymphocytic lymphoma</u> - <u>Multiple myeloma</u> • <u>Nonmyeloablative allogeneic transplants for</u> <ul style="list-style-type: none"> - <u>Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia</u> - <u>Advanced forms of myelodysplastic syndromes</u> - <u>Advanced Hodgkin's lymphoma</u> - <u>Advanced non-Hodgkin's lymphoma</u> - <u>Chronic lymphocytic leukemia</u> - <u>Chronic myelogenous leukemia</u> - <u>Early stage (indolent or non-advanced) small cell lymphocytic lymphoma</u> • Autologous transplants for: <ul style="list-style-type: none"> - Chronic Lymphocytic leukemia - Chronic myelogenous leukemia - Early stage (indolent or non advanced) small cell lymphocytic lymphoma <p>Note: We cover related medical and hospital expenses of the donor when we cover the recipient.</p> <p>Note: If the recipient resides more than 150 miles from the transplant facility: reimbursement for travel may be authorized.</p> <p>Lodging for one family member or one responsible adult may be authorized.</p>	10% of Plan allowance

Organ/tissue transplants - continued on next page

Benefit Description	You pay After the calendar year deductible...
Organ/tissue transplants (cont.)	
Lifetime limitaion for travel and lodging as determined by Coventry Health Care of Iowa, Inc. and reviewed annually.	10% of Plan allowance
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Donor screening tests and donor search expenses, except those performed for the actual donor</i> • <i>Implants of artificial organs</i> • <i>Transplants not listed as covered</i> 	<i>All Charges.</i>
Anesthesia	
Professional services provided in – <ul style="list-style-type: none"> • Hospital (inpatient) 	10% of the Plan allowance
Professional services provided in – <ul style="list-style-type: none"> • Hospital outpatient department • Skilled nursing facility • Ambulatory surgical center • Office 	10% of the Plan allowance

**Section 6(e) Services provided by a hospital or other facility,
and ambulance services**

Important things you should keep in mind about these benefits:

- 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 OF HOSPITAL STAYS.** Please refer to Section 3 to be sure which services require precertification.

Benefit Description	You Pay After the calendar year deductible...
Inpatient hospital	
Room and board, such as <ul style="list-style-type: none"> • Ward, semiprivate, or intensive care accommodations; • General nursing care; and • 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.	10% of the Plan allowance
Other hospital services and supplies, such as: <ul style="list-style-type: none"> • Operating, recovery, maternity, and other treatment rooms • Prescribed drugs and medicines • Diagnostic laboratory tests and X-rays • Administration of blood and blood products • Blood or blood plasma, if not donated or replaced • Dressings , splints , casts , and sterile tray services • Medical supplies and equipment, including oxygen • Anesthetics, including nurse anesthetist services • 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.) 	10% of the Plan allowance
<i>Not covered:</i> <ul style="list-style-type: none"> • <i>Custodial care</i> • <i>Non-covered facilities, such as nursing homes, schools</i> • <i>Personal comfort items, such as telephone, television, barber services, guest meals and beds</i> • <i>Private nursing care</i> 	<i>All Charges.</i>

Benefit Description	You Pay After the calendar year deductible...
Outpatient hospital or ambulatory surgical center	
<ul style="list-style-type: none"> • 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 <p>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.</p>	10% of the Plan allowance
<i>Not covered: Blood and blood derivatives not replaced by the member</i>	<i>All Charges.</i>
Extended care benefits/Skilled nursing care facility benefits	
<p>Extended care benefit:</p> <p>We cover a comprehensive range of benefits up to 62 days per calendar year when full-time skilled nursing is necessary and confinement in a skilled nursing facility is medically appropriate as determined by a plan doctor and approved by the plan.</p>	10% if the Plan allowance
<i>Not covered: Custodial care</i>	<i>All charges</i>
Hospice care	
<p>Supportive and palliative care for a terminally ill member is covered in the home or hospice facility. Services include inpatient and outpatient care and family counseling; these services are provided under the direction of the plan doctor who certifies that the patient is in the terminal stages of illness, with a life expectancy of approximately six months or less</p>	10% of the Plan allowance
<i>Not covered: Independent nursing, homemaker services</i>	<i>All charges.</i>

Benefit Description	You Pay After the calendar year deductible...
Ambulance	
Local professional ambulance service when medically appropriate	10% of the Plan allowance

Section 6(f) Emergency services/accidents

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

Emergencies within our service area: *If you are in an emergency situation, please contact your doctor. In extreme emergencies, if you are unable to contact your doctor, 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 must notify your doctor as soon as possible and/or contact the Plan within 48 hours of the emergency room visit. It is your responsibility to ensure that the Plan has been timely notified.

If you need to be hospitalized, the plan must be notified within 48 hours or on the first working day following your admission, unless it is not reasonably possible to notify the Plan within 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 and any ambulance charges are covered in full.

Benefits are available for care from non-Plan providers 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, a follow-up care recommended by non-Plan providers must be approved by the Plan.

The Plan pays reasonable charges for emergency services to the extent the services would have been covered if received from Plan providers. You pay deductible and 10% of the covered charges, per hospital emergency room visit or urgent care center visit for emergency services which are covered benefits of this Plan.

Emergencies outside our service area: Benefits are available for any medically necessary health service that is immediately required because of injury or unforeseen illness. **If you need to be hospitalized, you or a family member must notify the Plan within 48 hours or on the first working day following your admission, unless it was not reasonably possible to notify the Plan within that time.** If a Plan doctor believes that care can be better provided in a Plan hospital, you will be transferred when medically feasible with any ambulance charges covered in full.

