

Coventry Health Care of Kansas, Inc. (Kansas City area)



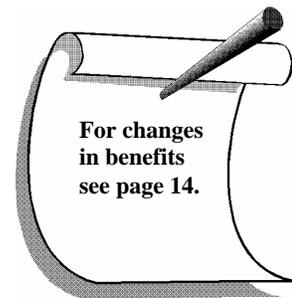
<http://www.chckansas.com>

2005

A Health Maintenance Organization with a High Deductible Health Plan Option

Serving: *Kansas City Metropolitan Area
Kansas and Missouri*

Enrollment in this plan is limited. You must live or work in our geographic service area to enroll. See page 13 for requirements.



Special Notice - This Plan is offering a High Deductible Health Plan (HDHP) option for the first time under the Federal Employees Health Benefits Program during the 2004 Open Season.

Enrollment codes for this Plan:

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

Authorized for distribution by the:



**United States
Office of Personnel Management**

Center for
Retirement and Insurance Services
<http://www.opm.gov/insure>

RI 73-128



UNITED STATES
OFFICE OF PERSONNEL MANAGEMENT
WASHINGTON, DC 20415-0001

OFFICE OF THE DIRECTOR

Dear Federal Employees Health Benefits Program Participant:

Welcome to the 2005 Open Season! By continuing to introduce pro-consumer health care ideas, the Office of Personnel Management (OPM) team has given you greater, cost effective choices. This year several national and local health plans are offering new options, strengthening the Federal Employees Health Benefits (FEHB) Program and highlighting once again its unique and distinctive market-oriented features. I remain firm in my belief that you, when fully informed as a Federal subscriber, are in the best position to make the decisions that meet your needs and those of your family. Plan brochures provide information to help subscribers make these fully informed decisions. Please take the time to review the plan's benefits, particularly Section 2, which explains plan changes.

Exciting new features this year give you additional opportunities to save and better manage your hard-earned dollars. For 2005, I am very pleased and enthusiastic about the new High Deductible Health Plans (HDHP) with a Health Savings Account (HSA) or Health Reimbursement Arrangement (HRA) component. This combination of health plan and savings vehicle provides a new opportunity to save and better manage your money. If an HDHP/HSA is not for you and you are not retired, I encourage you to consider a Flexible Spending Account (FSA) for health care. FSAs allow you to reduce your out-of-pocket health care costs by 20 to more than 40 percent by paying for certain health care expenses with tax-free dollars, instead of after-tax dollars.

Since prevention remains a major factor in the cost of health care, last year OPM launched the *HealthierFeds* campaign. Through this effort we are encouraging Federal team members to take greater responsibility for living a healthier lifestyle. The positive effect of a healthier lifestyle brings dividends for you and reduces the demands and costs within the health care system. This campaign embraces four key "actions" that can lead to a healthy America: be physically active every day, eat a nutritious diet, seek out preventive screenings, and make healthy lifestyle choices. Be sure to visit *HealthierFeds* at www.healthierfeds.opm.gov for more details on this important initiative. I also encourage you to visit the Department of Health and Human Services website on Wellness and Safety, www.hhs.gov/safety/index.shtml, which complements and broadens healthier lifestyle resources. The site provides extensive information from health care experts and organizations to support your personal interest in staying healthy.

The FEHB Program offers the Federal team the widest array of cost effective health care options and the information needed to make the best choice for you and your family. You will find comprehensive health plan information in this brochure, in the 2005 Guide to FEHB Plans, and on the OPM website at www.opm.gov/insure. I hope you find these resources useful, and thank you once again for your service to the nation.

Sincerely,

A handwritten signature in black ink, appearing to read "Kay C. James".

Kay Coles James

Director



Notice of the United States Office of Personnel Management's Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

By law, the United States Office of Personnel Management (OPM), which administers the Federal Employees Health Benefits (FEHB) Program, is required to protect the privacy of your personal medical information. OPM is also required to give you this notice to tell you how OPM may use and give out ("disclose") your personal medical information held by OPM.

OPM **will** use and give out your personal medical information:

- To you or someone who has the legal right to act for you (your personal representative),
- To the Secretary of the Department of Health and Human Services, if necessary, to make sure your privacy is protected,
- To law enforcement officials when investigating and/or prosecuting alleged or civil or criminal actions, and
- Where required by law.

OPM **has the right** to use and give out your personal medical information to administer the FEHB Program. For example:

- To communicate with your FEHB health plan when you or someone you have authorized to act on your behalf asks for our assistance regarding a benefit or customer service issue.
- To review, make a decision, or litigate your disputed claim.
- For OPM and the General Accounting Office when conducting audits.

OPM **may** use or give out your personal medical information for the following purposes under limited circumstances:

- For Government health care oversight activities (such as fraud and abuse investigations),
- For research studies that meet all privacy law requirements (such as for medical research or education), and
- To avoid a serious and imminent threat to health or safety.

By law, OPM must have your written permission (an "authorization") to use or give out your personal medical information for any purpose that is not set out in this notice. You may take back ("revoke") your written permission at any time, except if OPM has already acted based on your permission.

By law, you **have the right** to:

- See and get a copy of your personal medical information held by OPM.
- Amend any of your personal medical information created by OPM if you believe that it is wrong or if information is missing, and OPM agrees. If OPM disagrees, you may have a statement of your disagreement added to your personal medical information.
- Get a listing of those getting your personal medical information from OPM in the past 6 years. The listing will not cover your personal medical information that was given to you or your personal representative, any information that you authorized OPM to release, or that was given out for law enforcement purposes or to pay for your health care or a disputed claim.

- Ask OPM to communicate with you in a different manner or at a different place (for example, by sending materials to a P.O. Box instead of your home address).
- Ask OPM to limit how your personal medical information is used or given out. However, OPM may not be able to agree to your request if the information is used to conduct operations in the manner described above.
- Get a separate paper copy of this notice.

For more information on exercising your rights set out in this notice, look at www.opm.gov/insure on the Web. You may also call 202-606-0745 and ask for OPM's FEHB Program privacy official for this purpose.

If you believe OPM has violated your privacy rights set out in this notice, you may file a complaint with OPM at the following address:

Privacy Complaints
United States Office of Personnel Management
P.O. Box 707
Washington, DC 20004-0707

Filing a complaint will not affect your benefits under the FEHB Program. You also may file a complaint with the Secretary of the United States Department of Health and Human Services.

By law, OPM is required to follow the terms in this privacy notice. OPM has the right to change the way your personal medical information is used and given out. If OPM makes any changes, you will get a new notice by mail within 60 days of the change. The privacy practices listed in this notice are effective April 14, 2003.

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Introduction

This brochure describes the benefits of Coventry Health Care of Kansas, Inc., under our contract (CS 1948) with the United States Office of Personnel Management, as authorized by the Federal Employees Health Benefits law. The address for Coventry Health Care of Kansas, Inc., administrative offices is:

Coventry Health Care of Kansas, Inc.
8320 Ward Parkway
Kansas City, MO 64114

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, 2005, unless those benefits are also shown in this brochure.

OPM negotiates benefits and rates with each plan annually. Benefit changes are effective January 1, 2005, and changes are summarized on page 9. Rates are shown at the end of this brochure.

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 Kansas, Inc..
- We limit acronyms to ones you know. FEHB is the Federal Employees Health Benefits Program. OPM is the United States Office of Personnel Management. If we use others, we tell you what they mean 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 fehbwcomments@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 800-969-3343 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, DC 20415-1100**

Do not maintain as a family member on your policy:

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

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.

Give your doctor and pharmacist a list of all the medicines that you take, including non-prescription medicines.

Tell them about any drug allergies you have.

Ask about side effects and what to avoid while taking the medicine.

Read the label when you get your medicine, including all warnings.

Make sure your medicine is what the doctor ordered and know how to use it.

Ask the pharmacist about your medicine if it looks different than you expected.

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?

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

This Plan is a health maintenance organization (HMO). We require you to see specific physicians, hospitals, and other providers that contract with us. These Plan providers coordinate your health care services. The Plan is solely responsible for the selection of these providers in your area. Contact the Plan for a copy of their most recent provider directory.

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

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

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

This Plan also offers 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 conditions or chronic illness.

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

General features of an HDHP:

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

You are not required to select a Primary Care Physician.

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 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 spouses' 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 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.

- o An HRA does not earn interest.
- o 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.

How we pay providers

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

Who provides my healthcare

Coventry Health Care of Kansas, Inc., provides you with a comprehensive benefit package that covers many kinds of health services for a fixed payroll deduction and minimal copayments. As a participant of Coventry Health Care of Kansas, Inc., you will select a personal doctor for yourself and each member of your family. Depending on where you live, you will be able to choose from a directory of more than 900 primary care doctors whose offices are located throughout the Plan's service areas.

The first and most important decision each member must make is the selection of a primary care doctor. Your primary care doctor will be the manager and coordinator of your health care. If you require additional care, your primary care doctor, with your input, will select the specialist or hospital that best fits your needs. It is the responsibility of your primary care doctor to obtain any necessary authorizations from the Plan before referring you to a specialist or making arrangements for hospitalization.

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

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

Should you decide to enroll, you will be asked to complete a primary care doctor selection and send it to the Plan, indicating the name of the primary care doctor(s) selected for you and each member of your family. Members may change their doctor selection by notifying the Plan or by visiting our website at www.chckansas.com.

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 website (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 Kansas, Inc., is a for profit domiciled Kansas health maintenance organization (HMO) with certificates of authority to operate in both Kansas and Missouri. Coventry Health Care of Kansas, Inc., has been existence since 1961, and has two unique service areas: Kansas City and Wichita for a combined total membership of over 170,000. We are dedicated to providing quality health care at an affordable price, and we provide our members the security of knowing they are being offered a health care delivery system supported by a long tradition of quality and service.

If you want more information about us, call 1-800-969-3343, or write to Coventry Health Care of Kansas, 8320 Ward Parkway, Kansas City, MO 64114. You may also contact us by visiting our website at www.chckansas.com.

Service Area

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

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

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

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

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

Section 2. How we change for 2005

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

Program-wide changes

- In Section 9, we revised the Medicare Primary Payer Chart and updated the language regarding Medicare Advantage plans (formerly called Medicare + Choice plans).
- In Section 12, we revised the language regarding the Flexible Spending Account Program - *FSAFEDS* and the Federal Long Term Care Insurance Program.

Changes to this Plan

- This Plan is offering a High Deductible Health Plan (HDHP) option for the first time under the Federal Employees Health Benefits Program during the 2004 Open Season.
- To our service area we added Brown, Osage, Pottawatomie, Wabaunsee counties in Kansas, and Barton, Christian, Dade, Dallas, Greene, Jasper, Lawrence, Newton, Polk, Vernon and Webster counties in Missouri.

High Option Plan

- Your share of the non-Postal premium will increase by 12.5% for Self Only or 12.5% for Self and Family
- The specialist office visit copayment is now \$30 per visit instead of \$15
- Mammograms are now covered subject to 10% coinsurance per visit instead of \$15 per visit.
- The inpatient hospital admission copayment is now \$100 per day up to a \$300 maximum per admission.
- The urgent care center visit copayment is now \$50 instead of \$25.
- The hospital emergency room copayment is now \$100 per visit instead of \$75.
- We dropped the \$400 coverage limitation for ambulance service. You will continue to pay 30% of covered charges.
- Outpatient diagnostic testing is now covered subject to 10% coinsurance per test. Previously, you paid nothing.
- Retail prescription drug copayments are now \$10 per generic, \$30 per brand name formulary and \$55 per non-formulary. Previously, the copayments were \$10 per generic, \$20 per brand name formulary, and \$50 per non-formulary.
- Mail order maintenance drugs for a 93-day supply are now \$30 per generic and \$90 per brand name formulary. Previously, the copayments were \$20 per generic and \$40 per brand name formulary.
- Diabetic education copayment is now \$15 per visit. Previously, you paid nothing.
- The voluntary sterilization copayment is now \$50 per procedure instead of \$100.

Standard Option Plan

- The out-of-pocket maximums are \$2,500 for Self Only and \$5,000 for Self and Family.

- The primary care doctor's office visit copayment is \$20 per visit.
- The specialist office visit copayment is \$35 per visit.
- The hospital inpatient admissions copayment is \$300 per day up to a maximum of \$900.
- The outpatient surgery facility copayment is \$200 per facility use.
- The outpatient therapy copayment is \$20 per visit.
- The outpatient diagnostic testing copayment is \$100 per test.
- The emergency room copayment is \$125 per visit.
- Retail prescription drug copayments are now \$10 per generic, \$30 per brand name formulary and \$55 per non-formulary. Previously, the copayments were \$10 per generic, \$20 per brand name formulary, and \$50 per non-formulary.
- Mail order maintenance drugs for a 93-day supply are now \$30 per generic and \$90 per brand name formulary. Previously, the copayments were \$20 per generic and \$40 per brand name formulary.
- Diabetic education benefit copayment is \$20 per visit.
- The following benefits will be covered subject to no member coinsurance: Hospice care, Home health care, Injectable medications, Intravenous therapy.

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 Employee Express confirmation letter.

If you do not receive your ID card within 30 days after the effective date of your enrollment, or if you need replacement cards, call us at 1-800-969-3343 or write to us at Coventry Health Care of Kansas, Inc., 8320 Ward Parkway, Kansas City, MO 64114. You may also request replacement cards through our website at www.chckansas.com.

Where you get covered care

You get care from “Plan providers” and “Plan facilities.” You will only pay copayments, deductibles, and/or coinsurance, and you will not have to file claims.

- **Plan providers**

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

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

- **Plan facilities**

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

What you must do to get covered care

It depends on the type of care you need. First, you and each family member must choose a primary care physician. This decision is important since your primary care physician provides or arranges for most of your health care. The Plan’s provider directory lists primary care doctors (generally family practitioners, pediatricians, and internist), with their locations and phone numbers, and notes whether or not the doctor is accepting new patients. Directories are updated on a regular basis and are available at the time of enrollment or upon request by calling the Customer Service Department at 1-800-969-3343. You can also find out if your doctor participates by calling these numbers.

If you are interested in receiving care from a specific provider who is listed in the directory, call the provider to verify that he or she still participates with the Plan and is accepting new patients.

- **Primary care**

Your primary care physician will generally be a family practitioner, internist or pediatrician. Your primary care physician will provide most of your health care, or give you a referral to see a specialist.

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

- **Specialty care**

Your primary care physician will refer you to a specialist for needed care. You must receive a referral from your primary care doctor before seeing or obtaining special services, with the following exceptions: (1) Female members may visit a participating gynecologist without a referral from their primary care doctor; (2) All members may visit the Plan's mental health providers for mental conditions and substance benefits without a referral from their primary care doctor (See "Mental Conditions /Substance Abuse Benefits").

Referral to a participating specialist is given at your primary care doctor's discretion; if specialists or consultants are required beyond those participating in the Plan, your primary care doctor will make arrangements for appropriate referrals.

