

Coventry Health Care of Kansas, Inc.

<http://www.chckansas.com>

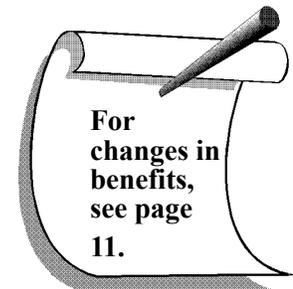


2011

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

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 10 for requirements.



Enrollment codes:

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

Special Note: We no longer offer this Plan in the Wichita Service Area.

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

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

OPM has determined that Coventry Health Care of Kansas, Inc. prescription drug coverage is, on average, expected to pay out as much as the standard Medicare prescription drug coverage will pay for all plan participants and is considered Creditable Coverage. Thus you do not need to enroll in Medicare Part D and pay extra for prescription drug benefits. If you decide to enroll in Medicare Part D later, you will not have to pay a penalty for late enrollment as long as you keep your FEHB coverage.

However, if you choose to enroll in Medicare Part D, you can keep your FEHB coverage and your FEHB plan will coordinate benefits with Medicare.

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

Please be advised

If you lose or drop your FEHB coverage and go 63 days or longer without prescription drug coverage that's as least as good as Medicare's prescription drug coverage, your monthly premium will go up a least 1% per month for every month that you did not have that coverage. For example, if you go 19 months without Medicare Part D prescription drug coverage, your premium will always be at least 19 percent higher than what many other people pay. You'll have to pay this higher premium as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the Annual Coordinated Election Period (November 15th through December 31st) to enroll in Medicare Part D.

Medicare's Low Income Benefits

For people with limited income and resources, extra help paying for a Medicare prescription drug plan is available. Information regarding this program is available through the Social Security Administration (SSA) online at www.socialsecurity.gov, or call the SSA at 1-800-772-1213 (TTY 1-800-325-0778).

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

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

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Introduction

This brochure describes the benefits of Coventry Health Care of Kansas, Inc., under our contract (CS 1948) with the United States Office of Personnel Management, as authorized by the Federal Employees Health Benefits law. The address for Coventry Health Care of Kansas, Inc., administrative office 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, 2011, unless those benefits are also shown in this brochure.

OPM negotiates benefits and rates with each Plan annually. Benefit changes are effective January 1, 2011 and changes are summarized on page 11. 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 fehbwebcomments@opm.gov. You may also write to OPM at the U.S. Office of Personnel Management, Insurance Operations, Program Planning & Evaluation, 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:

- Do not give your Plan identification (ID) number over the telephone or to people you do not know, except to your health care providers, authorized health benefits plan or OPM representative.
- Let only the appropriate medical professionals review your medical record or recommend services.
- Avoid using health care providers who say that an item or service is not usually covered, but they know how to bill us to get it paid.
- Carefully review explanations of benefits (EOBs) statements that you receive from us.
- Please review your claims history periodically for accuracy to ensure services are not being billed to your accounts that were never rendered.

- Do not ask your doctor to make false entries on certificates, bills or records in order to get us to pay for an item or service.
- If you suspect that a provider has charged you for services you did not receive, billed you twice for the same service, or misrepresented any information, do the following:
 - Call the provider and ask for an explanation. There may be an error.
 - If the provider does not resolve the matter, call us at 1-800-969-3343 and explain the situation.
 - If we do not resolve the issue:

**CALL - THE HEALTH CARE FRAUD HOTLINE
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);
 - Your child is age 26 or over (unless he/she was disabled and incapable of self-support prior to age 26).
- If you have any questions about the eligibility of a dependent, check with your personnel office if you are employed, with your retirement office (such as OPM) if you are retired, or with the National Finance Center if you are enrolled under Temporary Continuation of Coverage.
- 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 if you are no longer enrolled in the Plan.
- If your enrollment continues after you are no longer eligible for coverage (i.e., you have separated from Federal service) and premiums are not paid, you will be responsible for all benefits paid during the period in which premiums were not paid. You may be billed for services received directly from your provider. You may be prosecuted for fraud for knowingly using health insurance benefits for which you have not paid premiums. It is your responsibility to know when you or a family member are no longer eligible to use your health insurance coverage.

Preventing Medical Mistakes

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

1. Ask questions if you have doubts or concerns.

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

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

- Bring the actual medicines or give your doctor and pharmacist a list of all the medicines that you take, including non-prescription (over-the-counter) medicines.