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

The Plan pays reasonable charges for emergency services to the extent the services would have been covered if received from Plan providers. You pay deductible and 10% of covered charges, per hospital emergency room visit for emergency services received at a non-Plan facility or doctor's office or urgent care center.

Benefit Description	You pay After the calendar year deductible...
Emergency within our service area	
<ul style="list-style-type: none"> • Emergency care at a doctor’s office • Emergency care at an urgent care center • Emergency care as an outpatient in a hospital, including doctors’ services 	<p>\$20 primary care doctor's office visit; \$30 copayment at a specialist office</p> <p>10% of the Plan allowance</p>
<i>Not covered: Elective care or non-emergency care</i>	<i>All Charges.</i>
Emergency outside our service area	
<ul style="list-style-type: none"> • Emergency care at a doctor’s office • Emergency care at an urgent care center • Emergency care as an outpatient in a hospital, including doctors’ services 	<p>\$20 primary care doctor's office visit; \$30 copayment per visit at a specialists office</p> <p>10% of the Plan allowance</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Elective care or non-emergency care</i> • <i>Emergency care provided outside the service area if the need for care could have been foreseen before leaving the service area</i> • <i>Medical and hospital costs resulting from a normal full-term delivery of a baby outside the service area</i> 	<i>All Charges.</i>
Ambulance	
<p>Professional ambulance service when medically appropriate.</p> <p>Note: Air ambulance covered only when medically necessary</p> <p>Note: Refer to benefits for non emergency services</p>	10% of the Plan allowance

Section 6(g) Mental health and substance abuse benefits

When you get our approval for services and follow a treatment plan we approve, cost-sharing and limitations for Plan mental health and substance abuse benefits will be no greater than for similar benefits for other illnesses and conditions.

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

- 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 \$1,100 for Self Only enrollment and \$2,200 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.
- **YOU MUST GET PREAUTHORIZATION OF THESE SERVICES.** See the instructions after the benefits description below.

Benefit Description	You pay After the calendar year deductible...
Mental health and substance abuse benefits	
<p>When you get our approval for services and follow a treatment plan we approve, cost-sharing and limitations for in-network mental health and substance abuse benefits will be no greater than for similar benefits for other illnesses and conditions.</p> <p>We provide all diagnostic and treatment services recommended by a network provider and contained in a treatment plan that we approve. The treatment plan may include services, drugs, and supplies described elsewhere in this brochure.</p> <p>Note: In-network 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.</p>	<p>Your cost sharing responsibilities are no greater than for other illnesses or conditions.</p>
<ul style="list-style-type: none"> • Professional services, including individual or group therapy by providers such as psychiatrists, psychologists, or clinical social workers • Medication management 	<p>10% of the Plan allowance</p>
<ul style="list-style-type: none"> • Diagnostic tests 	<p>10% of the Plan allowance</p>
<ul style="list-style-type: none"> • Services provided by a hospital or other facility • Services in approved alternative care settings such as partial hospitalization, half-way house, residential treatment, full-day hospitalization, facility based intensive outpatient treatment 	<p>10% of the Plan allowance</p>

Mental health and substance abuse benefits - continued on next page

Benefit Description	You pay After the calendar year deductible...
Mental health and substance abuse benefits (cont.)	
<p><i>Not covered: Services we have not approved.</i></p> <p><i>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.</i></p>	<p><i>All Charges.</i></p>

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

All mental conditions/substance abuse services are coordinated by American Psych Systems (APS). To access your mental conditions/substance abuse benefits, call APS directly at 800-752-7242.

Limitation If you not not obtain an approved treatment plan, no services will be covered.

Section 6(h) 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.
- 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 \$1,100 for Self Only enrollment and \$2,200 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.

- **Who can write your prescription.** A licensed physician must write the prescription
- **Where you can obtain them.** You may fill the prescription at a Plan pharmacy, or by mail for a maintenance prescription. You must fill the prescription at a plan pharmacy, or by mail for a maintenance medication.
- **We have an open formulary.** If your physician believes a name brand product is necessary or there is no generic available, your physician may prescribe a name brand drug from a formulary list. This list of name brand drugs is a preferred list of drugs that we selected to meet patient needs at a lower cost. To order a prescription drug brochure, call 800-257-4692.
- **Prior Authorizations.** Some drugs require Prior Authorization prior in order for them to be Covered Services. These prescriptions include, but are not limited to, those that are not suggested for first-line therapy, may require special tests before starting them, or have limited approval for use. These drugs requiring a prior authorization are identified in our formulary with a “PA” next to the name. The list of the of the drugs are posted on the website, www.chciowa.com. Before you can fill a prescription order or refill for a drug requiring Prior Authorization, the member must obtain approval from us.
- **These are the dispensing limitations.**

One copayment is due each time a prescription is filled ore refilled up to a thirty-one (31) day supply. Maintenance drugs obtained through a mail order pharmacy designated by the Plan, may be dispensed with two (2) copayment for up to a ninety-three (93) day supply. Drugs that are not listed on the maintenance listing are not eligible for the mail order program

A generic equivalent will be dispensed if it is available, unless your physician specifically requires a name brand. If you receive a name brand drug when a Federally-approved generic drug is available, and your physician has not specified Dispense as Written for the name brand drug, you have to pay the difference in cost between the name brand drug and the generic. The difference is between the average wholesale price (AWP) of the brand name prescription and the MAC price of the generic prescription. **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 cost you – and us – less than a name brand prescription.