When you receive a referral from your primary care doctor, you must return to the primary care doctor after the consultation. All follow-up care must be provided or arranged by the primary care doctor. On referrals, the primary care doctor will give specific instructions to the consultant as to what services are authorized. If the consultant suggests additional services or visits, you must first check with your primary care doctor. Do not go to the specialist unless your primary care doctor has arranged for and the Plan has issued an authorization for the referral in advance.

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

- If you need to see a specialist frequently because of a chronic, complex, or serious medical condition, your primary care physician will work with the specialist to develop a treatment plan that allows you to see your specialist for a certain number of visits without additional referrals. Your primary care physician will use our criteria when creating your treatment plan (the physician may have to get an authorization or approval beforehand).
- If you are seeing a specialist when you enroll in our Plan, talk to your primary care physician. Your primary care physician will decide what treatment you need. If he or she decides to refer you to a specialist, ask if you can see your current specialist. If your current specialist does not participate with us, you must receive treatment from a specialist who does. Generally, we will not pay for you to see a specialist who does not participate with our Plan.
- If you are seeing a specialist and your specialist leaves the Plan, call your primary care physician, who will arrange for you to see another specialist. You may receive services from your current specialist until we can make arrangements for you to see someone else.
- If you have a chronic and disabling condition and lose access to your specialist because we:
 - Terminate our contract with your specialist for other than cause; or
 - Drop out of the Federal Employees Health Benefits (FEHB) Program and you enroll in another FEHB program Plan; or
 - Reduce our service area and you enroll in another FEHB Plan

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

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

- **Hospital care**

Your Plan primary care physician or specialist will make necessary hospital arrangements and supervise your care. This includes admission to a skilled nursing or other type of facility.

If you are in the hospital when your enrollment in our Plan begins, call our customer service department immediately at 1-800-969-3343. If you are new to the FEHB Program, we will arrange for you to receive care.

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 run out; or
- The 92nd day after you become a member of this Plan, whichever happens first.

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

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

Your primary care physician has authority to refer you for most services. For certain services, however, 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 and approval process prior authorization. Your physician must obtain for example, prior authorization from the Plan for outpatient surgeries or inpatient hospitalization. You may call customer service at 1-800-969-3343 to find out if a specific procedure treatment requires prior authorization.

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. You are responsible for paying copayments to providers at the time of service.

Example: When you see your primary care physician you pay a copayment of \$15 per office visit. When you go in the hospital, you pay \$100 copay per day up to a \$300 maximum per admission.

Deductible

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

Under our **High and Standard Option Plan** we do not have a deductible.

Under our **High Deductible Health Plan** the individual deductible applies to members enrolled in Self Only. The family deductible applies collectively to all members enrolled in Self and Family.

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. If your Plan has a deductible, Coinsurance doesn't begin until you meet your deductible.

Example: In our Plan, you pay 50% of our allowance for infertility services and 20% for covered durable medical equipment.

Your catastrophic protection out-of-pocket maximum

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

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

Under our **High Option Plan** the out-of-pocket maximum for Self Only is \$2,000 and \$4,000 for Self and Family.

Under our **Standard Option Plan** the out-of-pocket maximum for Self Only is \$2,500 and \$5,000 for Self and Family.

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

members enrolled in Self and Family.

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

When Government facilities bill us

Facilities of the Department of Veteran Affairs, the Department of Defense, and the Indian Health Services are entitled to seek reimbursement from us for certain services and supplies they provide to you or a family member. They may not seek more than their governing laws allow.

If we overpay you

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

Section 5. High and Standard Option Benefits – OVERVIEW

(See page 14 for how our benefits changed this year and page 119 for a benefits summary.)

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 6; they apply to the benefits in the following subsections. To obtain claim forms, claims filing advice, or more information about our HMO benefits, contact us at 1-800-969-3343 or at our website at www.chckansas.com.

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

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

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- 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.

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Benefit Description	High Option	Standard Option
Diagnostic and treatment services	You pay	You pay
Professional services of physicians <ul style="list-style-type: none"> • In a physician’s office 	\$15 per visit to your primary care physician \$30 per visit to a specialist	\$20 per visit to your primary care physician \$35 per visit to a specialist
Professional services of physicians <ul style="list-style-type: none"> • In an urgent care center 	Nothing	Nothing
<ul style="list-style-type: none"> • During a hospital stay • In a skilled nursing facility 	Nothing	Nothing
<ul style="list-style-type: none"> • Office medical consultations • Second surgical opinion 	\$15 per visit to your primary care physician \$30 per visit to a specialist	\$20 per visit to your primary care physician \$35 per visit to a specialist
At home	\$15 per visit to your primary care physician \$30 per visit to a specialist	\$20 per visit to your primary care physician \$35 per visit to a specialist

Lab, X-ray and other diagnostic tests	High Option You pay	Standard Option You pay
Laboratory tests, such as: <ul style="list-style-type: none"> • Blood tests • Urinalysis • Non-routine pap tests • Pathology 	\$15 per office visit to your primary care physician \$30 per visit to a specialist Nothing if you receive these services during your office visit	\$20 per office visit to your primary care physician \$35 per visit to a specialist Nothing if you receive these services during your office visit
Radiology and other diagnostic tests, such as: <ul style="list-style-type: none"> • X-rays • Electrocardiogram and EEG • CAT Scans/MRI • Ultrasound 	10% of our allowance	\$100 copayment per test
<ul style="list-style-type: none"> • Non-routine Mammograms 	Nothing	Nothing
Preventive care, adult		
Routine screenings, such as: <ul style="list-style-type: none"> • Total Blood Cholesterol • Colorectal Cancer Screening, including <ul style="list-style-type: none"> – Fecal occult blood test – Sigmoidoscopy, screening – every five years starting at age 50 – Colonoscopy screening – every ten years starting at age 50 	\$15 per visit to your primary care physician \$30 per visit to a specialist	\$20 per visit to your primary care physician \$35 per visit to a specialist
Routine Prostate Specific Antigen (PSA) test – one annually for men age 40 and older	\$15 per visit to your primary care physician \$30 per visit to a specialist	\$20 per visit to your primary care physician \$35 per visit to a specialist

Preventive care, adult – continued on next page

Preventive care, adult <i>(continued)</i>	High Option You pay	Standard Option You pay
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 visit to your primary care physician \$30 per visit to a specialist	\$20 per visit to your primary care physician \$35 per visit to a specialist
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 	Nothing	Nothing
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 to your primary care physician \$30 per visit to a specialist Nothing if you receive these services during your office visit	\$20 per office visit to your primary care physician \$35 per visit to a specialist Nothing if you receive these services during your 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>	<i>All charges</i>
Preventive care, children		
<ul style="list-style-type: none"> • Childhood immunizations recommended by the American Academy of Pediatrics 	Nothing	Nothing
<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 – Examinations done on the day of immunizations (up to age 22) 	\$15 per visit to your primary care physician \$30 per visit to a specialist	\$20 per visit to your primary care physician \$35 per visit to a specialist

Maternity Care	High Option You pay	Standard Option You pay
<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 11 for other circumstances, such as extended stays for you or your baby. • You may remain in the hospital up to 48 hours after a regular delivery and 96 hours after a cesarean delivery. We will extend your inpatient stay if medically necessary. • We cover routine nursery care of the newborn child during the covered portion of the mother’s maternity stay. We will cover other care of an infant who requires non-routine treatment only if we cover the infant under a Self and Family enrollment. (Surgical benefits, not maternity benefits, apply towards circumcision of the newborn; see page 35) • We pay hospitalization and surgeon services (delivery) the same as for illness and injury. See Hospital benefits (Section 5c) and Surgery benefits (Section 5b). 	<p>\$15 for initial office visit to your primary care physician to confirm pregnancy.</p> <p>\$30 for initial office visit to a specialist to confirm pregnancy.</p> <p>All other copayments for prenatal visits during the course of pregnancy are waived.</p>	<p>\$20 for initial office visit to your primary care physician to confirm pregnancy.</p> <p>\$35 for initial office visit to a specialist to confirm pregnancy.</p> <p>All other copayments for prenatal visits during the course of pregnancy are waived</p>
<i>Not covered: Routine sonograms to determine fetal age, size or sex.</i>	<i>All charges</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>	<p>\$50 copayment</p> <p>\$15 per visit to your primary care physician or \$30 per visit to a specialist applies to implanted or injectable contraceptive devices.</p>	<p>\$200 copayment</p> <p>\$20 per visit to your primary care physician or \$35 per visit to a specialist applies to implanted or injectable contraceptive devices.</p>

Family planning (continued)	High Option You pay	Standard Option You pay
<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>	<i>All charges</i>
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"> – <i>intravaginal insemination (IVI)</i> – <i>intracervical insemination (ICI)</i> – <i>intrauterine insemination (IUI)</i> 	50% of our allowance	50% of our allowance
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <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>Fertility drugs</i> 	<i>All charges</i>	<i>All charges</i>
Allergy care		
<ul style="list-style-type: none"> • Testing • Treatment/Allergy injections 	50% of our allowance \$15 per visit to your primary care physician or \$30 to a specialist.	50% of our allowance \$20 per visit to your primary care physician or \$35 to a specialist.
Allergy serum	Nothing	Nothing
<i>Not covered: Provocative food testing and sublingual allergy desensitization</i>	<i>All charges</i>	<i>All charges</i>

Treatment therapies	High Option You pay	Standard Option You pay
<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 39.</p>	\$30 for office visit; or 10% of our allowance for outpatient	\$35 for office visit; or \$100 for outpatient
<ul style="list-style-type: none"> Respiratory and inhalation therapy – outpatient rehabilitation limited to 60 visits per condition. 	\$15 copay	\$20 copay
<ul style="list-style-type: none"> Dialysis – hemodialysis and peritoneal dialysis 	Nothing	Nothing
<ul style="list-style-type: none"> Intravenous (IV)/Infusion Therapy – Home IV and antibiotic therapy 	\$30 office visit or; Nothing when provided in the home	\$35 office visit or; Nothing when provided in the home
<ul style="list-style-type: none"> Growth hormone therapy (GHT) <p>Note: Growth hormone is covered under the prescription drug benefit.</p> <p>Note: – We only cover GHT when we preauthorize the treatment. Call 1-800-969-3343 for preauthorization. We will ask you to submit information that establishes that the GHT is medically necessary. Ask us to authorize GHT before you begin treatment; 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>		
Physical and occupational therapies		
<p>60 days per condition for the services of each of the following:</p> <ul style="list-style-type: none"> qualified physical therapists occupational therapists chiropractors (coverage limited to subluxation and manipulation) <p>Note: We only cover therapy to restore bodily function when there has been a total or partial loss of bodily function due to illness or injury.</p> <ul style="list-style-type: none"> Cardiac rehabilitation following a heart transplant, bypass surgery or a myocardial infarction is provided for up to 60 sessions. 	<p>\$15 copay for each outpatient session;</p> <p>Nothing per visit during covered inpatient admission</p>	<p>\$20 copay for each outpatient session;</p> <p>Nothing per visit during covered inpatient admission</p>

Physical and occupational therapies (continued)	High Option You pay	Standard Option You pay
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • Long-term rehabilitative therapy • Exercise programs 	<i>All charges</i>	<i>All charges</i>
Speech therapy		
60 days per condition	\$15 copay for each outpatient session; Nothing per visit during covered inpatient admission	\$20 copay for each outpatient session; Nothing per visit during covered inpatient admission
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 (see <i>Preventive care, children</i>) 	\$15 per visit to your primary care physician \$30 per visit to a specialist	\$20 per visit to your primary care physician \$35 per visit to a specialist
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • All other hearing testing • Hearing aids, testing and examinations for them 	<i>All charges</i>	<i>All charges</i>
Vision services (testing, treatment, and supplies)		
<ul style="list-style-type: none"> • One pair of eyeglasses or contact lenses to correct an impairment directly caused by accidental ocular injury or intraocular surgery (such as for cataracts) • Eye exam to determine the need for vision correction for children through age 17 (see <i>Preventive care, children</i>) 	\$15 per visit to your primary care physician \$30 per visit to a specialist	\$20 per visit to your primary care physician \$35 per visit to a specialist
<ul style="list-style-type: none"> • Annual eye refractions <p>Note: See <i>Preventive care, children</i> for eye exams for children.</p>	\$15 per office visit	\$20 per office visit

Vision services (testing, treatment, and supplies) <i>(continued)</i>	High Option You pay	Standard Option You pay
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Eyeglasses or contact lenses and after age 17, examinations for them</i> • <i>Eye exercises and orthoptics</i> • <i>Radial keratotomy and other refractive surgery</i> 	<i>All charges</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> <p>Note: See Orthopedic and prosthetic devices for information on podiatric shoe inserts.</p>	<p>\$15 per visit to your primary care physician</p> <p>\$30 per visit to a specialist</p>	<p>\$20 per visit to your primary care physician</p> <p>\$35 per visit to a specialist</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> 	<i>All charges</i>	<i>All charges</i>
Orthopedic and prosthetic devices		
<p>We limit coverage to \$1,000 per member per calendar year.</p> <ul style="list-style-type: none"> • Orthopedic devices such as braces • Artificial limbs and eyes; stump hose • Externally worn breast prostheses and surgical bras, including necessary replacements following a mastectomy. External prosthetic devices, except those associated with reconstructive surgery after a mastectomy, are limited to one per member per lifetime. • 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. 	20% of our allowance	20% of our allowance

Orthopedic and prosthetic devices (continued)	High Option You pay	Standard Option You pay
<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>Orthotics (regular or custom, including but not limited to ankle foot orthotics or podiatric 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>Dental braces, devices, and appliances</i> • <i>Braces for aid in sports activities</i> • <i>Internally implanted devices, equipment, and prosthetics related to treatment of sexual dysfunction</i> • <i>Repair and replacement of orthopedic and prosthetic devices, unless necessitated by normal growth</i> • <i>Doc bands (Dynamic Orthotic Cranial Bands)</i> 	<i>All charges</i>	<i>All charges</i>

Durable medical equipment (DME)	High Option You pay	Standard Option You pay
<p>We limit coverage to \$1,000 per member per calendar year.</p> <p>Rental or purchase, at our option, including repair and adjustment, of durable medical equipment prescribed by your Plan physician, such as oxygen and dialysis equipment. Under this benefit, we also cover:</p> <ul style="list-style-type: none"> • Hospital beds; • Wheelchairs; • Crutches; • Walkers; • Ostomy and urological supplies; • Prosthetic and orthotic supplies; • Blood glucose monitors; and • Insulin pumps, and syringes for insulin pumps • Apnea monitor • Cane; • Replacement due to anatomical growth; • Repair and replacement of DME determined to be medically necessary. <p>Note: Call us at 800-969-3343 as soon as your Plan physician prescribes this equipment. We will arrange with a health care provider to rent or sell you durable medical equipment at discounted rates and will tell you more about this service when you call.</p>	<p>20% of our allowance</p>	<p>20% of our allowance</p>

Durable medical equipment (DME) (continued)	High Option You pay	Standard Option You pay
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Motorized wheelchairs</i> • <i>Comfort, convenience, or luxury items or features</i> • <i>Electric monitors of bodily functions, except for apnea monitors</i> • <i>Devices to perform medical testing of bodily fluids, excretions, or substances</i> • <i>Disposable supplies</i> • <i>Replacement of lost equipment</i> • <i>Repair, adjustment, or replacement necessitated by wear, tear, or misuse</i> • <i>More than one piece of durable medical equipment serving essentially the same function, except for replacement due to anatomical growth; spare equipment or alternate use equipment is not provided</i> 	<p><i>All charges</i></p>	<p><i>All charges</i></p>

Home health services	High Option You pay	Standard Option You pay
<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.), physical therapist, speech therapist, occupational therapist. • Services include oxygen therapy, intravenous therapy and medications 	Nothing	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>Services primarily for hygiene, feeding, exercising, moving the patient, homemaking, companionship or giving oral medication</i> • <i>Nursing care that could appropriately be rendered in a Plan medical office, affiliated hospital, or skilled nursing facility</i> • <i>Nursing care that can be performed safely and effectively by people whom, in order to provide the care do not require medical licenses or certificates, or the presence of a supervising licensed nurse</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>	<i>All charges</i>
Chiropractic		
See Physical and occupational therapies		
Alternative treatments		
<i>No benefit</i>	<i>All charges</i>	<i>All charges</i>
Educational classes and programs		
<p>Coverage is limited to:</p> <ul style="list-style-type: none"> • Diabetes self- management educational classes, as referred by your Plan physician 	\$15 per office visit	\$20 per office visit

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

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

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- 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.