- Tell them about any drug allergies you have.
- Ask about any risks or side effects of the medication and what to avoid while taking it. Be sure to write down what your doctor or pharmacist says.
- Make sure your medicine is what the doctor ordered. Ask the pharmacist about your medicine if it looks different than you expected.
- Read the label and patient package insert when you get your medicine, including all warnings and instructions
- Know how to use your medicine. Especially note the times and conditions when your medicine should and should not be taken.
- Contact your doctor or pharmacist if you have any questions.

3. Get the results of any test or procedure.

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

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

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

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

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

Patient Safety Links

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

Never Events

You will not be billed for inpatient services related to treatment of specific hospital acquired conditions or for inpatient services needed to correct Never Events, if you use (Plan Specific) preferred providers. This new policy will help protect you from preventable medical errors and improve the quality of care you receive.

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

We have a benefit payment policy that will encourage hospitals to reduce the likelihood of hospital-acquired conditions such as certain infections, severe bedsores and fractures; and reduce medical errors that should never happen called "Never Events". When a Never Event occurs, neither your nor your FEHB plan will incur cost to correct the medical error.

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.

Questions regarding what protections apply and what protections do not apply to a grandfathered health plan, and what might cause a plan to change status from grandfathered to non-grandfathered may be directed to customer service at 1-800-969-3343. You can also read additional information from the U.S. Department of Health and Human Services at www.healthcare.gov.

This plan is a "non-grandfathered health plan" under the Affordable Care Act. A non-grandfathered plan must meet immediate health care reforms legislated by the Act. Specifically, this plan must provide preventive services and screenings to you without any cost sharing; you may choose any available primary care provider for adult and pediatric care; visits for obstetrical or gynecological care do not require a referral; and emergency services, both in- and out-of-network, are essentially treated the same (i.e., the same cost sharing, no greater limits or requirements for one over the other; and no prior authorizations).

Questions regarding what protections apply may be directed to customer service at 1-800-969-3343. You can also read additional information from the U.S. Department of Health and Human Services at www.healthcare.gov.

General features of both our High and Standard Options

Features of our High Option

- A calendar year deductible of \$500 Self Only and limited to \$1,500 Self and Family.
- The catastrophic protection per calendar year is limited to \$2,500 for Self Only and \$5,000 for Self and Family.

Features of our Standard Option

- A calendar year deductible of \$1,500 Self Only and limited to \$4,500 Self and Family.
- The catastrophic protection per calendar year is limited to \$3,500 for Self Only and \$7,500 for Self and Family.

We have Open Access Benefits

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

How we pay providers

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

General features of our High Deductible Health Plan (HDHP)

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

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

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

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

Preventive care services

Preventive care services are paid as first dollar coverage.

Annual deductible

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

Health Savings Account (HSA)

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

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

Health Reimbursement Arrangement (HRA)

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

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

Catastrophic protection

We protect you against catastrophic out-of-pocket expenses for covered services. Your annual out-of-pocket expenses for covered services, including deductibles and copayments, cannot exceed \$3,500 for Self Only enrollment, or \$6,500 for Self and Family coverage.

Smart Payment From Coventry Consumer Choice

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

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

Copays: Pay to member

Deductible: Pay to provider

Coinsurance: Pay to provider

Pharmacy and other manual claims will always pay the member.

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

Claim #1: Save – don't pay

Claim #2: Pay to provider

Claim #3: Reimburse you

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

Who provides my healthcare

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

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

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

Your Rights

OPM requires that all FEHB Plans provide certain information to their FEHB members. You may get information about us, our networks, and our providers. OPM's FEHB website (www.opm.gov/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 a total membership of approximately 140,000. We are dedicated to providing quality health care at an affordable price, and we provide our members the security of knowing they are being offered a health care delivery system supported by a long tradition of quality and service.

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

Your medical and claims records are confidential

We will keep your medical and claims records confidential. Please note that we may disclose your medical and claims information (including your prescription drug utilization) to any of your treating physicians or dispensing pharmacies.

Service Area

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

Our Kansas City Metropolitan service area is:

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

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

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

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

Section 2. How we change for 2011

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

Program Wide Changes

- Several provisions of the Affordable Care Act (ACA) affect eligibility and benefits under the FEHB Program and FSAFEDS beginning January 1, 2011. For instance, children up to age 26 will be covered under a Self and Family enrollment. Please read the information in Sections 11 and 12 carefully.
- We have reorganized organ and tissue transplant benefit information to clarify coverage.