When you do have to file a claim. Plan pharmacies will submit you claim for you.

Benefit Description	You pay After the calendar year deductible...
<p>Covered medications and supplies</p> <p>We cover the following medications and supplies prescribed by a Plan physician and obtained from a Plan pharmacy or through our mail order program:</p> <ul style="list-style-type: none"> • Drugs and medicines that by Federal law of the United States require a physician’s prescription for their purchase, except those listed as <i>Not covered</i>. • Insulin-one copayment per vial • Disposable needles and syringes for the administration of covered medications • Maintenance drugs • Drugs for sexual dysfunction are limited to four tablets per month. Prior approval is required by the Plan (see Prior authorization) • Contraceptive drugs and devices • Medication used for maintenance of Multiple Sclerosis require prior authorization • Oral fertility drugs – Note: See section 5 (b) for coverage of Norplant implementation and removal. • Growth hormone • Self-administered injectables 	<p>In network</p> <p>Retail Pharmacy (31-day supply)</p> <p>\$10 per formulary generic drug and brand name insulin \$20 per formulary brand name drug \$45 per non-formulary drug</p> <p>Mail Order maintenance medications only (90-day supply)</p> <p>\$20 per formulary generic drug and brand name insulin \$40 per formulary brand name drug</p> <p>Note: Our mail order benefit is limited to the two tiers listed above.</p> <p>Note: If there is no generic equivalent available, you will still have to pay the brand name copay.</p> <p>Out of network: we do not have out of network prescription drug benefits.</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Drugs and supplies for cosmetic purposes</i> • <i>Drugs to enhance athletic performance</i> • <i>Drugs obtained at a non-Plan pharmacy; except for out-of-area emergencies</i> • <i>Vitamins, nutrients and food supplements even if a physician prescribes or administers them</i> • <i>Nonprescription medicines</i> 	<p><i>All charges.</i></p>

Section 6(i) Special features

Feature	Description
Flexible benefits option	<p>Under the flexible benefits option, we determine the most effective way to provide services.</p> <p>We may identify medically appropriate alternatives to traditional care and coordinate other benefits as a less costly alternative benefit.</p> <p>Alternative benefits are subject to our ongoing review.</p> <p>By approving an alternative benefit, we cannot guarantee you will get it in the future.</p> <p>The decision to offer an alternative benefit is solely ours, and we may withdraw it at any time and resume regular contract benefits.</p> <p>Our decision to offer or withdraw alternative benefits is not subject to OPM review under the disputed claims process.</p>
Services for deaf and hearing impaired	1-877-843-1942, Extension 6979
High risk pregnancies	<p>Members identified as having high risk pregnancies will be assigned to a nurse within our organization who will work with them to monitor their care.</p>
Centers of excellence	<p>Coventry Health Care of Iowa, Inc. utilizes a network of centers of excellence for transplant care.</p>
Travel benefit/services overseas	<p>Anytime you are outside of the service area, you and your covered dependents are always covered for true emergency situation.</p>

Section 6(j) 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.
- Plan dentists must provide or arrange your care.
- The deductible is \$1,100 for Self Only enrollment and \$2,200 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.
- 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 After the calendar year deductible...
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.	10% of Plan allowance
Dental benefits	
We have no other dental benefits.	<i>All charges.</i>

Section 6(k) Savings – HSAs and HRAs

Feature Comparison	Health Savings Account (HSA)	Health Reimbursement Arrangement (HRA) Provided when you are ineligible for an HSA
Administrator	<p>The Plan will establish an HSA for you with Corporate Benefit Services of America (CBSA), this HDHP’s fiduciary (an administrator, trustee or custodian as defined by Federal tax code and approved by IRS.)</p> <p>Corporate Benefit Services of American (CBSA) P.O. Box 270520 Golden Valley, MN55427 800-566-9311</p>	<p>CBSA is the HRA fiduciary for this Plan.</p> <p>Corporate Benefit Services of American (CBSA) P.O. Box 270520 Golden Valley, MN55427 800-566-9311</p>
Fees	Set-up fee is paid by the HDHP.	None.
Eligibility	<p>You must:</p> <ul style="list-style-type: none"> • 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 Part A or Part B • Not be claimed as a dependent on someone else’s tax return • Must not have received VA benefits in the last three months • Complete and return all banking paperwork. <p>Eligibility for contributions is determined on the first day of the month following your effective date of enrollment.</p>	<p>You must enroll in this HDHP.</p> <p>Eligibility is determined on the first day of the month following your effective day of enrollment and will be prorated for length of enrollment.</p>
Funding	<p>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.</p>	<p>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.</p>
<ul style="list-style-type: none"> • Self Only enrollment 	<p>For 2007, a monthly premium pass through of \$500 will be made by the HDHP directly into your HSA each month.</p>	<p>For 2007, your HRA annual credit is \$500 (prorated for length of enrollment).</p>
<ul style="list-style-type: none"> • Self and Family enrollment 	<p>For 2007, a monthly premium pass through of \$1000 will be made by the HDHP directly into your HSA each month.</p>	<p>For 2007, your HRA annual credit is \$1000 (prorated for length of enrollment).</p>