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Benefit Description	High Option	Standard Option
Surgical procedures	You pay	You pay
A comprehensive range of services, such as: <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 • Circumcision of a newborn • Correction of congenital anomalies (see Reconstructive surgery) 	\$15 per visit to your primary care physician \$30 per visit to a specialist Nothing for physician hospital visits	\$20 per visit to your primary care physician \$35 per visit to a specialist Nothing for physician hospital visits

Surgical procedures - continued on next page

Surgical procedures (continued)	High Option You pay	Standard Option You pay
<ul style="list-style-type: none"> • Surgical treatment of morbid obesity -- a condition in which an individual weighs 100 pounds or 100% over his or her normal weight according to current underwriting standards; eligible members must be age 18 or over • Insertion of internal prosthetic devices. See 5(a) – Orthopedic and prosthetic devices for device coverage information • 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>\$15 per visit to your primary care physician</p> <p>\$30 per visit to a specialist</p> <p>Nothing for physician hospital visits</p>	<p>\$20 per visit to your primary care physician</p> <p>\$35 per visit to a specialist</p> <p>Nothing for physician hospital visits</p>
<ul style="list-style-type: none"> • Voluntary sterilization (e.g., Tubal ligation, Vasectomy) 	<p>\$50 copayment</p>	<p>\$200 copayment</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>	<p><i>All charges</i></p>

Reconstructive surgery	High Option You pay	Standard Option You pay
<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 visit to your primary care physician</p> <p>\$30 per visit to a specialist</p> <p>Nothing for physician hospital visits</p>	<p>\$20 per visit to your primary care physician</p> <p>\$35 per visit to a specialist</p> <p>Nothing for physician hospital visits</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>	<p><i>All charges</i></p>

Oral and maxillofacial surgery	High Option You pay	Standard Option You pay
<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. • Treatment of TMJ 	<p>\$15 per visit to your primary care physician</p> <p>\$30 per visit to a specialist</p> <p>Nothing for physician hospital visits</p>	<p>\$20 per visit to your primary care physician</p> <p>\$35 per visit to a specialist</p> <p>Nothing for physician hospital visits</p>
<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>TMJ related dental work</i> 	<p><i>All charges</i></p>	<p><i>All charges</i></p>

Organ/tissue transplants	High Option You pay	Standard Option You pay
<p>Limited to:</p> <ul style="list-style-type: none"> • Cornea • Heart • Heart/lung • Kidney • Kidney/Pancreas • Liver • Lung: Single – Double • Pancreas • Allogeneic (donor) bone marrow transplants • Autologous bone marrow transplants (autologous stem cell and peripheral stem cell support) for the following conditions: acute lymphocytic or non-lymphocytic leukemia; advanced Hodgkin’s lymphoma; advanced non-Hodgkin’s lymphoma; advanced neuroblastoma; breast cancer; multiple myeloma; epithelial ovarian cancer; and testicular, mediastinal, retroperitoneal and ovarian germ cell tumors • Intestinal transplants (small intestine) and the small intestine with the liver or small intestine with multiple organs such as the liver, stomach, and pancreas <p>Limited Benefits – Treatment for breast cancer, multiple myeloma, and epithelial ovarian cancer may be provided 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.</p> <p>Note: We cover related medical and hospital expenses of the donor when we cover the recipient provided the recipient is a plan member. After referral to a transplant facility, the following will apply:</p> <ul style="list-style-type: none"> • If our Medical Director or the referral facility decides you do not satisfy criteria for a transplant, we only pay for covered services you receive before that decision is made • We, and the plan providers are not responsible for finding, furnishing, or ensuring the availability of a bone marrow or organ donor • We cover reasonable medical and hospital expenses as long as the expenses are directly related to a covered transplant of the donor or an individual identified as a potential donor, even if a member • Unless otherwise authorized by our Medical Director, we provide transplants only at approved Transplant Network facilities 	Nothing	Nothing

Organ/tissue transplants (continued)	High Option You pay	Standard Option You pay
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • Donor screening tests and donor search expenses, except those performed for the actual donor • Any related conditions or complications for a member who is donating an organ or tissue when the recipient is not a member • Outpatient immunosuppressive agents • Any transplant procedure that is performed in a facility that has not been designated by the Medical Director as a approved transplant facility • Implants of non-human or artificial organs • Transplants not listed as covered 	All charges.	All charges.
Anesthesia		
Professional services provided in – <ul style="list-style-type: none"> • Hospital (inpatient) 	Nothing	Nothing
Professional services provided in – <ul style="list-style-type: none"> • Hospital outpatient department • Skilled nursing facility • Ambulatory surgical center 	Nothing	Nothing
<ul style="list-style-type: none"> • Office 	\$15 per visit to your primary care physician \$30 per visit to a specialist	\$20 per visit to your primary care physician \$35 per visit to a specialist

Section 5(c) Services provided by a hospital or other facility, and ambulance services

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

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- 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.

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Benefit Description	High Option	Standard Option
<p>Inpatient hospital</p> <p>Room and board, such as</p> <ul style="list-style-type: none"> • Ward, semiprivate, or intensive care accommodations; • General nursing care; and • Meals and special diets • Special duty nursing care when medically necessary <p>Note: If you want a private room when it is not medically necessary, you pay the additional charge above the semiprivate room rate.</p>	<p>You pay</p> <p>\$100 per day up to a \$300 maximum per admission</p>	<p>You pay</p> <p>\$300 per day up to a \$900 maximum per admission</p>

Inpatient hospital - continued on next page.

Inpatient hospital <i>(continued)</i>	High Option You pay	Standard Option You pay
<p>Other hospital services and supplies, such as:</p> <ul style="list-style-type: none"> • Operating, recovery, maternity, and other treatment rooms • Prescribed drugs and medicines • Diagnostic laboratory tests and X-rays • Blood or blood plasma, if not donated or replaced • Dressings, splints, casts, and sterile tray services • Medical supplies and equipment, including oxygen • Anesthetics, including nurse anesthetist services • Medical supplies, appliances, medical equipment, and any covered items billed by a hospital for use at home 	Nothing	Nothing
<p><i>Not covered:</i></p> <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>	<i>All charges</i>

Outpatient hospital or ambulatory surgical center	High Option You pay	Standard Option You pay
<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>	\$50 per surgery	\$200 per surgery
<i>Not covered: Blood and blood derivatives not replaced by the member</i>	<i>All charges</i>	<i>All charges</i>
Extended care benefits/Skilled nursing care facility benefits		
<p>A comprehensive range of benefits covered for 60 days per calendar year with no day limit when full-time skilled nursing care is necessary and confinement in a skilled nursing facility is medically appropriate as determined by a Plan doctor and approved by the Plan. All necessary services are covered, including:</p> <p>Bed, board and general nursing care</p> <p>Drugs, biologicals, supplies, and equipment ordinarily provided and arranged by the skilled nursing facility when prescribed by a Plan doctor.</p>	\$100 copay per day up to a \$300 maximum per admission if separate admission	\$300 copay per day up to a \$900 maximum per admission if separate admission
<i>Not covered: Custodial care</i>	<i>All charges</i>	<i>All charges</i>
Hospice care		
<ul style="list-style-type: none"> • Supportive and Palliative care for a terminally ill member is covered in the home or hospice facility. Services include inpatient and outpatient care and family counseling. These services are provided under the direction of a Plan doctor who certifies that the patient is in the terminal stages of illness, with a life expectancy of approximately six months or less. 	Nothing	Nothing

Hospice care (continued)	High Option You pay	Standard Option You pay
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Service in the member's home outside of the service area</i> • <i>Any service for which the hospice does not customarily charge the member, or his or her family</i> • <i>Independent nursing, homemaker services</i> 	<i>All charges</i>	<i>All charges</i>
Ambulance		
<ul style="list-style-type: none"> • Local professional ambulance service to the nearest hospital equipped to handle your medical condition when medically appropriate. • Air ambulance when medically appropriate 	30% of our allowance	30% of our allowance

Section 5(d) Emergency services/accidents

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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.
- 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.

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What is a medical emergency?

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

What to do in case of emergency:

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

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

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

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

We also provide several Urgent Care centers which are open on evenings, weekends and holidays, and are designed to give our members fast, effective quality care for non-emergent conditions such as: sprains, influenza, sore throats, ear infections, minor lacerations, and upper respiratory infections.

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

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

Benefit Description	High Option	Standard Option
Emergency within our service area	You pay	You pay
<ul style="list-style-type: none"> Emergency care at a doctors' office 	\$15 per visit to your primary care physician \$30 per visit to a specialist	\$20 per visit to your primary care physician \$35 per visit to a specialist
<ul style="list-style-type: none"> Emergency care at an urgent care center Emergency care as an outpatient or inpatient at a hospital, including doctors' services 	\$50 per urgent care visit \$100 per visit; waived if admitted to hospital	\$50 per urgent care visit \$125 per visit; waived if admitted to hospital
<i>Not covered: Elective care or non-emergency care</i>	<i>All charges</i>	<i>All charges</i>
Emergency outside our service area		
<ul style="list-style-type: none"> Emergency care at a doctor's office 	\$15 per visit to your primary care physician \$30 per visit to a specialist	\$20 per visit to your primary care physician \$35 per visit to a specialist
<ul style="list-style-type: none"> Emergency care at an urgent care center 	\$50 per urgent care visit	\$50 per urgent care visit
<ul style="list-style-type: none"> Emergency care as an outpatient or inpatient at a hospital, including doctor's services 	\$100 per visit; waived if admitted to hospital	\$125 per visit; waived if admitted to hospital
<i>Not covered:</i> <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>	<i>All charges</i>
Ambulance		
<ul style="list-style-type: none"> Local professional ambulance service to the nearest hospital equipped to handle your medical condition when medically appropriate. Air ambulance when medically appropriate <p>Note: See 5(c) for non-emergency service.</p>	30% of our allowance	30% of our allowance

Section 5(e) Mental health and substance abuse benefits

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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.
- 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.

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Benefit Description	High Option	Standard Option
Mental health and substance abuse benefits	You pay	You pay
<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>	Your cost sharing responsibilities are no greater than for other illnesses or conditions.	Your cost sharing responsibilities are no greater than for other illnesses or conditions.
<p>Diagnostic and treatment of psychiatric conditions, mental illness and mental disorders. Services include:</p> <ul style="list-style-type: none"> • Diagnostic evaluation • Professional services, including individual or group therapy by providers such as psychiatrists, psychologists, or clinical social workers • Crisis intervention for acute episodes • Medication management 	\$30 per visit	\$35 per visit
<ul style="list-style-type: none"> • Psychological testing necessary to determine the appropriate treatment 	\$30 per visit	\$35 per visit

Mental health and substance abuse benefits – continued on next page.

Mental health and substance abuse benefits <i>(continued)</i>	High Option You pay	Standard Option You pay
<p>Diagnosis and treatment of alcoholism and drug abuse. Services include:</p> <ul style="list-style-type: none"> • Detoxification (medical management of withdrawal from the substance) • Treatment and counseling (including individual and group therapy visits) • Rehabilitation <p>Note: Your mental health or substance abuse provider will develop a treatment plan to assist you in improving or maintaining your condition and functional level, or to prevent relapse.</p> <p>Note: You may see an outpatient mental health or substance abuse provider without referral from your primary care physician. However, before you see a mental health provider you must obtain authorization for the visit from United Behavioral Health at 1-866-607-5970. They can be reached 24 hours a day, 7 days a week to answer questions and assist you in choosing appropriate services. Your mental health provider will obtain subsequent authorizations for treatment.</p>	\$30 per visit	\$35 per visit
<ul style="list-style-type: none"> • Inpatient Psychiatric care • Services provided by a hospital or other facility • Inpatient substance abuse care • Inpatient detoxification • Residential treatment 	\$100 per day up to a \$300 maximum per admission	\$300 per day up to a \$900 maximum per admission
<ul style="list-style-type: none"> • Services in approved alternative care settings such as partial hospitalization, half-way house, full-day hospitalization, facility based intensive outpatient. 	\$30 per visit	\$35 per visit
<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>	<i>All charges</i>	<i>All charges</i>

Preauthorization

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

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

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

Limitation

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

Section 5(f) Prescription drug benefits

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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.
- 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.

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

- **Who can write your prescription.** A licensed physician, referral physician or oral surgeon must write the prescription.
- **Where you can obtain them.** You may fill the prescription at a participating pharmacy. You may obtain maintenance medication through Caremark, our mail order prescription drug program. **Caremark's Customer Service number is 1-800-378-7040**
- **We use a formulary.** A formulary is a list of specific generic and brand name prescription drugs authorized by the Health Plan, and subject to periodic review and modification. Since there may be more than one brand name of a prescription drug, not all brands of the same prescription drug (e.g., different manufactures) may be included in the Formulary. If you would like information on whether a specific drug is included in our drug formulary, please call Customer Service at 1-800-969-3343.

If your pan physician specifically prescribes a non-formulary drug because it is medically necessary, you will receive the non-formulary drug at the Plan non-formulary copayment. If you request a non-formulary drug when your physician has prescribed a substitution, we will not provide the non-formulary drug. However, you may purchases the non-formulary drug from a Plan pharmacy at our allowance.