Changes to the Plan (All Options)

- QuitNet is now available free of charge. QuitNet is a comprehensive tobacco cessation program that includes telephonic support, nicotine replacement therapy, web support, email support, printed Quit Guide and prescription drug coverage.
- Prosthetic and Durable Medical Equipment is an unlimited benefit, instead of a \$3,000 per calendar year benefit maximum.

Changes to High Option Only

- Your share of the non-postal premium will increase for Self-Only and increase for Self and Family. See page 130.
- The out-of-pocket maximum is now \$2,500 for Self Only or \$5,000 Self and Family. Previously, the out-of-pocket maximum was \$1,850 for Self Only or \$3,700 for Self and Family.
- The calendar year Deductible is now \$1,500 Self and Family. Previously, the deductible was \$1,000 for Self and Family.
- The specialist office visit copay is now \$50 per visit instead of \$40.
- The member coinsurance is now 15%, instead of 10%.
- The Hi Tech diagnostic test such as MRIs, MRA, CAT, and PET scans, cardiac cathertization and thallium scans is now \$250 per test instead of \$200.
- The emergency care at a hospital within and outside the service area requires a \$250 copayment per visit, instead of \$200.
- Mental health and substance abuse benefits are now available for \$0 Copayment. Previously, these services were subject to a \$40 Copayment.
- Prescription Drugs have changed to a four-tier format. See page 53.
- Speech generating devices up to \$1,000 per device per year is now available.
- Donor screening tests for bone marrow transplants per year for individuals unrelated to the patient, in addition to testing of family members, is now available for up to four (4) donors.

Changes to Standard Option Only

- Your share of the non-postal premium will increase for Self-Only and increase for Self and Family. See page 130.
- The specialist office visit copay is now \$60 per visit instead of \$50.
- The Hi Tech diagnostic test such as MRIs, MRA, CAT, and PET scans, cardiac cathertization and thallium scans is now \$250 per test instead of \$200.
- The emergency care at a hospital within and outside the service area requires a \$350 copayment per visit, instead of \$300.
- Mental health and substance abuse benefits are now available for \$0 Copayment. Previously, these services were subject to a \$50 Copayment.
- Prescription Drugs has changed to a four-tier format. See page 53.
- Speech generating devices up to \$1,000 per device per year is now available.

- Donor screening tests for bone marrow transplants per year for individuals unrelated to the patient, in addition to testing of family members, is now available for up to four (4) donors.

Changes to High Deductible Health Plan (HDHP) Only

- Your share of the non-postal premium will increase for Self-Only or increase for Self and Family. See page 130
- The calendar year deductible is now \$3,500 Self Only and \$6,500 Self and Family. Previously, the calendar year deductible was \$3,000 Self Only and \$6,000 Self and Family.
- Beginning January 1, 2011, currently eligible over-the-counter (OTC) products that are medicines or drugs will not be eligible for reimbursement from your Health Savings Account (HSA) or your Health Reimbursement Arrangement (HRA) – unless – you have a prescription for that item written by your physician. The only exception is insulin - you will not need a prescription from January 1, 2011 forward. Other currently eligible OTC items that are not medicines or drugs will not require a prescription.
- The penalty for withdrawals from an HSA for non-medical expenses increases from 10% to 20% after January 1, 2011.

Section 3. How you get care

Identification cards

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

If you do not receive your ID card within 30 days after the effective date of your enrollment, or if you need medical replacement cards, call us at 1-800-969-3343 or write to us at Coventry Health Care of Kansas, Inc., 8320 Ward Parkway, Kansas City, MO 64114. You may also request replacement cards through our website at www.chckansas.com. If you need dental replacement cards, call Coventry Dental at 1-866-690-4910 or write to us at Coventry Dental, 111 Rockville Pike, Suite 950; P.O. Box 10949; Rockville, MD 20849. You may also request replacement cards through the website at www.chckansas.com.

Where you get covered care

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

- **Plan providers**

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

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

- **Plan facilities**

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

What you must do to get covered care

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

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

- **Primary care**

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

- **Specialty care**

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

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

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

If you are hospitalized when your enrollment begins

We pay for covered services from the effective date of your enrollment. However, if you are in the hospital when your enrollment in our Plan begins, call our Customer Service Department immediately at 1-800-969-3343. If you are new to the FEHB Program, we will arrange for you to receive care and provide benefits for your covered services while you are in the hospital beginning on the effective date of your coverage.