Section 6(l) Health education resources and account management tools

Special features	Description
<p>Health education resources</p>	<p>We publish an e-newsletter to keep you informed on a variety of issues related to your good health. Visit our Web site at www.chciowa.com for the <i>Living Well newsletter</i>.</p> <p>Visit the “Member” tab on our Web site at www.chciowa.com for information on:</p> <p>General health topics</p> <p>Links to health care news</p> <p>Cancer and other specific diseases</p> <p>Drugs/medication interactions</p> <p>Kids’ health</p> <p>Patient safety information</p> <p>and several helpful Web site links.</p>
<p>Account management tools</p>	<p>For each HSA and HRA account holder, we maintain a complete claims payment history online through https://services.cbsainc.com/eehome.asp.</p> <p>Your balance will also be shown on your explanation of benefits (EOB) form.</p> <p>You will receive an EOB after every claim.</p> <p>If you have an HSA,</p> <ul style="list-style-type: none"> • You will receive a <i>quarterly statement from CBSA</i> outlining your account balance and activity for the month. • You may also access your account on-line at https://services.cbsainc.com/eehome.asp. <p>If you have an HRA,</p> <ul style="list-style-type: none"> • Your HRA balance will be available online through https://services.cbsainc.com/eehome.asp • Your balance will also be shown on your EOB form.
<p>Consumer choice information</p>	<p>As a member of this HDHP, you may choose any network provider. Our provider search function on our website (www.chciowa.com) is updated every month. It lets you easily search for a participating physician based on the criteria You choose, such as provider specialty, gender, secondary languages spoken, or hospital affiliation.</p> <p>You can even specify the maximum distance you’re willing to travel and, in most instances, get driving direction and a map to the offices of identified providers.</p> <p>Pricing information for medical care is available at www.chciowa.com.</p> <p>Pricing information for prescription drugs is available through our link to the website of our pharmacy benefit manager, Caremark, which you can assess via www.chciowa.com.</p> <p>Educational materials on the topics of HSAs, HRAs and HDHPs are available at www.chciowa.com</p>

Care support	<p>Our complex case management programs offer special assistance to members with intricate, long term medical needs. Our disease management program fosters a proactive approach to managing care from prevention through treatment and management. Your physician can help arranged for participation in these programs, or you can simply contact our member service department.</p> <p>Patient safety information is available online at www.chciowa.com.</p> <p>Care support is also available to you, in the form of a relationship that we have established with the <i>College of American Pathologists</i> for e-mail reminder notifications. We'll send a message to the e-mail address you provide on a scheduled basis, reminding you to arrange for screening tests.</p>
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Section 7 General exclusions – things we don't cover

The exclusions in this section apply to all benefits. **Although we may list a specific service as a benefit, we will not cover it unless your Plan doctor determines it is medically necessary to prevent, diagnose, or treat your illness, disease, injury, or condition.**

We do not cover the following:

- Care by non-plan providers except for authorized referrals or emergencies (see *Emergency services/accidents*);
- Services, drugs, or supplies you receive while you are not enrolled in this Plan;
- Services, drugs, or supplies not medically necessary;
- Services, drugs, or supplies not required according to accepted standards of medical, dental, or psychiatric practice;
- Experimental or investigational procedures, treatments, drugs or devices;
- Services, drugs, or supplies related to abortions, except when the life of the mother would be endangered if the fetus were carried to term, or when the pregnancy is the result of an act of rape or incest;
- Services, drugs, or supplies related to sex transformations;
- Services, drugs, or supplies you receive from a provider or facility barred from the FEHB Program; or
- Services, drugs, or supplies you receive without charge while in active military service.

Section 8 Filing a claim for covered services

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

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

How to claim benefits

To obtain claim forms or other claims filing advice or answers about our benefits, contact us at 800-257-4692, or at our Web site at www.chciowa.com

In most cases, providers and facilities file claims for you. Your physician must file on the form HCFA-1500, Health Insurance Claim Form. Your facility must file on the UB-92 form. For claims questions and assistance, call us at 800-257-4692

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

- Covered member’s name 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; and
- 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 Iowa, Inc.*

P.O. Box 7709

London , KY40742

Prescription drugs

In most cases, participating pharmacies will file the claims for you. However, if you should need to file a claim for reimbursement (if you have to obtain a prescription out of the area), receipts should be itemized and show:

- Covered member’s name and ID number;
- Name and address of the dispensing pharmacy;
- Date the prescription was obtained; and
- Receipt reflecting that you paid for your prescription

Submit your claims to: *Caremark, Inc.*

P.O. Box 686005

San Antonio , TX78268-6005

Records

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

Deadline for filing your claim

Send us all the documents for your claim as soon as possible. You must submit the claim by December 31 of the year after the year you received the service, unless timely filing was prevented by administrative operations of Government or legal incapacity, provided the claim was submitted as soon as reasonably possible.

When we need more information

Please reply promptly when we ask for additional information. We may delay processing or deny benefits for your claim if you do not respond.

Section 9 The disputed claims process

Follow this Federal Employees Health Benefits Program disputed claims process if you disagree with our decision on your claim or request for services, drugs, or supplies – including a request for preauthorization/prior approval . 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 4320 114th St., Urbandale, Iowa 50322 ; and
 - c) Include a statement about why you believe our initial decision was wrong, based on specific benefit provisions in this brochure; and
 - d) Include copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms.

- 2** We have 30 days from the date we receive your request to:
 - a) Pay the claim (or, if applicable, arrange for the health care provider to give you the care); or
 - b) Write to you and maintain our denial - go to step 4; or
 - c) Ask you or your provider for more information. If we ask your provider, we will send you a copy of our request—go to step 3.