- **These are the dispensing limitations.** Prescription Drugs will be dispensed in the quantity determined by the Prescribing Provider. The following also apply:
 - One (1) applicable copayment is due each time a prescription is filled or refilled at a retail pharmacy for up to a thirty-one (31) day supply.
 - Mail Order Drugs are obtained through Caremark, our mail order prescription drug program, and may be dispensed with three (3) applicable copayment(s), or \$30 formulary generic and \$90 brand name formulary, for a ninety-three (93) day supply. **To order prescriptions or refills please contact Caremark's Customer Service at 1-800-378-7040 or visit the website www.rxrequest.com. Available 24 hours a day – 7 days a week.**
- **Members called to active military duty in a time of national or other emergency who need to obtain a greater-than-normal supply of prescribed medications should call us at 1-800-969-3343.**
- If a brand name Prescription Drug is dispensed, and an equivalent generic Prescription Drug is available, you pay an Ancillary Charge in addition to the formulary brand name copayment. The Ancillary Charge will be due regardless of whether or not the Prescribing Provider indicates that the pharmacy is to "Dispense as Written." The Ancillary Charge is the difference between the average wholesale price of the brand name and the maximum allowable cost price of the generic prescription. Copayments and Ancillary Charges do not apply to the Catastrophic Protection Out-of-Pocket Maximum.

Prescription drug benefits begin on the next page

Prescription drugs (continued)

- **Why use generic drugs?** Generic drugs are lower-priced drugs that are the therapeutic equivalent to more expensive brand-name drugs. They must contain the same active ingredients and must be equivalent in strength and dosage to the original brand-name product. Generics cost less than the equivalent brand-name product. The U.S. Food and Drug Administration sets quality standards for generic drugs to ensure that these drugs meet the same standards of quality and strength as brand-name drugs. Generic drugs are indicated on the formulary listing of prescription drugs.
- **When you do have to file a claim.** When you receive drugs from a Plan pharmacy, you do not have to file a claim. For a covered out-of-area emergency, you will need to file a claim when you receive drugs from a non-Plan pharmacy.

Benefit Description	You pay
<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 (per vial) and lancets • Glucose test strips • Disposable needles and syringes for the administration of covered medications • Contraceptive drugs and devices • Immunosuppressant drugs required after a covered transplant • Injectable contraceptive drugs (such as Depo Provera) • Growth hormones and other self-administered injectables 	<p>Retail Pharmacy</p> <p>\$10 per generic formulary</p> <p>\$30 per brand name formulary</p> <p>\$55 per non-formulary</p> <p>Mail Order (93 day supply)</p> <p>\$30 per generic formulary</p> <p>\$90 per brand name formulary</p> <p>Noted: If there is no generic equivalent available, you will still have to pay the brand name copay.</p>
<ul style="list-style-type: none"> • Drugs to treat sexual dysfunction (Prior Authorization required) 	<p>50% of our allowance</p>
<ul style="list-style-type: none"> • Insulin – Under retail pharmacy benefit, you can obtain up to a 3 month supply of insulin. 	<p>\$30 generic, \$90 brand name formulary, \$165 non-formulary</p>
<ul style="list-style-type: none"> • Oral Contraceptive drugs – Under retail pharmacy benefit, you can obtain up to a 3 month supply of oral contraceptive drugs 	<p>\$30 generic, \$90 brand name formulary, \$165 non-formulary</p>

Covered medications and supplies – continued on next page

Covered medications and supplies <i>(continued)</i>	You pay	
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Drugs and supplies for cosmetic purposes</i> • <i>Medical supplies such as dressings and antiseptics</i> • <i>Smoking cessation drugs, and devices including nicotine gum</i> • <i>Drugs to enhance athletic performance</i> • <i>Fertility drugs</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>Drugs available without a prescription or for which there is a non-prescription equivalent</i> • <i>Appetite suppressants and other drugs to assist in weight control (except for the treatment of morbid obesity when authorized by us and your primary care physician)</i> • <i>Prescription drugs for a non-covered service</i> • <i>Drugs used for hair restoration</i> • <i>Nonprescription medicines; except those designated by the plan.</i> 	<i>All charges</i>	<i>All charges</i>

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.
24 hour nurse line	<p>Call FirstHelp anytime you or a family member experience health symptoms that need attention. Nurses are available to you and your family 24 a day, 7 days a week and are trained to handle your questions. Any member who visits an emergency room or urgent care center as a result of advice from FirstHelp will automatically have associated claims approved. With FirstHelp authorization, you will know in advance if medical services will be covered. You may call 1-800-622-9528 or for the hearing impaired call 1-800-735-2966.</p>
Services for deaf and hearing impaired	<p>The Kansas TDD relay number is 1-800-766-3777.</p> <p>The Missouri TDD relay number is 1-800-735-2966.</p>
Transplant Network	<p>In order to provide members requiring a transplant the opportunity for the best outcomes and experiences, we use our own Coventry Transplant Network.</p>

Section 5 (h) Dental benefits

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 dentally necessary.
- We have no calendar year deductible. There are no out-of-network benefits.
- You must pay the dentist the listed copay at the time of service. You are not limited to a specific number of visits per year. You do not have to be assigned to a certain provider office. You may visit any dentist in the plan. A plan dentist must provide or arrange your care.
- We cover hospitalization for dental procedures only when a non-dental physical impairment exist which makes hospitalization necessary to safeguard the health of the patient. See section 5(c) for inpatient benefits.
- 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.
- This is not a complete list of our Dental benefits. For a complete list of our Dental benefits, contact **National Dental Plans (NDP)** a CompDent company toll free at **1-800-456-5500** or visit NDP's website at **www.compdent.com**.
- Important Note: Prior to treatment, always discuss all fees with the dentist. Some of our benefits list the amount you pay for the service. For other covered benefits, you pay a percentage of the dentist's usual and customary fee. **IT IS YOUR RESPONSIBILITY TO BE INFORMED ABOUT YOUR DENTAL COVERAGE.**

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Accidental injury benefit	You pay
We cover emergency restorative services and supplies necessary to promptly repair (but not replace) sound natural teeth. The need for these services must result from an accidental injury.	The remaining cost after a 20% reduction of participating specialist fees
Dental Benefits	
Service	You pay
General dentist (you pay restorative services)	
Amalgam (fillings silver, plastic or composite)	\$33 - \$55
Crowns (Stainless steel, cast or porcelain/metal)	\$431 - 458
Periodontic services	
Root planning (per quadrant)	\$44 - \$114
Orthodontic services	
Standard fully banded case (available to members age 19 and under)	The remaining cost after a 20% reduction of the participating specialist usual & customary fees for services provided
Endodontic services	
Root canals	The remaining cost after a 20% reduction of the participating specialist usual & customary fees for services provided

Dental benefits - continued on next page

Dental benefits <i>(continued)</i>	You pay
<p>Preventive services</p> <p>Infection control</p> <p>Periodic oral evaluation</p> <p>Prophylaxis</p> <p>Fluoride</p> <p>Sealant</p> <p>Bitewing x-rays</p>	<p>\$8</p> <p>\$10</p> <p>\$23 (adult) \$16 (child)</p> <p>\$12 (child)</p> <p>\$13 (per tooth for child)</p> <p>\$18 (four film); \$26 (7-8 films); \$35 (Panoramic); \$37 (complete series or Intraoral)</p>
<p>Oral surgery</p> <p>Simple extraction</p> <p>Extractions (each additional tooth)</p> <p>Surgical removal of erupted tooth</p>	<p>\$45</p> <p>\$39</p> <p>\$85</p>
<p>Prosthetic services</p> <p>Dentures (complete upper or lower)</p> <p>Partial dentures</p>	<p>\$540</p> <p>\$455</p>
<ul style="list-style-type: none"> Any treatment provided by a participating specialist (advanced degree) will be charged at a 20% reduction of participating specialist fees for that particular case. Note: Some specialists may require a consultation visit before treatment is initiated. 	<p>The remaining cost after a 20% reduction of the participating specialist usual & customary fees for services provided</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <i>Services for injuries or conditions that are covered under Workman's Compensation or Employer Liability Laws.</i> <i>Services which are provided without cost to the member by any municipality, county, or other political subdivision.</i> <i>Cost of dental care that is covered under automobile medical, no fault, or similar type insurance.</i> <i>General anesthesia, IV sedation, nitrous oxide, hospitalization or hospital medical charges of any kind.</i> <i>Osseointegrated implants</i> <i>Member's dental fees apply only when treatment is performed at a participating dental office. If the services of a non-participating specialist or non-participating general dentist are required, these dental fees do not apply, and the patient will be responsible for the non-participating dentist's usual, customary and reasonable fee.</i> 	<p><i>All charges</i></p>

Dental benefits <i>(continued)</i>	You pay
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Reduced fees will not be honored if the dental treatment is already in progress or if the patient's membership is no longer valid.</i> • <i>Any member accepted for orthodontics must remain a member of the dental plan for the full duration of their treatment or risk additional charges from their participating Orthodontist.</i> • <i>A patient's existing dental or medical condition may necessitate extra precautionary procedures and require additional charges.</i> <p>Please discuss all fees with the dentist prior to treatment.</p>	

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Summary

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 6; they apply to the benefits in the following subsections. To obtain claim forms, claims filing advice, or more information about our HDHP benefits, contact us at 1-800-969-3343 or at our website at www.chckansas.com.

Summary

Our high-deductible health plan option provides comprehensive coverage for high-cost medical events and a tax-advantaged way to help you build savings for future medical expenses. The Plan gives you greater control over how you use your health care benefits and you are not required to select a Primary Care Physician. When you enroll in this HDHP option, we establish either a Health Savings Account (HSA) or a Health Reimbursement Arrangement (HRA) for you. Each month, we automatically pass through a portion of the total health Plan premium to your HSA or HRA based upon your eligibility as of the first day of the month.

With this Plan, preventive care is covered in full less your copayments. As you receive other non-preventive medical care, you must meet the Plan's deductible before we pay benefits according to the benefit chart on page 120. You can choose to use funds available in your HSA to make payments toward the deductible or you can pay toward your deductible entirely out-of-pocket, allowing your savings to continue to grow.

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

- **In-network preventive care** The Plan covers preventive care services, such as periodic health evaluations (e.g., annual physicals), screening services (e.g., mammograms), routine prenatal and well-child care, child and adult immunizations. These services are covered if you use a network provider and are fully described in Section 5.1(a). *You do not have to meet the deductible before using these services*

- **Traditional in-network medical care** After you have paid the Plan's deductible, we pay benefits under traditional in-network coverage described in Section 5.1(b).

Covered services include:
 - Medical services and supplies provided by physicians and other health care professionals
 - Surgical and anesthesia services provided by physicians and other health care professionals
 - Hospital services; other facility or ambulance services
 - Emergency services/accidents
 - Mental health and substance abuse benefits
 - Prescription drug benefitsDental benefits.

- **Savings** Health Savings Accounts or Health Reimbursement Arrangements provide a means to help you pay out-of-pocket expenses (see Section 5.1(c) for more details).

- **HSA**

By law, HSAs are available to members who are not eligible for Medicare or do not have other health insurance coverage. In 2005, for each month you are eligible for an HSA premium pass through, we will contribute to your HSA \$41.67 per month for a Self-Only enrollment or \$83.33 per month for a Self and Family enrollment. In addition to our monthly contribution, you have the option to make additional tax-free contributions to your HSA, so long as total contributions do not exceed the limit established by law, which is \$1,050 for Self-Only and \$2,100 for Self and Family - see maximum contribution information in Section 5.1(c). You can use funds in your HSA to help pay your health plan deductible.

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

HSA features include:

- Your HSA is administered by Corporate Benefit Services of America, Inc.
- Your contributions to the HSA are tax deductible
- Your HSA earns tax-free interest
- You can make tax-free withdrawals for qualified medical expenses for you, your spouse and dependents. (See IRS publication 502 for a complete list of eligible expenses.)
- Your unused HSA funds and interest accumulate from year to year
- It's portable - the HSA is owned by you and is yours to keep, even when you leave Federal employment or retire
- When you need it, funds up to the actual HSA balance are available.

- **HRA**

For members who aren't eligible for an HSA, are eligible for Medicare or have another health plan, we will administer and provide an HRA.

In 2005, we will give you an HRA credit of \$41.67 per month for a Self-Only enrollment and \$83.33 per month for a Self and Family enrollment. You can use funds in your HRA to help pay your health plan deductible and/or for certain expenses that don't count toward the deductible.

HRA features include:

- For our HDHP option, the HRA is administered by Corporate Benefit Services of America, Inc.
- Tax-free credit can be used to pay for qualified medical expenses for you and any individuals covered by this HDHP
- Unused credits carryover from year to year
- HRA credit does not earn interest
- HRA credit is forfeited if you leave Federal employment or switch health insurance plans.

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

When you use network providers, your annual maximum for out-of-pocket expenses (deductibles, coinsurance and copayments) for covered services is limited to \$5,000 per person or \$10,000 per family enrollment. However, certain expenses do not count toward your out-of-pocket maximum and you must continue to pay these expenses once you reach your out-of-pocket maximum (such as expenses in excess of the Plan's allowable amount or benefit maximum). Refer to Section 4 *Your catastrophic protection out-of-pocket maximum*, Section 5.1(b) *Traditional medical coverage subject to the deductible*, and Section 5.1(c) *Catastrophic protection for out-of-pocket expenses* for more details.

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

Section 5.1(e) describes the health education resources and account management tools available to you to help you manage your health care and your health care dollars.

Section 5.1(a) Preventive care

Here are some important things you should keep in mind about these preventive care benefits:

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- The Plan pays for preventive care services listed in this Section as long as you use a network provider.
- For all other covered expenses, please see Section 5.1(b) –Traditional Medical Coverage.
- Some covered services that you receive during a preventive service office visit may not qualify as preventive services, and consequently, will be subject to applicable deductibles. In order to be exempt from applicable deductibles, preventive services must qualify as preventive services and listed in Section 223 of the Internal Revenue Code.
- 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.

Benefits Description	You pay
Preventive care, adult	
Professional services, such as: <ul style="list-style-type: none"> • Routine physicals • Routine screenings • Routine immunizations 	\$20 per visit to your primary care physician \$35 per visit to a specialist
<i>Not covered:</i> <ul style="list-style-type: none"> • <i>Physical exams required for obtaining or continuing employment or insurance, attending schools, camp or travel.</i> • <i>Immunizations, boosters, and medications for travel.</i> 	<i>All charges</i>

Preventive care, children	You pay
Professional services, such as: <ul style="list-style-type: none"> • Well-child visits for routine examinations, immunizations and care (up to age 22) 	\$20 per visit to your primary care physician \$35 per visit to a specialist
<ul style="list-style-type: none"> • Childhood immunizations recommended by the American Academy of Pediatrics • 1 routine eye exam every 12 months • 1 routine hearing exam every 24 months 	No additional charge \$20 per visit to your primary care physician \$20 per visit to your primary care physician; \$35 per visit to a specialist
<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 5.1(b) Traditional Medical Coverage subject to the deductible

Here are some important things you should keep in mind about your these benefits:

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- 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 \$1,050 per person or \$2,100 per family enrollment. The family deductible can be satisfied by one or more family members. The deductible applies to almost all benefits in Section 5.1. You must pay your deductible before your Traditional Medical Coverage may begin.
- Under Traditional Medical Coverage, you are responsible for your coinsurance and copayments for covered expenses.
- When you use network providers, you are protected by an annual catastrophic maximum on out-of-pocket expenses for covered services. After your coinsurance, copayments and deductibles total \$5,000 per person or \$10,000 per family enrollment in any calendar year, you do not have to pay any more for covered services from network providers. However, certain expenses do not count toward your out-of-pocket maximum and you must continue to pay these expenses once you reach your out-of-pocket maximum (such as expenses in excess of the Plan’s benefit maximum, and payments for dental care services).
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage.