If you changed from another FEHB Plan to us, your former plan will pay for the hospital stay until:

- You are discharged, not merely moved to an alternative care center; 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.

How to get approval for...

- **Your hospital stay** Your participating physician will obtain any necessary authorizations from the Plan prior to rendering services.
- **How to precertify an admission** Your participating physician will obtain any necessary authorizations from the Plan prior to rendering services
- **Maternity care** Your participating physician will obtain any necessary authorizations from the Plan prior to rendering services.

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

A 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.

<ul style="list-style-type: none"> • Hospital inpatient procedures / admissions • Observation stays • Skilled nursing / extended care stays • Chemotherapy • Dialysis • Home health care • Hospice • Hyperbaric services • Implantable pain and insulin pumps, spinal stimulators and trials • Rehabilitation, full- or partial-day • Short term rehabilitation, including cardiac and pulmonary • Specialized infusion clinics • Transplants 	<ul style="list-style-type: none"> • Wound care • Durable medical equipment over \$1000 • Genetic testing / counseling • Injectable medications • Neuropsych testing • Orthotics and prosthetics • Speech therapy • Pain management (all services beyond initial evaluation) • Sleep studies • MRA, MRI and PET Scans • Nuclear cardiology / stress testing in an outpatient hospital setting ** • Sclerotherapy
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*** These services do not require prior authorization when performed in the physician’s office.*

Pharmacy and Mental Health & Substance Abuse Pre-Authorization Requirements

- Prior-authorization, step therapy, non-preferred diabetic supplies, and self-administered injectibles as listed in formulary
- All Mental Health and Substance Abuse Benefits

Benefit Limitations: The following services require prior authorization or precertification as many of these procedures may be viewed as cosmetic surgery and/or may have certain benefit limitations or exclusions.

<ul style="list-style-type: none"> • Tummy Tuck / Abdominoplasty • Eyelid Surgery / Ptosis repair • Nose Surgery / Rhinoplasty • Breast implant / breast reconstruction • Breast mastectomy / reduction mammoplasty • Experimental / investigational services • Facelift / bodylift surgery • Scar abrasion / revisions • Liposuction • Morbid obesity services 	<ul style="list-style-type: none"> • Oral surgery / dental accident / dental services • Pectus surgery • Penile implants • Laparoscopies/Hysteroscopies/Infertility services or procedures to promote fertility • Varicose vein surgery / Sclerotherapy • Tattoo removal • Temporomandibular joint disease (TMJ) services • Vision therapy - eye exercises
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Note: The Plan reserves the right to modify this list or to exclude certain authorization requirements based on the Service Area.

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 hospitalizations. You may call Customer Service at 1-800-969-3343 to find out if a specific procedure or treatment requires prior authorization.

Section 4. Your costs for covered services

This is what you will pay out-of-pocket for covered care.

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 for services described in Section 5.

Example: In our Plan, you pay 50% of our allowance for infertility services and 50% of our allowance for covered durable medical equipment, the deductible does not apply to these services.

Copayments

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

Example: When you see a primary care physician or OB/GYN under the High Option you pay a copayment of \$20 per office visit.

Cost-sharing

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

Deductible

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

High Option Plan:

The calendar year deductible is \$500 Self Only and \$1,500 Self and Family.

Standard Option Plan:

The calendar year deductible is \$1,500 Self Only and \$4,500 Self and Family.

High Deductible Health Plan: The calendar year deductible is \$3,500 for Self Only and \$6,500 for Self and Family. The individual deductible applies to members enrolled in Self Only. The family deductible applies collectively to all members enrolled in Self and Family. After you have paid your Single Only or Self and Family calendar year deductible amount, we pay 100% of our allowable for covered Traditional services for the remainder of the calendar year.

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

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

Your catastrophic protection out-of-pocket maximum

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

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

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

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

Under our **Standard Option Plan** the out-of-pocket maximum for Self Only is \$3,500 and \$7,500 for Self and Family.

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

Under our **High Deductible Health Plan** the out-of-pocket maximum for Self Only is \$3,500 and \$6,500 for Self and Family. Deductible and copayments are included in your out-of-pocket maximum.

When Government facilities bill us

Facilities of the Department of Veterans Affairs, the Department of Defense, and the Indian Health Services are entitled to seek reimbursement from us for certain services and supplies they provide to you or a family member. They may not seek more than their governing laws allow. You may be responsible to pay for certain services and charges. Contact the government facility directly for more information.