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

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

We will write to you with our decision.

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

You must write to OPM within

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

Write to OPM at: United States Office of Personnel Management, Insurance Services Programs, Health Insurance Group x, 1900 E Street, NW, Washington, DC 20415-xxxx.

Send OPM the following information:

- A statement about why you believe our decision was wrong, based on specific benefit provisions in this brochure;
- Copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms;
- Copies of all letters you sent to us about the claim;
- Copies of all letters we sent to you about the claim; and
- Your daytime phone number and the best time to call.

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

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

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

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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

- a) We haven't responded yet to your initial request for care or preauthorization/prior approval, then call us at 800-257-4692 and we will expedite our review; or
- b) We denied your initial request for care or preauthorization/prior approval, then:
 - If we expedite our review and maintain our denial, we will inform OPM so that they can give your claim expedited treatment too, or
 - You may call OPM's Health Insurance Group 3 at 202/606-0737 between 8 a.m. and 5 p.m. eastern time.

Section 10 Coordinating benefits with other coverage

When you have other health coverage

You must tell us if you or a covered family member have coverage under any other health plan or have automobile insurance that pays health care expenses without regard to fault. This is called “double coverage.”

When you have double coverage, one plan normally pays its benefits in full as the primary payer and the other plan pays a reduced benefit as the secondary payer. We, like other insurers, determine which coverage is primary according to the National Association of Insurance Commissioners’ guidelines.

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

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

What is Medicare?

Medicare is a Health Insurance Program for:

- People 65 years of age or older;
- Some people with disabilities under 65 years of age; and
- 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 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 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 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. Some things are not covered under Original Medicare, such as most prescription drugs (but coverage through private prescription drug plans will be available starting in 2006).

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 payer, we process the claim first.

When Original Medicare is the primary payer, Medicare processes your claim first. In most cases, your claim will be coordinated automatically and we will then provide secondary benefits for covered charges. You will not need to do anything. To find out if you need to do something to file your claim, call us at 800-257-4692 or see our Web site at chciowa.com.

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

- **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) or at www.medicare.gov.

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

This Plan and another plan's Medicare Advantage plan: You may enroll in another plan's Medicare Advantage plan and also remain enrolled in our FEHB plan. We will still provide benefits when your Medicare Advantage plan is primary, even out of the Medicare Advantage plan's network and/or service area (if you use our Plan providers), 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.

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 payer, we process the claim first. If you enroll in Medicare Part D and we are the secondary payer, 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 payer. The following chart illustrates whether Medicare or this Plan should be the primary payer for you according to your employment status and other factors determined by Medicare. It is critical that you tell us if you or a covered family member has Medicare coverage so we can administer these requirements correctly.

Primary Payer Chart		
A. When you - or your covered spouse - are age 65 or over and have Medicare and you?	The primary payer for the individual with Medicare is?	
	Medicare	This Plan
1) Have FEHB coverage on your own as an active employee or through your spouse who is an active employee		✓
2) Have FEHB coverage on your own as an annuitant or through your spouse who is an annuitant	✓	
3) Are a reemployed annuitant with the Federal government and your position is excluded from the FEHB (your employing office will know if this is the case) and you are not covered under FEHB through your spouse under #1 above	✓	
4) Are a reemployed annuitant with the Federal government and your position is not excluded from the FEHB (your employing office will know if this is the case) and • You have FEHB coverage on your own or through your spouse who is also an active employee		✓
• You have FEHB coverage through your spouse who is an annuitant	✓	
5) Are a Federal judge who retired under title 28, U.S.C., or a Tax Court judge who retired under Section 7447 of title 26, U.S.C. (or if your covered spouse is this type of judge) and you are not covered under FEHB through your spouse under #1 above	✓	
6) Are enrolled in Part B only, regardless of your employment status	✓ for Part B services	✓ for other services
7) Are a former Federal employee receiving Workers' Compensation and the Office of Workers' Compensation Programs has determined that you are unable to return to duty	✓ *	
B. When you or a covered family member?		
1) Have Medicare solely based on end stage renal disease (ESRD) and • It is within the first 30 months of eligibility for 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 payer before eligibility due to ESRD		✓ for 30-month coordination period
• Medicare was the primary payer before eligibility due to ESRD	✓	
C. When either you or 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.

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

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

Medicaid

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

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

**When other Government
agencies are responsible
for your care**

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

**When others are
responsible for injuries**

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

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

Section 11 Definitions of terms we use in this brochure

Calendar year	January 1 through December 31 of the same year. For new enrollees, the calendar year begins on the effective date of their enrollment and ends on December 31 of the same year.
Coinsurance	Coinsurance is the percentage of our allowance that you must pay for your care. You may also be responsible for additional amounts. See page 14.
Copayment	A copayment is a fixed amount of money you pay when you receive covered services. See page 14.
Covered services	Care we provide benefits for, as described in this brochure.
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 14
Experimental or investigational service	<p>Any treatment, procedure, facility, equipment, drug or drug usage, device or supply that is not accepted as standard medical practice by the general medical community or us, or does not have Federal government agency approval for its use or application.</p> <p>The Plan's experimental/investigational determination process is based on authoritative information obtained from medical literature, medical consensus bodies, health care standards, database searches, evidence from national medical organizations, State and Federal government agencies and research organizations. The review and approval process for medical policies and clinical practice guidelines includes clinical input from doctors with specialty expertise in the subject.</p>
Medical necessity	A service or supply for prevention, diagnosis, or treatment that as determined by us, is, consistent with the illness or injury and is consistent with the approved, and generally accepted medical or surgical practice.
Plan allowance	<p>Our Plan allowance is the amount we use to determine our payment and your coinsurance for covered services. Providers that participate with us agree to accept our Plan allowance as payment in full, minus any copayment or coinsurance.</p> <p>For more information, see <i>Differences between our allowance and the bill</i> in Section 4.</p>
Us/We	Us and We refer to Coventry Health Care of Iowa, Inc.
You	You refers to the enrollee and each covered family member.