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Deductible before Traditional Medical Coverage begins	You pay
The deductible applies to almost all benefits in this Section. In the <i>You pay</i> 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 \$1,050 for Self-Only or \$2,100 for Self and Family.
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.

Section 5.1(b)(1).Medical services and supplies provided by physicians and other health care professionals

Benefit Description	After the deductible, you pay
Diagnostic and treatment services	
Professional services of physicians	
<ul style="list-style-type: none"> • In physician’s office • In an urgent care center for routine services • During a hospital stay • In a skilled nursing facility • At home 	<p>\$20 per visit to your primary care physician; \$35 per visit to a specialist</p> <p>20% of the Plan allowance</p> <p>20% of the Plan allowance</p> <p>20% of the Plan allowance</p> <p>\$20 per visit to your primary care physician; \$35 per visit to a specialist</p>
Lab, X-ray and other diagnostic tests	
Tests, such as:	20% of our allowance
<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 	

Maternity care	After the deductible, you pay
<p>Complete maternity (obstetrical) care, such as:</p> <ul style="list-style-type: none"> • Prenatal care • Delivery • Postnatal care • Note: Here are some things to keep in mind: • You do not need to precertify your normal delivery; see below for other circumstances, such as extended stays for you or your baby. • You may remain in the hospital up to 48 hours after a regular delivery and 96 hours after a cesarean delivery. We will cover an extended inpatient stay if medically necessary but you, your representatives, your doctor, or your hospital must recertify the extended stay. • We cover routine nursery care of the newborn child during the covered portion of the mother's maternity stay. We will cover other care of an infant who requires non-routine treatment only if we cover the infant under a Self and Family enrollment. (Surgical benefits, not maternity benefits, apply towards circumcision the newborn; see page 74). • We pay hospitalization and surgeon services (delivery) the same as for illness and injury. See Hospital benefits (see page 79) and Surgery benefits (see page 74). 	<p>\$20 for initial office visit to your primary care physician to confirm pregnancy; or \$35 for initial office visit to a specialist to confirm pregnancy</p> <p>20% of our allowance for delivery</p> <p>\$20 for initial office visit to your primary care for postnatal care; or \$35 for initial office visit to a specialist for postnatal care</p>
<p><i>Not covered: Routine sonograms to determine fetal age, size or sex.</i></p>	<p><i>All charges</i></p>
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 5.1 (b)(2)) • Injectable contraceptive drugs (such as Depo Provera) • Intrauterine devices (IUDs) • Diaphragms <p>Note: We cover oral contraceptives under the prescription drug benefit</p>	<p>20% of our allowance</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Reversal of voluntary sterilization</i> • <i>Genetic counseling</i> 	<p><i>All charges</i></p>

Infertility services	After the deductible, you pay
<p>Diagnosis and treatment of infertility such as:</p> <ul style="list-style-type: none"> • Artificial insemination: <ul style="list-style-type: none"> intrauterine insemination (IUI) intrauterine insemination (IUI) intrauterine insemination (IUI) <p>Note: We cover injectible fertility drugs under medical benefits and oral fertility drugs under the prescription drug benefit.</p>	20% of our allowance
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • Assisted reproductive technology (ART) procedures, such as: <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>Fertility drugs</i> 	<i>All charges</i>
Allergy care	
<ul style="list-style-type: none"> • Testing • Treatment/Allergy injections 	<p>20% of the Plan allowance</p> <p>\$20 per visit to a primary care physician; \$35 per visit to a specialist</p>
<ul style="list-style-type: none"> • Allergy serum 	Nothing
<p><i>Not covered: Provocative food testing and sublingual allergy desensitization</i></p>	<i>All charges</i>

Treatment therapies	After the deductible, you pay
<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 77.</p>	<p>\$20 for office visit to your primary care physician</p> <p>\$35 for office visit to a specialist</p> <p>20% of our allowance all other settings</p>
<p>Respiratory and inhalation therapy – limited to 60 visits per condition</p>	<p>\$20 for office visit to your primary care physician</p> <p>\$35 for office visit to a specialist</p> <p>20% of our allowance all other settings</p>
<p>Dialysis – hemodialysis and peritoneal dialysis</p>	<p>\$20 for office visit to your primary care physician</p> <p>\$35 for office visit to a specialist</p> <p>20% of our allowance all other settings</p>
<p>Intravenous (IV) Infusion Therapy – Home IV and antibiotic therapy</p>	<p>\$20 for office visit to your primary care physician</p> <p>\$35 for office visit to a specialist</p> <p>20% of our allowance all other settings</p>
<p>Growth hormone therapy (GHT)</p> <p>Note: Growth Hormone Therapy is covered under the prescription drug benefit</p> <p>Note: – We only cover GHT when we preauthorize the treatment. Call 1-800-969-3343 for preauthorization. We will ask you to submit information that establishes that the GHT is medically necessary. Ask us to authorize GHT before you begin treatment; 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>	

Physical and occupational therapies	After the deductible, you pay
<p>60 days per condition for the services of each of the following:</p> <ul style="list-style-type: none"> • qualified physical therapists • occupational therapists • chiropractors (coverage limited to subluxation and manipulation) <p>Note: We only cover therapy to restore bodily function when there has been a total or partial loss of bodily function due to illness or injury.</p> <ul style="list-style-type: none"> • Cardiac rehabilitation following a heart transplant, bypass surgery or a myocardial infarction is provided for up to 60 sessions. 	\$35 for office visit
<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	
60 days per condition	\$35 for office visit
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 22 (see <i>Preventive care, children</i>) 	<p>\$20 per visit to your primary care physician</p> <p>\$35 per visit to a specialist</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>All charges</i>

Vision services (testing, treatment, and supplies)	After the deductible, you pay
<ul style="list-style-type: none"> • One pair of eyeglasses or contact lenses to correct an impairment directly caused by accidental ocular injury or intraocular surgery (such as for cataracts) • Eye exam to determine the need for vision correction for children through age 22 (see Preventive care, children) 	\$20 per visit to your primary care physician \$35 per visit to a specialist
<ul style="list-style-type: none"> • Annual eye refractions <p>Note: See Preventive care, children for eye exams for children.</p>	\$20 per office visit
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Eyeglasses or contact lenses and after age 22 examinations for them</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> <p>Note: See Orthopedic and prosthetic devices for information on podiatric shoe inserts.</p>	\$20 per visit to your primary care physician \$35 per visit to a specialist
<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	After the deductible, you pay
<p>We limit coverage to \$1,000 per member per calendar year.</p> <ul style="list-style-type: none"> • Orthopedic devices such as braces • Artificial limbs and eyes; stump hose • Externally worn breast prostheses and surgical bras, including necessary replacements following a mastectomy. External prosthetic devices, except those associated with reconstructive surgery after a mastectomy, are limited to one per member per lifetime. • Internal prosthetic devices, such as artificial joints, pacemakers, cochlear implants, and surgically implanted breast implant following mastectomy. Note: See 5.1(b)(3) for coverage of the surgery to insert the device. • Corrective orthopedic appliances for non-dental treatment of temporomandibular joint (TMJ) pain dysfunction syndrome. 	<p>20% of our Plan allowance</p>
<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>Orthotics (regular or custom, including but not limited to ankle foot orthotics or podiatric 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>Dental braces, devices, and appliances</i> • <i>Braces for aid in sports activities</i> • <i>Internally implanted devices, equipment, and prosthetics related to treatment of sexual dysfunction</i> • <i>Repair and replacement of orthopedic and prosthetic devices, unless necessitated by normal growth</i> • <i>Doc bands (Dynamic Orthotic Cranial Bands)</i> 	<p><i>All charges</i></p>

Durable medical equipment (DME)	After the deductible, you pay
<p>We limit coverage to \$1,000 per member per calendar year.</p> <p>Rental or purchase, at our option, including repair and adjustment, of durable medical equipment prescribed by your Plan physician, such as oxygen and dialysis equipment. Under this benefit, we also cover:</p> <ul style="list-style-type: none"> • Hospital beds; • Wheelchairs; • Crutches; • Walkers; • Ostomy and urological supplies; • Prosthetic and orthotic supplies; • Blood glucose monitors; and • Insulin pumps, and syringes for insulin pumps • Apnea monitor • Cane; • Replacement due to anatomical growth; • Repair and replacement of DME determined to be medically necessary. <p>Note: Call us at 800-969-3343 as soon as your Plan physician prescribes this equipment. We will arrange with a health care provider to rent or sell you durable medical equipment at discounted rates and will tell you more about this service when you call.</p>	<p>20% of our allowance</p>

Durable medical equipment (DME) (continued)	After the deductible, you pay
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Motorized wheelchairs</i> • <i>Comfort, convenience, or luxury items or features</i> • <i>Electric monitors of bodily functions, except for apnea monitors</i> • <i>Devices to perform medical testing of bodily fluids, excretions, or substances</i> • <i>Disposable supplies</i> • <i>Replacement of lost equipment</i> • <i>Repair, adjustment, or replacement necessitated by wear, tear, or misuse</i> • <i>More than one piece of durable medical equipment serving essentially the same function, except for replacement due to anatomical growth; spare equipment or alternate use equipment is not provided</i> 	<p><i>All charges</i></p>
<p>Home health services</p>	
<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.), physical therapist, speech therapist, occupational therapist. • Services include oxygen therapy, intravenous therapy and medications 	<p>20% of our allowance</p>
<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>Services primarily for hygiene, feeding, exercising, moving the patient, homemaking, companionship or giving oral medication</i> • <i>Nursing care that could appropriately be rendered in a Plan medical office, affiliated hospital, or skilled nursing facility</i> • <i>Nursing care that can be performed safely and effectively by people whom, in order to provide the care do not require medical licenses or certificates, or the presence of a supervising licensed nurse</i> • <i>Home care primarily for personal assistance that does not include a medical component and is not diagnostic, therapeutic, or rehabilitative.</i> 	<p><i>All charges</i></p>

Chiropractic	After the deductible, you pay
See Physical and occupational therapies	
Alternative treatments	
<i>No benefit</i>	<i>All charges</i>
Educational classes and programs	
Coverage is limited to: <ul style="list-style-type: none"> • Diabetes self- management educational classes, as referred by your Plan physician 	\$20 per office visit

Section 5.1(b)(2) Surgical and anesthesia services provided by physicians and other health care professionals

Benefit Description	After the deductible, you pay
Surgical procedures	
<p>YOU MUST GET PRECERTIFICATION FOR SOME SURGICAL PROCEDURES. Please refer to the precertification information in Section 3 to be sure which services require precertification.</p>	
<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 • Circumcision of a newborn • Correction of congenital anomalies (see Reconstructive surgery) • Surgical treatment of morbid obesity -- a condition in which an individual weighs 100 pounds or 100% over his or her normal weight according to current underwriting standards; eligible members must be age 18 or over • Insertion of internal prosthetic devices. See 5.1(b)(1) – Orthopedic and prosthetic devices for device coverage information • Treatment of burns • Note: Generally, we pay for internal prostheses (devices) according to where the procedure is done. For example, we pay Hospital benefits for a pacemaker and Surgery benefits for insertion of the pacemaker • Voluntary sterilization (e.g., Tubal ligation, Vasectomy). 	20% of our allowance
<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> 	<i>All charges</i>

Reconstructive surgery	After the deductible, you pay
<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>20% of our allowance</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	After the deductible, you pay
<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. • Treatment of TMJ 	<p>20% of our allowance</p>
<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>TMJ related dental work</i> 	<p><i>All charges</i></p>

Organ/tissue transplants	After the deductible, you pay
<p>Limited to:</p> <ul style="list-style-type: none"> • Cornea • Heart • Heart/lung • Kidney • Kidney/Pancreas • Liver • Lung: Single – Double • Pancreas • Allogeneic (donor) bone marrow transplants • Autologous bone marrow transplants (autologous stem cell and peripheral stem cell support) for the following conditions: acute lymphocytic or non-lymphocytic leukemia; advanced Hodgkin’s lymphoma; advanced non-Hodgkin’s lymphoma; advanced neuroblastoma; breast cancer; multiple myeloma; epithelial ovarian cancer; and testicular, mediastinal, retroperitoneal and ovarian germ cell tumors • Intestinal transplants (small intestine) and the small intestine with the liver or small intestine with multiple organs such as the liver, stomach, and pancreas <p>Limited Benefits – Treatment for breast cancer, multiple myeloma, and epithelial ovarian cancer may be provided 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.</p> <p>Note: We cover related medical and hospital expenses of the donor when we cover the recipient provided the recipient is a plan member. After referral to a transplant facility, the following will apply:</p> <ul style="list-style-type: none"> • If our Medical Director or the referral facility decides you do not satisfy criteria for a transplant, we only pay for covered services you receive before that decision is made • We, and the plan providers are not responsible for finding, furnishing, or ensuring the availability of a bone marrow or organ donor • We cover reasonable medical and hospital expenses as long as the expenses are directly related to a covered transplant of the donor or an individual identified as a potential donor, even if a member • Unless otherwise authorized by our Medical Director, we provide transplants only at approved Transplant Network facilities 	<p>20% of our allowance</p>

Organ/tissue transplants (continued)	After the deductible, you pay
<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>Any related conditions or complications for a member who is donating an organ or tissue when the recipient is not a member</i> • <i>Outpatient immunosuppressive agents</i> • <i>Any transplant procedure that is performed in a facility that has not been designated by the Medical Director as a approved transplant facility</i> • <i>Implants of non-human or artificial organs</i> • <i>Transplants not listed as covered</i> 	<p><i>All charges</i></p>
Anesthesia	
<p>Professional services provided in –</p> <ul style="list-style-type: none"> • Hospital (inpatient) • Hospital outpatient department • Skilled nursing facility • Ambulatory surgical center 	<p>20% of our allowance</p>

**Section 5.1(b)(3) Services provided by a hospital or other facility,
and ambulance services**

Benefit Description	After the deductible, you pay
<p>Inpatient hospital</p> <p>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 5.1(a) or (b).</p> <p>YOUR PHYSICIAN MUST GET PRECERTIFICATION OF HOSPITAL STAYS. Please refer to the precertification information shown in Section 3.</p>	
<p>Room and board, such as</p> <ul style="list-style-type: none"> • Ward, semiprivate, or intensive care accommodations; • General nursing care; and • Meals and special diets. <p>Note: If you want a private room when it is not medically necessary, you pay the additional charge above the semiprivate room rate.</p>	<p>20% of our allowance</p>
<p>Other hospital services and supplies, such as:</p> <ul style="list-style-type: none"> • Operating, recovery, maternity, and other treatment rooms • Prescribed drugs and medicines • Diagnostic laboratory tests and X-rays • Blood or blood plasma, if not donated or replaced • Dressings, splints, casts, and sterile tray services • Medical supplies and equipment, including oxygen • Anesthetics, including nurse anesthetist services • Medical supplies, appliances, medical equipment, and any covered items billed by a hospital for use at home 	<p>20% of our allowance</p>

Inpatient hospital (continued)	After the deductible, you pay
<p><i>Not covered:</i></p> <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> 	<p><i>All charges</i></p>
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>	<p>20% of our allowance</p>
<p><i>Not covered: Blood and blood derivatives not replaces by the member</i></p>	<p><i>All charges</i></p>
Extended care benefits/Skilled nursing care facility benefits	
<p>A comprehensive range of benefits covered for 60 days per calendar year with no day limit when full-time skilled nursing care is necessary and confinement in a skilled nursing facility is medically appropriate as determined by a Plan doctor and approved by the Plan. All necessary services are covered, including:</p> <p>Bed, board and general nursing care</p> <p>Drugs, biologicals, supplies, and equipment ordinarily provided and arranged by the skilled nursing facility when prescribed by a Plan doctor.</p>	<p>20% of our allowance</p>
<p><i>Not covered: Custodial care</i></p>	<p><i>All charges</i></p>

Hospice care	After the deductible, you pay
<ul style="list-style-type: none"> Supportive and Palliative care for a terminally ill member is covered in the home or hospice facility. Services include inpatient and outpatient care and family counseling. These services are provided under the direction of a Plan doctor who certifies that the patient is in the terminal stages of illness, with a life expectancy of approximately six months or less. 	20% of our allowance
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <i>Service in the member's home outside of the service area</i> <i>Any service for which the hospice does not customarily charge the member, or his or her family</i> <i>Independent nursing, homemaker services</i> 	<i>All charges</i>
Ambulance	
<ul style="list-style-type: none"> Local professional ambulance service to the nearest hospital equipped to handle your medical condition when medically appropriate. Air ambulance when medically appropriate. 	20% of our allowance

Section 5.1(b)(4) Emergency services/accidents

What is a medical emergency?