If we overpay you

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

High and Standard Option Benefits

See page 11 for how our benefits changed this year. On page 127 and page 128 is a benefit summary of each option. Make sure that you review the benefits that are available under the option which you are enrolled.

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Summary of benefits for the High Option of Coventry Health Care of Kansas, Inc. - 2011127

Summary of benefits for the Standard Option of Coventry Health Care of Kansas, Inc. - 2011128

Section 5. High and Standard Option Benefits Overview

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

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

Each option offers unique features.

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

Features of our High Option

- A calendar year deductible of \$500 Self Only and limited to \$1,500 Self and Family.
- Catastrophic protection per calendar year is limited to \$2,500 for Self Only and \$5,000 for Self and Family.

Features of our Standard Option

- A calendar year deductible of \$1,500 Self Only and limited to \$4,500 Self and Family.
- Catastrophic protection per calendar year is limited to \$3,500 for Self Only and \$7,500 for Self and Family.

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

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan physicians must provide or arrange your care.
- A facility copay applies to services that appear in this section but are performed in an ambulatory surgical center or the outpatient department of a hospital.
- High Option: The calendar year deductible is \$500 Self Only and \$1,500 Self and Family. The calendar year deductible applies to almost all benefits in this Section. We added ("No Deductible") to show when the calendar year deductible does not apply.
- Standard Option: The calendar year deductible is \$1,500 Self Only and \$4,500 Self and Family. The calendar year deductible applies to almost all benefits in this Section. We added ("No Deductible") to show when the calendar year deductible does not apply.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

Benefit Description	You pay After the calendar year deductible. . .	
Diagnostic and treatment services	High Option	Standard Option
Professional services of physicians • In physician's office, not including minor surgery	\$20 per visit to a primary care physician or OB/GYN, No Deductible \$50 per visit to a specialist, No Deductible	\$30 per visit to a primary care physician or OB/GYN, No Deductible \$60 per visit to a specialist, No Deductible
Professional services of physicians • In an urgent care center	Nothing	Nothing
During a hospital stay	15% of our allowance	20% of our allowance
In a skilled nursing facility	15% of our allowance	20% of our allowance
• Office medical consultations • Second Surgical opinion • At home	\$20 per visit to a primary care physician or OB/GYN, No Deductible \$50 per visit to a specialist, No Deductible	\$30 per visit to a primary care physician or OB/GYN, No Deductible \$60 per visit to a specialist, No Deductible
Lab, X-ray and other diagnostic tests	High Option	Standard Option
Tests, such as: • Blood tests • Urinalysis • Non-routine Pap tests • Pathology	\$20 per office visit to a primary care physician or OB/GYN, No Deductible \$50 per visit to a specialist, No Deductible Nothing if you receive these services during your office visit	\$30 per office visit to a primary care physician or OB/GYN, No Deductible \$60 per visit to a specialist, No Deductible No additional copayment if you receive these services during your office visit

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

Benefit Description	You pay After the calendar year deductible. . .	
	High Option	Standard Option
Lab, X-ray and other diagnostic tests (cont.)		
<ul style="list-style-type: none"> • X-ray 	15% of our allowance	Nothing
Hi Tech Diagnostics - including, but not limited to <ul style="list-style-type: none"> • MRI • MRA • CAT and PET Scans • Cardiac Catheterization • Thallium Scans 	\$250 per visit, No Deductible	\$250 per visit, No Deductible
<ul style="list-style-type: none"> • Non-routine Mammograms 	Nothing	Nothing
Preventive care, adult	High Option	Standard Option
Routine physical, which includes: 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 	Nothing	Nothing
<ul style="list-style-type: none"> • Colonoscopy, screening - every ten years starting at age 50 	Nothing	Nothing
Routine Prostate Specific Antigen (PSA) test – one annually for men age 40 and older	Nothing	Nothing
Routine Pap test	Nothing	Nothing
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
<ul style="list-style-type: none"> • 1 routine eye exam every 12 months • 1 routine hearing exam every 24 months 	Nothing, No Deductible	Nothing, No Deductible
Adult routine immunizations endorsed by the Centers for Disease Control and Prevention (CDC):	Nothing	Nothing
<i>Not covered: Physical exams and immunizations required for obtaining or continuing employment or insurance, attending schools or camp, or travel.</i>	<i>All charges</i>	<i>All charges</i>