Section 12 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.

Where you can get information about enrolling in the FEHB Program

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

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

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

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

We don't determine who is eligible for coverage and, in most cases, cannot change your enrollment status without information from your employing or retirement office.

Types of coverage available for you and your family

Self Only coverage is for you alone. Self and Family coverage is for you, your spouse, and your unmarried dependent children under age 22, including any foster children or stepchildren your employing or retirement office authorizes coverage for. Under certain circumstances, you may also continue coverage for a disabled child 22 years of age or older who is incapable of self-support.

If you have a Self Only enrollment, you may change to a Self and Family enrollment if you marry, give birth, or add a child to your family. You may change your enrollment 31 days before to 60 days after that event. The Self and Family enrollment begins on the first day of the pay period in which the child is born or becomes an eligible family member. When you change to Self and Family because you marry, the change is effective on the first day of the pay period that begins after your employing office receives your enrollment form; benefits will not be available to your spouse until you marry.

Your employing or retirement office will **not** notify you when a family member is no longer eligible to receive benefits, nor will we. Please tell us immediately when you add or remove family members from your coverage for any reason, including divorce, or when your child under age 22 marries or turns 22.

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

Children's Equity Act

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

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

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

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

When benefits and premiums start

The benefits in this brochure are effective 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 2007 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 2006 benefits until the effective date of your coverage with your new plan. Annuitants' coverage and premiums begin on January 1. If you joined at any other time during the year, your employing office will tell you the effective date of coverage.

When you retire

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

When you lose benefits

When FEHB coverage ends

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

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

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

Upon divorce

If you are divorced from a Federal employee or annuitant, you may not continue to get benefits under your former spouse's enrollment. This is the case even when the court has ordered your former spouse to provide health coverage 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 Employees Health Benefits Plans for Temporary Continuation of Coverage and Former Spouse Enrollees*, or other information about your coverage choices. You can also download the guide from OPM's Web site, www.opm.gov/insure.

Temporary Continuation of Coverage (TCC)

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

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

Enrolling in TCC. Get the RI 79-27, which describes TCC, and the RI 70-5, the *Guide to Federal Employees Health Benefits Plans for Temporary Continuation of Coverage and Former Spouse Enrollees*, from your employing or retirement office or from www.opm.gov/insure. It explains what you have to do to enroll.

Converting to individual coverage

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

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

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

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

Getting a Certificate of Group Health Plan Coverage

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

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

Section 13 Three Federal Programs complement FEHB benefits

Important information

OPM wants to be sure you are aware of three Federal programs that complement the FEHB Program.

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

Second, the **Federal Flexible Spending Account Program**, also known as **FSAFEDS**, lets you set aside pre-tax money to pay for health and dependent care expenses. The result can be a discount of 20% to more than 40% on services you routinely pay for out-of-pocket.

Third, the new **Federal Employees Dental and Vision Insurance Program (FEDVIP)**, offers a variety of dental plans and vision plans to anyone who is eligible to enroll in the Federal Employees Health Benefits Program. Under **FEDVIP** you may choose self only, self plus one, or self and family coverage for yourself and any qualified dependents. Premiums are on an enrollee-pays-all basis

The Federal Long Term Care Insurance Program – *FLTCIP*

It's important protection

Why should you consider applying for coverage under the **Federal Long Term Care Insurance Program(FLTCIP)**?

- **FEHB plans do not cover the cost of long term care.** Also called “custodial care,” 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. The need for long term care can strike anyone at any age and the cost of care can be substantial.
- **The Federal Long Term Care Insurance Program can help protect you from the potentially high cost of long term care.** This coverage gives you options regarding the type of care you receive and where you receive it. With FLTCIP coverage, you won't have to worry about relying on your loved ones to provide or pay for your care.
- **It's to your advantage to apply sooner rather than later.** In order to qualify for coverage under the FLTCIP, you must apply and pass a medical screening (called underwriting). Certain medical conditions, or combinations of conditions, will prevent some people from being approved for coverage. By applying while you're in good health, you could avoid the risk of having a future change in your health disqualify you from obtaining coverage. Also, the younger you are when you apply, the lower your premiums.
- **You don't have to wait for an open season to apply.** The Federal Long Term Care Insurance Program accepts applications from eligible persons at any time. You will have to complete a full underwriting application, which asks a number of questions about your health. However, if you are a new or newly eligible employee, you (and your spouse, if applicable) have a limited opportunity to apply using the abbreviated underwriting application, which asks fewer questions. Newly married spouses of employees also have a limited opportunity to apply using abbreviated underwriting.
- **Qualified relatives are also eligible to apply.** Qualified relatives include spouses and adult children of employees and annuitants, and parents, parents-in-law, and stepparents of employees.

To request an Information Kit and application. Call 1-800-LTC-FEDS (1-800-582-3337) (TTY 1-800-843-3557) or visit www.ltcfeds.com.

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.