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

What to do in case of emergency:

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

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

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

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

We also provide several Urgent Care centers which are open on evenings, weekends and holidays, and are designed to give our members fast, effective quality care for non-emergent conditions such as: sprains, influenza, sore throats, ear infections, minor lacerations, and upper respiratory infections.

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

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

Benefit Description	After deductible, you pay
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 or inpatient at a hospital, including doctor’s services 	<p>\$20 for office visit to your primary care physician; or \$35 for office visit to a specialist</p> <p>20% of our allowance all other settings</p>
<i>Not covered: Elective 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 or inpatient at a hospital, including doctor’s services 	<p>\$20 for office visit to your primary care physician; or \$35 for office visit to a specialist</p> <p>20% of our allowance all other settings</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	
<ul style="list-style-type: none"> • Local professional ambulance service to the nearest hospital equipped to handle your medical condition when medically appropriate. • Air ambulance when medically appropriate. 	20% of our allowance

Section 5.1(b)(5) Mental health and substance abuse benefits

Benefit Description	After the deductible, you pay
In-network 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 	\$35 per visit copay
<ul style="list-style-type: none"> • Diagnostic tests 	\$35 per visit copay
<ul style="list-style-type: none"> • Services provided by a hospital or other facility • Residential Treatment 	20% of the Plan allowance
<ul style="list-style-type: none"> • Services in approved alternative care settings such as partial hospitalization, half-way house, full-day hospitalization, facility based intensive outpatient 	\$35 per visit copay
<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>	<i>All charges</i>

Preauthorization

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

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

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

In-network limitation

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

Section 5.1(b)(6) Prescription drug benefits

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

- **Who can write your prescription.** A licensed physician, referral physician or oral surgeon must write the prescription.
- **Where you can obtain them.** You may fill the prescription at a participating pharmacy. You may obtain maintenance medication through Caremark, our mail order prescription drug program. **Caremark's Customer Service number is 1-800-378-7040**
- **We use a formulary.** A formulary is a list of specific generic and brand name prescription drugs authorized by the Health Plan, and subject to periodic review and modification. Since there may be more than one brand name of a prescription drug, not all brands of the same prescription drug (e.g., different manufactures) may be included in the Formulary. If you would like information on whether a specific drug is included in our drug formulary, please call Customer Service at 1-800-969-3343.

If your pan physician specifically prescribes a non-formulary drug because it is medically necessary, you will receive the non-formulary drug at the Plan non-formulary copayment. If you request a non-formulary drug when your physician has prescribed a substitution, we will not provide the non-formulary drug. However, you may purchases the non-formulary drug from a Plan pharmacy at our allowance.

- **These are the dispensing limitations.** Prescription Drugs will be dispensed in the quantity determined by the Prescribing Provider. The following also apply:
 - One (1) applicable copayment is due each time a prescription is filled or refilled at a retail pharmacy for up to a thirty-one (31) day supply.
 - Mail Order Drugs are obtained through Caremark, our mail order prescription drug program, and may be dispensed with three(3) applicable copayment(s), or \$45 formulary generic and \$75 brand name generic, for a ninety-three (93) day supply. **To order prescriptions or refills please contact Caremark's Customer Service at 1-800-378-7040 or visit the website www.rxrequest.com. Available 24 hours a day – 7 days a week.**
 - **Members called to active military duty in a time of national or other emergency who need to obtain a greater-than-normal supply of prescribed medications should call us at 1-800-969-3343.**
 - If a brand name Prescription Drug is dispensed, and an equivalent generic Prescription Drug is available, you pay an Ancillary Charge in addition to the formulary brand name copayment. The Ancillary Charge will be due regardless of whether or not the Prescribing Provider indicates that the pharmacy is to "Dispense as Written." The Ancillary Charge is the difference between the average wholesale price of the brand name and the maximum allowable cost price of the generic prescription. Copayments and Ancillary Charges do not apply to the Catastrophic Protection Out-of-Pocket Maximum
 - **Why use generic drugs?** Generic drugs are lower-priced drugs that are the therapeutic equivalent to more expensive brand-name drugs. They must contain the same active ingredients and must be equivalent in strength and dosage to the original brand-name product. Generics cost less than the equivalent brand-name product. The U.S. Food and Drug Administration sets quality standards for generic drugs to ensure that these drugs meet the same standards of quality and strength as brand-name drugs. Generic drugs are indicated on the formulary listing of prescription drugs.
 - **When you do have to file a claim.** When you receive drugs from a Plan pharmacy, you do not have to file a claim. For a covered out-of-area emergency, you will need to file a claim when you receive drugs from a non-Plan pharmacy.
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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 (per vial) and lancets • Glucose test strips • Disposable needles and syringes for the administration of covered medications • Contraceptive drugs and devices • Immunosuppressant drugs required after a covered transplant • Injectable contraceptive drugs (such as Depo Provera) • Growth hormones and other self-administered injectables • Insulin – Under retail pharmacy benefit, you can obtain up to a 3 month supply of insulin • Oral Contraceptive drugs – Under retail pharmacy benefit, you can obtain up to a 3 month supply of oral contraceptive drugs 	<p>Retail Pharmacy</p> <p>\$15 per generic formulary</p> <p>\$25 per brand name formulary</p> <p>\$50 per non-formulary</p> <p>Mail Order (93 day supply)</p> <p>\$45 per generic formulary</p> <p>\$75 per brand name formulary</p> <p>Noted: If there is no generic equivalent available, you will still have to pay the brand name copay</p>
<ul style="list-style-type: none"> • Drugs to treat sexual dysfunction (Prior Authorization required) 	<p>50% of our allowance</p>

Covered medications and supplies <i>(continued)</i>	After the deductible, you pay
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Drugs and supplies for cosmetic purposes</i> • <i>Medical supplies such as dressings and antiseptics</i> • <i>Smoking cessation drugs, and devices including nicotine gum</i> • <i>Drugs to enhance athletic performance</i> • <i>Fertility drugs</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>Drugs available without a prescription or for which there is a non-prescription equivalent</i> • <i>Appetite suppressants and other drugs to assist in weight control (except for the treatment of morbid obesity when authorized by us and your primary care physician)</i> • <i>Prescription drugs for a non-covered service</i> • <i>Drugs used for hair restoration</i> • <i>Nonprescription medicines; except those designated by the plan.</i> 	<p><i>All charges.</i></p>

Section 5.1(b)(7) Special features

Special 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.
24 hour nurse line	<p>Call FirstHelp anytime you or a family member experience health symptoms that need attention. Nurses are available to you and your family 24 a day, 7 days a week and are trained to handle your questions. Any member who visits an emergency room or urgent care center as a result of advice from FirstHelp will automatically have associated claims approved. With FirstHelp authorization, you will know in advance if medical services will be covered. You may call 1-800-622-9528 or for the hearing impaired call 1-800-735-2966.</p>
Services for deaf and hearing impaired	<p>The Kansas TDD relay number is 1-800-766-3777.</p> <p>The Missouri TDD relay number is 1-800-735-2966.</p>
Transplant Network	<p>In order to provide members requiring a transplant the opportunity for the best outcomes and experiences, we use our own Coventry Transplant Network.</p>

Section 5.1(c) 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, Inc. (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 America, Inc. P.O. Box 270520 Golden Valley, MN 55427 1-800-566-9311 or https://services.cbsainc.com/eehome.asp</p>	<p>Corporate Benefit Services of America, Inc. (CBSA) is the HRA fiduciary for this Plan.</p> <p>Corporate Benefit Services of America, Inc. P.O. Box 270520 Golden Valley, MN 55427 1-800-566-3911 or https://services.cbsainc.com/eehome.asp</p>
Fees	Set-up fee, and monthly maintenance fee are paid by the HDHP as long as you are enrolled in the HDHP.	Set-up fee paid by the HDHP.
Eligibility	<ul style="list-style-type: none"> • Enrolled in Coventry Flex Choice HDHP P.O. Box 270520 Golden Valley, MN 55427 • No other health insurance coverage (does not apply to specific injury, accident, disability, dental, vision or long-term care coverage) • Not eligible for Medicare Part A or Part B • Not claimed as a dependent on someone else’s tax return • Complete and return all banking paperwork • Eligibility is determined on the first day of the month 	<ul style="list-style-type: none"> • Enrolled in Coventry Flex Choice HDHP P.O. Box 270520 Golden Valley, MN 55427 • Eligibility is determined on the first day of the month

<p>Funding</p> <ul style="list-style-type: none"> • Self Only coverage • Self and Family coverage 	<p><i>\$500</i> annual premium pass through by HDHP directly into account prorated on a monthly basis.</p> <p><i>\$1000</i> premium pass through by HDHP directly into account, prorated on a monthly basis.</p> <p>Eligibility for contributions will be determined on the first day of the month and will be prorated for length of enrollment.</p>	<p><i>\$500</i> annual credit (prorated monthly and credited to the account) provided by the HDHP upon effective date</p> <p><i>\$1000</i> annual credit (prorated monthly) provided by the HDHP upon effective date</p> <p>Eligibility for annual credit will be determined on the first day of the month and will be prorated for length of enrollment.</p>
<p>Contributions/credits</p> <ul style="list-style-type: none"> • Self Only coverage • Self and Family coverage 	<p>The maximum that can be contributed to your HRA is an annual combination of HDHP premium pass through and enrollee contribution funds, which when combined, do not exceed the amount of the deductible, which is <i>\$1,050 for Self-Only and \$2100 for Self and Family</i></p> <p>For each month you are eligible for HSA contributions,</p> <p>The HDHP will make a premium pass through of <i>\$41.67 per month</i>. You may make an additional annual contribution of <i>\$550</i>.</p> <p>The HDHP will make a premium pass through of <i>\$83.33 per month</i>. You may make an additional annual contribution of <i>\$1,100</i>.</p> <p>If you choose to contribute to your HSA,</p> <ul style="list-style-type: none"> -You must deduct 1/12 of total annual maximum contribution for every month you are not eligible for the HDHP the whole month. For instance, if your enrollment in this Plan was not effective on January 1, 2005, you cannot receive a credit for January and you would need to deduct 1/12 of the annual maximum contribution. -You may rollover funds you have in other HSAs to this HDHP HSA (rollover funds do not affect your annual maximum contribution under this HDHP). - HSAs earn tax-free interest (does not affect your annual maximum contribution). 	<p>The full HRA credit will be available, subject to proration, on the effective date of enrollment. The HRA does not earn interest. You cannot contribute to the HRA.</p> <p>The HDHP will credit the HRA account <i>\$41.67 per month</i>.</p> <p>The HDHP will credit the HRA account <i>\$83.33 per month</i>.</p>

<p>Access funds</p>	<p>You can access your HSA by the following methods</p> <ul style="list-style-type: none"> • Withdrawal form 	<p>For qualified medical expenses under your HDHP, you will be automatically reimbursed when claims are submitted through <i>Coventry's Flex Choice HDHP</i>. For expenses not covered by the HDHP, such as orthodontia, a reimbursement form will be sent to you.</p>
<p>Distributions/withdrawals</p> <ul style="list-style-type: none"> • Medical 	<p>For meeting the deductible or paying the out-of-pocket expenses for yourself, your spouse or your dependents even if they are not covered by the HDHP from the funds available in your HSA.</p> <p>Medical expenses are not allowable if they occur before the first full month your enrollment is effective, and they are not reimbursable from your HSA until the first of the month following the effective date of your enrollment in this HDHP and the date your HSA account is established.</p> <p>For most Federal enrollees (those not paid on a monthly basis), the earliest date medical expenses will be allowable is February 1, 2005.</p> <p>See IRS Publication 502 for a complete list of eligible expenses.</p>	<p>For meeting the deductible or paying the out-of-pocket expenses for qualified medical expenses for individuals covered under the HDHP.</p> <p>Non-reimbursed qualified medical expenses are allowable if they occur after the effective date of your enrollment in this Plan.</p> <p>See <i>Availability of funds</i> below for information on when funds are available in the HRA.</p> <p>See IRS Publication 502 for a complete list of eligible expenses.</p>
<ul style="list-style-type: none"> • Non-medical 	<p>If you are under age 65, withdrawal of funds for non-medical expenses will create a 10% income tax penalty in addition to any other income taxes you may owe on the accumulated funds.</p> <p>When you turn age 65, distributions can be used for any reason without being subject to the 10% penalty</p>	<p>Not applicable – distributions will not be made for anything other than non-reimbursed qualified medical expenses</p>
<p>Availability of funds</p>	<p>Funds are not available until:</p> <ul style="list-style-type: none"> • Your enrollment in this HDHP is effective (effective date is determined by your agency in accord with the event permitting the enrollment change) • The HDHP receives record of your enrollment and initially establishes your HSA account with the fiduciary by providing information it must furnish and by contributing the minimum amount required to establish an HSA 	<p>Funds are not available until:</p> <ul style="list-style-type: none"> • Your enrollment in this HDHP is effective (effective date is determined by your agency in accord with the event permitting the enrollment change) • The HDHP receives record of your enrollment and initially establishes your HRA account with the fiduciary by providing information it must furnish to establish an HSA
<p>Account owner</p>	<p>FEHB enrollee</p>	<p>HDHP</p>

Portable	Yes, you can take this account with you when you separate or retire.	<p>If you retire and remain in this HDHP, you may continue to use and accumulate credits in your HRA.</p> <p>If you terminate employment or change health plans, only eligible expenses incurred while covered under the HDHP will be eligible for reimbursement subject to timely filing requirements. Unused funds are forfeited.</p>
Annual rollover	Yes, accumulates without a maximum cap.	Yes, accumulates without a maximum cap.