There are four three types of FSAs offered by FSAFEDS. The Each type has a minimum annual election of \$250 and a maximum annual election is of \$5,000. per year.

- **Health Care FSA (HCFSA)** –Pays for eligible health care expenses for you and your dependents which are not covered or reimbursed by FEHBP coverage or other insurance.
- **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 dependents, which are not covered or reimbursed, by FEHBP or FEDVIP coverage or other insurance.
- **Dependent Care FSA (DCFSA)** – Pays for eligible dependent care expenses that allow you (and your spouse if married) to work, look for work (as long as you have earned income for the year), or attend school full-time.

What expenses can I pay with an FSAFEDS account?

For the HCFSA – Health plan copayments, deductibles, over-the-counter medications and products, sunscreen, eyeglasses, contacts, other vision and dental expenses (but not insurance premiums).

For the LEX HCFSA– Dental and vision care expenses including eligible over-the-counter medicines and products related to dental and vision care (but not insurance premiums).

For the DCFSA – Daycare expenses (including summer camp) for your child(ren) under age 13, dependent care expenses for dependents unable to care for themselves.

AND MUCH MORE! Visit www.FSAFEDS.com

Who is eligible to enroll?

Most Federal employees in the Executive branch and many in non-Executive branch agencies are eligible. For specifics on eligibility, 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., EST. TTY: 1-800-952-0450.

When can I enroll?

If you wish to participate, you must make an election to enroll each year by visiting www.FSAFEDS.com or calling the number above during the FEHB Open Season or within 60 days of employment (for new employees).

Even if you enrolled for 2006, you must make a new election to continue participating in 2007. Enrollment DOES NOT carry over from year to year.

Who is SHPS?

SHPS is the Third Party Administrator hired by OPM to manage the FSAFEDS Program. SHPS is responsible for enrollment, claims processing, customer service, and day-to-day operations of FSAFEDS.

Who is BENEFEDES?

BENEFEDES is the name of the voluntary benefits portal hired by OPM to work with the FSAFEDS Program to set up payroll deductions for FSAFEDS allotments.

The Federal Employees Dental and Vision Insurance Program – *FEDVIP*

Important Information

The Federal Employees Dental and Vision Insurance Program (FEDVIP) is a brand new program separate and different from the FEHB Program, established by the Federal Employee Dental and Vision Benefits Enhancement Act of 2004.

OPM has contracted with several insurance carriers to make supplemental dental and vision benefits available to eligible Federal and USPS employees, annuitants, and their eligible family members.

Dental Insurance

Dental plans will provide a comprehensive range of services, including the following:

- Class A (Basic) services, which include roal examinations, prophylaxis, diagnostic evaluations, sealants and x-rays.
- Class B (Intermediate) services, which include restorative procedures such as fillings, prefabricated stainless steel crowns, periodontal sealing, 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 (Orthodontics) services with 24 month waiting period.

Please review the dental plans' benefits material for detailed information on the benefits covered, cost-sharing requirements, and preferred provider listings.

Vision Insurance

Vision plans will provide comprehensive eye examinations and coverage for lenses, frames and contact lenses. Other benefits such as discount on LASIK surgery may also be available.

Please review the vision plans' benefits material for detailed information on the benefits covered, cost-sharing requirements, and preferred provider listings.

What plans are available?

You can find a comparison of the plans available and their premiums on the OPM website at www.opm.gov/insur/dentalvision. This site also provides links to each plan's website, where you can view detailed information about benefits and preferred providers.

Premiums

The premiums will vary by plan and by enrollment type (self, self plus one, or self and family). There is no government contributions to the premiums. If you are an active employee, your premiums will be taken from your salary on a pre-tax basis when your salary is sufficient to make the premium withholding. If you are an annuitant, premiums will be withheld from your monthly annuity check when your annuity is sufficient. Pre-tax premiums are not available to annuitants. For information on each plan's specific premiums, visit www.opm.gov/insur/dentalvision.

Who is eligible to enroll?

Federal and Postal Service employees eligible for FEHB coverage (whether or not enrolled) and annuitant (regardless of FEHB status) are eligible to enroll in a dental plan and or a vision plan.

- Self-only, which covers only the enrolled employee or annuitant:
- Self plus one, which covers the enrolled employee or annuitant plus one eligible family member specified by the enrollee; and
- Self and family, which covers the enrolled employee or annuitant and all eligible family members.

Eligible family members include your spouse, unmarried dependent children under age 22, and unmarried dependent children age 22 or over incapable of self-support because of a mental or physical disability that existed before age 22.

Eligible employees and annuitants can enroll in a dental and/or vision plan during this open season- November 13 to December 11, 2006. You can enroll, disenroll, or change your enrollment during subsequent annual open seasons, or because of a qualified life event. New employees will have 60 days from their first eligibility date to enroll.

You enroll on the Internet at www.BENEFEDS.com. BENEFEDS is a secure enrollment website sponsored by OPM where you enter your name, personal information like address and Social Security Number, the agency you work for (or retirement plan that pays your annuity), and the dental and/or vision plan you select. For those without access to a computer, call 1-877-888-FEDS (TTY 1-877-TTY-5680). If you do not have access to a computer or a phone, contact your employing office or retirement system for guidance on how to enroll.

You cannot enroll in a FEDVIP plan using the Health Benefits Elections Form (SF 2809) or through an agency self-service system, such as Employee Express, MyPay, or Employee Personal Page. However, those sites may provide a link to BENEFEDS.