Health Savings Accounts

Is the “premium pass through” to my HSA considered taxable income?

“Premium pass through” contributions by the HDHP are not considered taxable income.

Can I contribute to my HSA?

Yes. All contributions are aggregated and cannot exceed the annual maximum contribution. You may contribute your own money to your account through payroll deductions (if available), or you may make a lump sum contribution at any time, in any amount up to an annual maximum limit. Others can also make contributions to your HSA on your behalf. If you (or someone on your behalf) contribute a lump-sum, you can claim the total amount contributed for the year as a tax deduction when you file your income taxes. You receive tax advantages in any case. You have until April 15 of the following year to make HSA contributions for the current year.

IRS contribution rules reduce the total annual maximum contribution if you are not eligible for the HDHP during the whole month. For instance, if your enrollment in this Plan was not effective on January 1, 2005, you cannot receive a credit for January and you would need to deduct 1/12 of the annual maximum contribution. Contact *Corporate Benefit Services of America, Inc.*, <https://services.cbsainc.com/eehome.asp> for more details.

Catch-up contributions

If you are age 55 or older, the IRS permits you to make additional catch-up contributions to your HSA. In 2005, you may contribute up to \$500 in “catch-up” contributions. Catch-up contributions in later years increase up to a maximum of \$1,000 in 2009 and beyond. Contributions must stop once an individual is eligible for Medicare. Additional details are available on the IRS Web site at www.irs.gov.

Rate of interest earned

Depending on how you choose to invest your HSA savings, the interest rate and payment of interest will vary. Contact *CBSA* at <https://services.cbsainc.com/eehome.asp> for more details on the investment options available to you.

What happens to my HSA if I leave my health plan or job?

You own your account, so you keep your HSA even if you change health plans, leave Federal employment, become eligible for Medicare, or any of the other events which may make you ineligible for further contributions to your HSA. Even when you are not eligible to make contributions to your HSA, you may request withdrawals.

What happens to my HSA if I die?

Your HSA would pass to your surviving spouse or named beneficiary tax free. If you do not have a named beneficiary, the money is disbursed to your estate and is taxable.

What expenses can I pay for with my HSA?

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

When you become Medicare-eligible, you can use the account to purchase any health insurance other than a Medigap policy. You may not, however, continue to make contributions to your HSA once you are Medicare eligible.

For the complete list of IRS-allowable expenses, request a copy of IRS Publication 502 by calling 1-800-829-3676, or visit the IRS website at www.irs.gov and click on “Forms and Publications.”

Non-qualified health expenses	You may withdraw money from your HSA for items other than qualified health expenses, but it will be subject to income tax and if you are under 65 years old, an additional 10% penalty tax on the amount withdrawn.
Tracking your HSA balance	You will receive a periodic statement that shows the “premium pass through” and withdrawals, and interest earned on your account. In addition, you will receive an Explanation of Payment statement when you withdraw money from your HSA.
Minimum reimbursements from your HSA	You can request reimbursement in any amount. However, funds will not be disbursed until your reimbursement totals at least \$25.

Health Reimbursement Arrangements

How do I know if I qualify for an HRA?	If you don’t qualify for an HSA when you enroll, or later become ineligible for an HSA, the HDHP will establish an HRA for you. If you are Medicare eligible, even if you have not elected to enroll in Medicare, you are ineligible for an HSA and your HDHP will establish an HRA for you.
HRA and HSA differences	<p>Please review the chart at the beginning of this Section which details the differences. The major differences are:</p> <ul style="list-style-type: none"> • you cannot make contributions to an HRA • funds are forfeited if you leave the HDHP • an HRA does not earn interest, and • HRAs can only pay for qualified medical expenses, such as deductibles, copayments, and coinsurance expenses, for individuals covered by the HDHP.

Section 5.1(d) Catastrophic protection for out-of-pocket expenses

We will track and accumulate those expenses applicable to the determination of the out-of-pocket expenses for the HDHP. These expenses include copayments, coinsurance payments, and deductibles applied to Covered Services. Some expenses may not apply to satisfying the out-of-pocket maximum; these include but are not limited to ancillary fees for pharmacy, copayments for dental services and expenses for non-Covered Services.

Section 5.1(e) Health education resources and account management tools

Special features	Description
<p>Health education resources</p>	<p>Visit the Health Information section of our website at www.chckansas.com for information to help you take command of your health. This section is organized in simple, user-friendly, sections:</p> <ul style="list-style-type: none"> - Assess Your Health – where you will find a simple, free, online health risk assessment tool to benchmark your wellness, and better understand your overall health status and risks. - About Your Health – for information about a specific condition or general preventive guidelines. - Patient Safety - WebMD – our link to this health site also provides wellness and disease information to help improve health. <ul style="list-style-type: none"> • Prescription Drug educational materials are also accessible through our website, through a link to our pharmacy benefit manager, Caremark. There, you will find: <ul style="list-style-type: none"> - Detailed information about a wide range of prescription drugs; - A drug interaction tool to help easily determine if a specific drug can have any adverse interactions with each other, with over-the-counter drugs, or with herbals and vitamins; - Facts about why FDA-approved generic drugs should be a first choice for effective, economical treatment. <p>Another key health information tool that we make available to you is our online quality tools, powered by HealthShare®. You can review the frequency of procedures performed by a provider, knowing the correlation between frequency of service and quality of outcomes. We post additional quality outcome information, such as re-admission rates within 30 days, post operative complications, and even death rates.</p> <p>We also publish an e-newsletter to keep you informed on a variety of issues related to your good health. Visit our website at www.chckansas.com for back editions of this publication, <i>Living Well</i>.</p> <p>In addition, we augment our health education tools with access to our Nurse Advisor Services. Experienced RNs are available through an inbound call center 24x7x365 to assist you and help you to maximize your benefits, by providing clinical and economic information to make an informed decision on how to proceed with care.</p>
<p>Account management tools</p>	<p>For each HSA and HRA account holder, we maintain a complete claims payment history online through Coventry Health Care of Kansas, Inc.'s password-protected, self-service functionality, My Online Services, at www.chckansas.com</p> <ul style="list-style-type: none"> • You will receive an EOB after every claim.

	<ul style="list-style-type: none"> • If you have an HSA, • You will receive a quarterly statement by mail outlining your account balance and activity. <ul style="list-style-type: none"> ✓ You may also access your account and review your activity on a daily basis online, via My Online Services, at www.chckansas.com <p>If you have an HRA,</p> <ul style="list-style-type: none"> ✓ You will receive a quarterly statement by mail outlining your account balance and activity. 1) You may also access your account and review your activity on a daily basis online, via My Online Services, at www.chckansas.com.
<p>Consumer choice information</p>	<ul style="list-style-type: none"> • As a member of this HDHP, you may choose any provider. However, you will receive discounts when you see a network provider. Our provider search function on our website www.chckansas.com, is updated every week. It lets you easily search for a participating physician based on the criteria <u>you</u> choose, such as provider specialty, gender, secondary languages spoken, or hospital affiliation. You can even specify the maximum distance you're willing to travel and, in most instances, get driving directions and a map to the offices of identified providers. • Pricing information for medical care is available at www.chckansas.com. There, you will find our Health Services Pricing Tools, which provide average cost information for some the most common categories of service. The easy-to-understand information is sorted by categories of service, including physician office visits, diagnostic tests, surgical procedures, and hospitalization. • Pricing information for prescription drugs is available through our link to the website of our pharmacy benefit manager, Caremark (which you can access via www.chckansas.com. Through a password-protected account, you will have the ability to estimate prescription costs before ordering. • Link to online pharmacy through to the website of our pharmacy benefit manager, Caremark which you can access via www.chckansas.com. <p>Educational materials on the topics of HSAs, HRAs and HDHPs are available at www.chckansas.com.</p>
<p>Care support</p>	<ul style="list-style-type: none"> • Our complex case management programs offer special assistance to members with intricate, long term medical needs. Our disease management program fosters a proactive approach to managing care from prevention through treatment and management. Your physician can help arranged for participation in these programs, or you can simply contact our member service department. • Patient safety information is available online at www.chckansas.com. <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>

Section 5.2 Non-FEHB benefits available to Plan members

The benefits on this page are not part of the FEHB contract or premium, **and you cannot file an FEHB disputed claim about them.** Fees you pay for these services do not count toward FEHB deductibles or out-of-pocket maximums.

Vision One Discount Program:

Contact Vision One for a participating Vision One Provider near you, **1-800-804-4384**

Vision One	You pay
<p>Frames-Retail</p> <p>Priced up to \$60.99</p> <p>Priced \$61.00-\$80.99</p> <p>Priced \$81.00-\$100.99</p> <p>Priced \$101.00 and over</p>	<p>\$25.00</p> <p>\$35.00</p> <p>\$45.00</p> <p>65%</p>
<p>Lenses (uncoated plastic)</p> <p>Single Vision</p> <p>Bifocal</p> <p>Trifocal</p> <p>Lenticular</p>	<p>\$30.00</p> <p>\$50.00</p> <p>\$60.00</p> <p>\$100.00</p>
<p>Lens Options (add to lens cost)</p> <p>Standard Progressive (no line)</p> <p>Polycarbonate</p> <p>Scratch Resistant Coating</p> <p>Anti-Reflective Coating</p> <p>Ultraviolet Coating</p> <p>Solid Tint</p> <p>Gradient Tint</p> <p>Photochromic</p> <p>Glass</p>	<p>\$50.00</p> <p>\$30.00</p> <p>\$12.00</p> <p>\$35.00</p> <p>\$12.00</p> <p>\$8.00</p> <p>\$8.00</p> <p>\$30.00</p> <p>\$15.00</p>
<p>Eye Examinations</p> <p>Note: Your medical plan may already cover eye exams. This fee is for subsequent eye exams once your existing eye exam benefit is exhausted.</p>	<p>\$35.00 (Fixed eye exam rate – spectacle exam only)</p>
<p>Contact Lenses</p> <p>Use the Vision One Contact Lens Replacement program for additional savings and convenience.</p>	<p>20% off regular retail prices; 10% discount on disposables</p>
<p>All Other Materials (sunglasses, accessories, etc.)</p>	<p>20% discount off regular retail prices</p>

Prices are subject to change without notice.

Section 6. 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 Benefits);
- 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 7. 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:

Medical, hospital, and drug benefits

In most cases, providers and facilities file claims for you. Physicians must file on the form HCFA-1500, Health Insurance Claim Form. Your facility will file on the UB-92 form. For claims questions and assistance, call us at 1-800-969-3343.

When you must file a claim – such as for services you receive outside 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;
- A copy of the explanation of benefits, payments, or denial from any primary payer – such as the Medicare Summary Notice (MSN); and
- Receipts, if you paid for your services.

Submit your claims to:

Coventry Health Care of Kansas, Inc.

P.O. Box 7109

London, KY 40742

Deadline for filing your claim

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

When we need more information

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

Section 8. 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:

Step	Description
1	<p>Ask us in writing to reconsider our initial decision. You must:</p> <ol style="list-style-type: none">Write to us within 90 days from the date of our decision; andSend your request to us at: Coventry Health Care of Kansas, Inc., Attn: Member Appeals, 8320 Ward Parkway, Kansas City, MO 64114; andInclude a statement about why you believe our initial decision was wrong, based on specific benefit provisions in this brochure; andInclude copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms.
2	<p>We have 30 days from the date we receive your request to:</p> <ol style="list-style-type: none">Pay the claim (or, if applicable, arrange for the health care provider to give you the care); orWrite to you and maintain our denial – go to step 4; orAsk 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	<p>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.</p> <p>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.</p> <p>We will write to you with our decision.</p>
4	<p>If you do not agree with our decision, you may ask OPM to review it.</p> <p>You must write to OPM within:</p> <ul style="list-style-type: none">90 days after the date of our letter upholding our initial decision; or120 days after you first wrote to us – if we did not answer that request in some way within 30 days; or120 days after we asked for additional information. <p>Write to OPM at: United States Office of Personnel Management, Insurance Services Programs, Health Insurance Group 3, 1900 E Street, NW, Washington, DC 20415-3630.</p>

The disputed claims process (*continued*)

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.

5 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 1-800-969-3343 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 202-606-0755 between 8 a.m. and 5 p.m. eastern time.

Section 9. 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 another group 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.
- People with End-Stage Renal Disease (permanent kidney failure requiring dialysis or a transplant).

Medicare has two 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. (Someone who was a Federal employee on January 1, 1983 or since automatically qualifies.) 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.

• 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 both 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 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. Your care must continue to be authorized by your Plan PCP, or precertified as required.

We will waive some copayments, coinsurance, and deductibles, as follows: When Original Medicare is the primary payor, we will waive your out-of-pocket costs including copayments and coinsurance. After the primary plan pays, we will pay what is left of our allowance, up to our regular benefit. We will not pay more than our allowance.

Claims process when you have the Original Medicare Plan – You probably will never have 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 1-800-969-3343 or see our website at www.chckansas.com.

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

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

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 re-employed 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 re-employed 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

- **Medicare Advantage**

If you are eligible for Medicare, you may choose to enroll in and get your Medicare benefits from a Medicare Advantage plan. These are health care choices (like HMOs) in some areas of the country. In most Medicare Advantage plans, you can only go to doctors, specialists, or hospitals that are part of the plan. Medicare Advantage plans provide all the benefits that Original Medicare covers. Some cover extras, like prescription drugs. To learn more about enrolling in a Medicare Advantage plan, contact Medicare at 1-800-MEDICARE (1-800-633-4227) or at www.medicare.gov. **We do not offer a Medicare Advantage Plan.**

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 and also remain enrolled in our FEHB plan. We will still provide benefits when your Medicare Advantage plan is primary, and we will waive your out-of-pocket costs like copayments, and coinsurance, up to our allowed amount. 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.

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 the program.

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. You must use our providers.