The new Program will be effective December 31, 2006. Coverage for those who enroll during this year's open season (November 13- December 11, 2006) will be effective December 31, 2006. Coverage for any other enrollments will be effective on/or after December 31, 2006.

Some FEHB plans already cover some dental and vision services. When you are covered by more than one health/dental plan, federal law permits your insurers to follow a procedure call "coordination of benefits" to determine how much each should pay when you have a claim. The goal is to make sure that the combined payments of all plans do not add up to more than your covered expenses.

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 will reduce your out-of-pocket cost.

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Summary of benefits for the High Option - 2007

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

High Option Benefits	You pay	Page
Medical services provided by physicians:		
Diagnostic and treatment services provided in the office	Office visit copay: \$15 primary care; \$30 specialist	18
Services provided by a hospital:		
• Inpatient	\$100 per day up to a \$300 maximum per admission	30
• Outpatient	Nothing	
Emergency benefits:		
• In-area	\$15 per office visit; \$30 per urgent care center visit; \$50 or 50% of charge, whichever is less per emergency room visit	34
• Out-of-area	\$50 or 50% of charge, whichever is less per emergency room visit	
Mental health and substance abuse treatment:	Regular cost sharing	35
Prescription drugs:	Retail Pharmacy (31-day supply) \$10 per formulary generic drug and brand name insulin; \$20 per formulary brand name drug; \$45 per non-formulary drug Mail Order maintenance medications only (93-day supply) \$20 per formulary generic drug and brand name insulin; \$40 per formulary brand name drug; \$90 per non-formulary drug	38
Dental care (Accidental injury only)	20% of Allowable Charges	41
Vision care:	No benefit.	xx
Special features:	Flexible benefits option; Services for deaf and hearing impaired; High risk pregnancies: centers for excellence: Travel benefits/ services overseas	40
Protection against catastrophic costs (out-of-pocket maximum)	Nothing after \$750/ Self Only of \$1500/ Family Enrollment	15

	Pharmacy benefits, office visits, and inpatient copayments do not count towards this protection	
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Summary of benefits for the HDHP Option - 2007

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

In 2007 for each month you are eligible for the HSA, will deposit \$41.67 per month for Self Only enrollment or \$83.33 per month for Self and Family enrollment to your HSA. For the Health Savings Account (HSA), you must satisfy your calendar year deductible of \$1100 for Self Only and \$2200 for Self and Family before using your HSA. Once you satisfy your calendar year deductible, Traditional medical coverage begins.

For the Health Reimbursement Arrangement (HRA), your health charges are applied to your annual HRA Fund of \$500 for Self Only and \$1000 for Self and Family. Once your HRA is exhausted, you must satisfy your calendar year deductible. Once your calendar year deductible is satisfied, Traditional medical coverage begins.

Under this Plan, most traditional medical care (other than some preventative care) is subject to a deductible. After you meet the deductible, you pay the indicated copayments or coinsurance up to the annual catastrophic protection maximum for out-of-pocket expenses.

HDHP Option Benefits	You Pay (After calendar year deductible)	Page
Medical services provided by physicians		
Diagnostic and treatment services provided in the office	In-network office visit copay: \$20 primary care; \$30 specialists Out-of-network: No benefit	49
Services provided by a hospital:		
<ul style="list-style-type: none"> • Inpatient • Outpatient 	In-network: 10% of Plan allowance Out-of-network: No benefit	58
Emergency benefits:		
<ul style="list-style-type: none"> • In-area • Out-of-area 	In-network: 10% of Plan allowance Out-of-network: No benefit	60
Mental health and substance abuse treatment	In-network: Regular cost sharing Out-of-network: No benefit	58
Prescription drugs:		
<ul style="list-style-type: none"> • Retail pharmacy 	In network Retail Pharmacy (31-day supply) \$10 per formulary generic drug and brand name insulin; \$20 per formulary brand name drug; \$45 per non-formulary drug Out of network: No benefit	62
<ul style="list-style-type: none"> • Mail order 	Mail Order maintenance medications only (90-day supply) \$20 per formulary generic drug and brand name insulin; \$40 per formulary brand name drug Note: Our mail order benefit is limited to the two tiers listed above.	62

Dental care(Accidental injury only)	10% of Plan Allowance	66
Protection against catastrophic costs (out-of-pocket maximum):	Nothing after \$5,000/Self Only or \$10,000/ Family Enrollment per year Pharmacy and office visit copayments do not count toward this protection	15

2007 Rate Information for Coventry Health Care of Iowa, Inc.

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

Postal rates apply to career Postal Service employees. Most employees should refer to the FEHB Guide for United States Postal Service Employees, RI 70-2. Different postal rates apply and a special FEHB guide is published for Postal Service Inspectors and Office of Inspector General (OIG) employees (see RI 70-2IN).

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

Type of Enrollment	Enrollment Code	Non-Postal Premium				Postal Premium	
		Biweekly		Monthly		Biweekly	
		Gov't Share	Your Share	Gov't Share	Your Share	USPS Share	Your Share
High Option Self Only	SV1	\$123.22	\$41.07	\$266.97	\$88.99	\$145.81	\$18.48
High Option Self and Family	SV2	\$321.89	\$121.68	\$697.43	\$263.64	\$380.01	\$63.56
HDHP Option Self Only	SV4	\$113.18	\$37.72	\$245.21	\$81.74	\$133.92	\$16.98
HDHP Option Self and Family	SV5	\$293.14	\$97.71	\$635.13	\$211.71	\$346.88	\$43.97