Medicaid

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

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

When other Government agencies are responsible for your care

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

When others are responsible for injuries

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

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

Section 10. Definitions of terms we use in this brochure

Calendar year	January 1 through December 31 of the same year. For new enrollees, the calendar year begins on the effective date of their enrollment and ends on December 31 of the same year.
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 19.
Copayment	A copayment is a fixed amount of money you pay when you receive covered services. See page 19.
Covered services	Care we provide benefits for, as described in this brochure.
Custodial care	Care that is primarily for meeting personal needs: such as walking, getting in and out of bed, bathing, dressing, shopping, eating and preparing meals, performing general household services, or taking medicine. Custodial care that lasts 90 days or more is sometimes know as Long term care.
Deductible	A deductible is a fixed amount of covered expenses you must incur for certain covered services and supplies before we start paying benefits for those services. See page 19.
Experimental or investigational services	A health product or service is deemed Experimental Investigational or Unproven if one of the following criteria are met: (1) Any drug not approved for use by the FDA; any drug that is classified as IND (investigational new drug) by the FDA; any drug requiring pre-authorization that is proposed for off-label prescribing; (2) Any health service or product that is subject to Investigational Review Board (IRB) review or approval; (3) Any health service or product that is the subject of a clinical trial that meets criteria for Phase I, Phase II or Phase III as set forth by FDA regulations; (4) Any health product or service that is not considered standard treatment by the medical community, based on clinical evidence reported by peer review medical literature and by generally recognized academic experts.
Group health coverage	Health care benefits that are available as a result of your employment, or the employment of your spouse, and that are offered by an employer or through membership in an employee organization. Health care coverage may be insured or indemnity coverage, self-insured or self-funded coverage, or coverage through health maintenance organizations or other managed care plans.
Medical necessity	Health services and supplies which are deemed by the Plan to medically appropriate and (1) necessary to meet the basic health needs of the Plan member; (2) rendered in the most cost-efficient manner and type of setting appropriate for the delivery of the health service; (3) consistent in type, frequency and duration of treatment with relevant guidelines of national medical, research or health care coverage organizations and governmental agencies; (4) consistent with the diagnosis of the condition; (5) required for reasons other than the comfort or convenience of the Plan member or his or her provider; and (6) of demonstrated medical value. The fact that a Physician has performed or prescribed a procedure or treatment, or the fact that it may be the only treatment for a particular injury or sickness, does not mean that the procedure or treatment is medically necessary.
Our allowance	Our allowance is the amount we use to determine our payment and your coinsurance for covered services. When you receive services or supplies from Plan providers, it is the amount that we set for the services or supplies if we were to charge for them. When you receive services from non-Plan providers, we determine the amount we believe is usual and customary for the service or supply, and compare it to the charges. Our allowance is based upon the reasonableness of the charges. If the charges exceed what we believe is reasonable, you may be responsible for excess over our allowance in addition to your coinsurance.

Us/We/Our

Us and We refer to Coventry Health Care of Kansas, Inc.

You

You refers to the enrollee and each covered family member.

Section 11. 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. 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 2005 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 2004 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.)

- **Spouse equity coverage**

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. But, you may be eligible for your own FEHB coverage under 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 website 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 12. Two Federal Programs complement FEHB benefits

Important information

OPM wants to make sure you are aware of two Federal programs that complement the FEHB Program. First, the **Flexible Spending Account (FSA) 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. Second, the **Federal Long Term Care Insurance Program (FLTCIP)** helps cover long term care costs, which are not covered under the FEHB.

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. *By using an FSA, you can reduce your taxes while paying for services you would have to pay for anyway, producing a discount that can be over 40%.*

There are two types of FSAs offered by FSAFEDS:

Health Care Flexible Spending Account (HCFSA)

- Covers eligible health care expenses not reimbursed by this Plan, or any other medical, dental, or vision care plan you or your dependents may have.
- Eligible dependents for this account include anyone you claim on your Federal income tax return as a qualified dependent under the U.S. Internal Revenue Service (IRS) definition and/or with whom you jointly file your Federal income tax return, even if you don't have self and family health benefits coverage. *Note:* The IRS has a broader definition of a "family member" than is used under the FEHB Program to provide benefits by your FEHB Plan.
- The maximum annual amount that can be allotted for the HCFSA is \$4,000. *Note:* The Federal workforce includes a number of employees married to each other. If each spouse/employee is eligible for FEHB coverage, both may enroll for a HCFSA up to the maximum of \$4,000 each (\$8,000 total). Both are covered under each other's HCFSA. The minimum annual amount is \$250.

Dependent Care Flexible Spending Account (DCFSA)

- Covers eligible dependent care expenses incurred so you, and your spouse, if married can work, or look for work or attend school full-time.
- Qualifying dependents for this account include your dependent children under age 13, or any person of any age whom you claim as a dependent on your Federal income tax return (and who is mentally or physically incapable of self care).
- The maximum annual amount that can be allotted for the DCFSA is \$5,000. The minimum annual amount is \$250. *Note:* The IRS limits contributions to a DCFSA. For single taxpayers and taxpayers filing a joint return, the maximum is \$5,000 per year. For taxpayers who file their taxes separately with a spouse, the maximum is \$2,500 per year. The limit includes any child care subsidy you may receive.

• Enroll during Open Season

You **must make an election** to enroll in an FSA during the FEHB Open Season. Even if you enrolled during 2004, you must make a new election to continue participating in 2005. Enrollment is easy!

- **Online:** visit www.FSAFEDS.com and click on Enroll.
- Telephone: call an FSAFEDS Benefits Counselor toll-free at 1-877-FSAFEDS (372-3337) Monday through Friday; from 9 a.m. until 9 p.m. Eastern Time. TTY: 1-800-952-0450.

What is SHPS?

SHPS is a third-party administrator hired by OPM to manage the FSAFEDS Program. SHPS is the largest FSA administrator in the nation and is responsible for enrollment, claims processing, customer service, and day-to-day operations of FSAFEDS.

Who is eligible to enroll?

If you are a Federal employee eligible for FEHB – even if you’re not enrolled in FEHB – you can choose to participate in either, or both, of FSAs. If you are not eligible for FEHB, you are not eligible to enroll for a Health Care FSA. *However, if you enroll in a High Deductible Health Plan (HDHP) with a Health Savings Account (HAS), you are not eligible to participate in an HCFSA.*

Almost all Federal employees are eligible to enroll for a DCFSA. The only exception is intermittent (also called “when actually employed” [WAE]) employees expected to work fewer than 180 days during the year.

Note: FSAFEDS is the FSA Program established for all Executive Branch employees and Legislative Branch employees whose employers have signed on. Under IRS law, FSAs are not available to annuitants. Also, the U.S. Postal Service and the Judicial Branch, among others, have their own plans with slightly different rules. However, the advantages of having an FSA are the same regardless of the agency for which you work.

• How much should I contribute to my FSA?

Plan carefully when deciding how much to contribute to an FSA. Because of the tax benefits an FSA, provides, the IRS places strict guidelines on how the money can be used. Under current IRS tax rules, you are required to forfeit any money for which you did not incur an eligible expense under your FSA account(s) during the Plan Year. This is known as the “use-it-or-lose-it” rule. You will have until April 30, following the end of the Plan Year to submit claims for your eligible expenses incurred from January 1 through December 31. For example if you enroll in FSAFEDS for the 2005 Plan Year, you will have until April 30, 2006, to submit claims for eligible expenses.

The FSAFEDS Calculator at www.FSAFEDS.com will help you plan your FSA allocations and provide an estimate of your tax savings based on your individual situation.

• What can my HCFSA pay for?

Every FEHB plan includes cost sharing features, such as deductibles you must meet before the Plan provides benefits, coinsurance or copayments that you pay when you and the Plan share costs, and medical services and supplies that are not covered by the Plan and for which you must pay. These out-of-pocket costs are summarized on pages 120 and 121 and are detailed throughout this brochure. Your HCFSA will reimburse you when those costs are for qualified medical care that you, your spouse and/or your dependents receive that is NOT covered or reimbursed by this FEHB Plan or any other coverage that you have.

Under the High Option of this plan, typical out-of-pocket expenses include: copays for office visits, hospital services and emergency room services. Three common expenses not covered by this Plan are glasses and/or contacts, laser vision surgery and hearing aids.

Under the Standard Option of this plan, typical out-of-pocket expenses include: copays for office visits, hospital services and emergency room services. Three common expenses not covered by this Plan are glasses and/or contacts, laser vision surgery and hearing aids.

The IRS governs expenses reimbursable by a HCFSA. See Publication 502 for a comprehensive list of tax-deductible medical expenses. **Note: While you will see insurance premiums listed in Publication 502, they are NOT a reimbursable expense for FSA purposes.** Publication 502 can be found on the IRS Website at <http://www.irs.gov/pub/irs-pdf/p502.pdf>. The FSAFEDS Website also has a comprehensive list of eligible expenses at www.FSAFEDS.com/fsafeds/eligibleexpenses.asp. If you do not see your service or expense listed please call an FSAFEDS Benefits Counselor at 1-877-FSAFEDS (372-3337), who will be able to answer your specific questions.

- **Tax savings with an FSA**

An FSA lets you allot money for eligible expenses *before* your agency deducts taxes from your paycheck. This means the amount of income that your taxes are based on will be lower, so your tax liability will be less. Without an FSA, you would still pay for these expenses, but you would do so using money remaining in your paycheck after Federal (and often state and local) taxes are deducted. The following chart illustrates a typical tax savings example:

Annual Tax Savings Example	With FSA	Without FSA
If your taxable income is:	\$50,000	\$50,000
And you deposit this amount into an FSA:	\$2,000	-\$0-
Your taxable income is now:	\$48,000	\$50,000
Subtract Federal & Social Security taxes:	\$13,807	\$14,383
If you spend after-tax dollars for expenses:	-\$0-	\$2,000
Your real spendable income is:	\$34,193	\$33,617
Your tax savings:	\$576	-\$0-

Note: This example is intended to demonstrate a typical tax savings based on 27% Federal and 7.65% FICA taxes. Actual savings will vary based upon the retirement system in which you are enrolled (CSRS or FERS), your state of residence, and your individual tax situation. In this example, the individual received \$2,000 in services for \$1,424, a discount of almost 36%! You may also wish to consult a tax professional for more information on the tax implications of an FSA.

- **Tax credits and deductions**

You *cannot* claim expenses on your Federal income tax return if you receive reimbursement for them from your HCFSA or DCFSA. Below are some guidelines that may help you decide whether to participate in FSAFEDS.

- Health care expenses**

The HCFSA is Federal Income Tax-Free from the first dollar. In addition, you may be reimbursed from your HCFSA at any time during the year for expenses up to the annual amount you've elected to contribute.

Only health care expenses exceeding 7.5% of your adjusted gross income are eligible to be deducted on your Federal income tax return. Using the example shown above, only health care expenses exceeding \$3,750 (7.5% of \$50,000) would be eligible to be deducted on your Federal income tax return. In addition, money set aside through an HCFSA is also exempt from FICA taxes. This exemption is not available on your Federal income tax return.

- Dependent care expenses**

The DCFSA generally allows many families to save more than they would with the Federal tax credit for dependent care expenses. Note that you may only be reimbursed from the DCFSA up to your current account balance. If you file a claim for more than your current balance, it will be held until additional payroll allotments have been added to your account.

Visit www.FSAFEDS.com and download the Dependent Care Tax Credit Worksheet from the Forms and Literature page to help you determine what is best for your situation. You may also wish to consult a tax professional for more details.

- **Does it cost me anything to participate in**

No. Section 1127 of the National Defense Authorization Act (Public Law 108-136) requires agencies that offer FSAFEDS to employees to cover the administrative fee(s) on behalf of their employees. However, remember that participating in FSAFEDS can cost you money if you

FSAFEDS?

don't spend your entire account balance by the end of the Plan Year, resulting in the forfeiture of funds remaining in your account balance (the IRS "use-it-or-lose-it" rule).

• Contact us

To learn more or to enroll, please visit the **FSAFEDS website** at www.FSAFEDS.com, or contact SHPS via email or by phone. FSAFEDS Benefit Counselors are available Monday through Friday, from 9:00 a.m. until 9:00 p.m. Eastern Time.

- E-mail: FSAFEDS@shps.net
- Telephone: 1-877-FSAFEDS (1-877-372-3337)
- TTY: 1-800-952-0450

The Federal Long Term Care Insurance Program

• It's important protection

Why should 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 find out more and to request an application

Call 1-800-LTC-FEDS (1-800-582-3337) (TTY 1-800-843-3557) or visit www.ltcfeds.com.

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

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Summary of benefits for the Coventry Health Care of Kansas, Inc. HMO - 2005

- **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.

Benefits	High Option You pay	Standard Option You pay	Page
Medical services provided by physicians:	\$15 for PCP	\$ 20 for PCP	23
• Diagnostic and treatment services provided in the office	\$30 for Specialist	\$35 for Specialist	
Preventive Services	\$15 for PCP \$30 for Specialist	\$ 20 for PCP \$35 for Specialist	24
Services provided by a hospital:			
• Inpatient	\$100 per day for maximum of \$300 per admission	\$300 per day for a maximum of \$900 per admission	41
• Outpatient	\$50 copay	\$200 copay	43
Emergency benefits	\$100 copay	\$125 copay	45
• Emergency room visits			
Mental health and substance abuse treatment	Regular cost sharing		47
Prescription drugs Retail pharmacy	\$10/30/55	\$10/30/55	49
Dental care	Comprehensive benefit		53
Vision care Refraction	\$15 copay	\$20 copay	29
Special features: 24 hour nurse line; Services for deaf and hearing impaired, Transplant Network, Flexible Benefits Option			52
Protection against catastrophic costs	\$2,000 Self Only	\$2,500 Self Only	19
(your catastrophic protection out-of-pocket maximum)	\$4,000 Self Only & Family	\$5,000 Self Only & Family	

Summary of benefits for the Coventry Health Care of Kansas, Inc. HDHP - 2005

- **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.

Benefits	HDHP You pay	Page
Medical services provided by physicians:	\$20 for PCP	64
• Diagnostic and treatment services provided in the office	\$35 for Specialist After deductible	
Preventive Services	\$20 for PCP \$35 for Specialist	61
Services provided by a hospital:	20% of our allowance after deductible	79
• Inpatient		
• Outpatient		
Emergency benefits	20% of our allowance after deductible	82
• Emergency room visits		
Mental health and substance abuse treatment	Regular cost sharing	84
Prescription drugs Retail pharmacy	\$15/25/50 after deductible	85
Dental care	Comprehensive benefit	53
Vision care Refraction	\$20 copay after deductible	69
Special features: 24 hour nurse line; Services for deaf and hearing impaired, Transplant Network, Flexible Benefits Option 77		
Protection against catastrophic costs	\$5,000 Self Only	219
(your catastrophic protection out-of-pocket maximum)	\$10,000 Self Only & Family	

2005 Rate Information for Coventry Health Care of Kansas, Inc.

Non-Postal rates apply to most non-Postal employees. If you are in a special enrollment category, refer to the 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.

		Non-Postal Premium				Postal Premium	
		<u>Biweekly</u>		<u>Monthly</u>		<u>Biweekly</u>	
Type of Enrollment	Code	Gov't Share	Your Share	Gov't Share	Your Share	USPS Share	Your Share
KANSAS CITY METROPOLITAN AREA; KANSAS AND MISSOURI							
High Option Self Only	HA1	\$111.63	\$37.21	\$241.87	\$80.62	\$132.10	\$16.74
High Option Self and Family	HA2	\$288.08	\$96.03	\$624.18	\$208.06	\$340.90	\$43.21
Standard Option Self Only	HA4	\$105.73	\$35.24	\$229.08	\$76.36	\$125.11	\$15.86
Standard Option Self & Family	HA5	\$272.84	\$90.95	\$591.16	\$197.05	\$322.86	\$40.93
HDHP Self Only	9H1	\$96.67	\$32.22	\$209.45	\$69.81	\$114.39	\$14.50
HDHP Self & Family	9H2	\$249.40	\$83.13	\$540.36	\$180.12	\$295.12	\$37.41