Benefit Description	You pay After the calendar year deductible. . .	
	High Option	Standard Option
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 Ear exams through age 17 Examinations done on the day of immunizations (up to age 22) 	Nothing	Nothing
<i>Not covered: Physical exams and immunizations required for obtaining or continuing employment or insurance, attending schools or camp, or travel.</i>	<i>All charges</i>	<i>All charges</i>
Maternity care	High Option	Standard Option
<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 12 for other circumstances, such as extended stays for you or your baby. You may remain in the hospital up to 48 hours after a regular delivery and 96 hours after a cesarean delivery. We will extend your inpatient stay if medically necessary. We cover routine nursery care of the newborn child during the covered portion of the mother's maternity stay. We will cover other care of an infant who requires non-routine treatment only if we cover the infant under a Self and Family enrollment. We pay hospitalization and surgeon services for non-maternity care the same as for illness and injury. 	<p>\$20 for initial office visit confirm pregnancy, No Deductible</p> <p>All other copayments for prenatal visits during the course of pregnancy are waived. See Section 5(b) for Maternity Care received at an Inpatient Hospital.</p>	<p>\$30 for initial office visit to confirm pregnancy, No Deductible</p> <p>All other copayments for prenatal visits during the course of pregnancy are waived. See Section 5(b) for Maternity Care received at an Inpatient Hospital.</p>
Family planning	High Option	Standard Option
<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)) 	15% of our allowance	20% of our allowance

Family planning - continued on next page

High and Standard Option

Benefit Description	You pay After the calendar year deductible. . .	
Family planning (cont.)	High Option	Standard Option
<ul style="list-style-type: none"> • 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>	\$20 per visit to a primary care physician and OB/GYN or \$50 per visit to a specialist applies to implanted or injectable contraceptive devices, No Deductible	\$30 per visit to a primary care physician and OB/GYN or \$60 per visit to a specialist applies to implanted or injectable contraceptive devices, No Deductible
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • Reversal of voluntary surgical sterilization • Genetic counseling 	<i>All charges</i>	<i>All charges</i>
Infertility services	High Option	Standard Option
<p>Diagnosis and treatment of infertility such as:</p> <ul style="list-style-type: none"> • Artificial insemination: <ul style="list-style-type: none"> - intravaginal insemination (IVI) - intracervical insemination (ICI) - intrauterine insemination (IUI) 	50% of our allowance	50% 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"> - in vitro fertilization - embryo transfer, gamete intra-fallopian transfer (GIFT) and zygote intra-fallopian transfer (ZIFT) - Zygote transfer • Services and supplies related to ART procedures • Cost of donor sperm • Cost of donor egg • Fertility drugs 	<i>All charges</i>	<i>All charges</i>
Allergy care	High Option	Standard Option
<ul style="list-style-type: none"> • Testing and treatment 	15% of our allowance	20% of our allowance
<ul style="list-style-type: none"> • Allergy injections 	\$5 Copayment	\$5 Copayment
<ul style="list-style-type: none"> • Allergy serum 	Nothing	Nothing
<p><i>Not covered: Provocative food testing and sublingual allergy desensitization</i></p>	<i>All charges</i>	<i>All charges</i>

Benefit Description	You pay After the calendar year deductible. . .	
	High Option	Standard Option
<p>Treatment therapies</p> <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 35.</p>	15% of our allowance	20% of our allowance
<ul style="list-style-type: none"> • Respiratory and inhalation therapy-outpatient rehabilitation limited to 60 visits per condition. 	15% of our allowance	20% of our allowance
<ul style="list-style-type: none"> • Dialysis – hemodialysis and peritoneal dialysis 	15% of our allowance	20% of our allowance
<ul style="list-style-type: none"> • Intravenous (IV)/Infusion Therapy – Home IV and antibiotic therapy 	15% of our allowance	20% of our allowance
<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>		
<p>Physical and occupational therapies</p>	<p>High Option</p>	<p>Standard Option</p>
<p>60 visits per condition for the each of the following services:</p> <ul style="list-style-type: none"> • qualified physical therapists and • occupational therapists <p>(Chiropractors coverage included in the visit limit, See Chiropractic)</p> <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> <p>Cardiac rehabilitation following a heart transplant, bypass surgery or a myocardial infarction is provided for up to 60 sessions.</p>	15% of our allowance	20% of our allowance
<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>	<i>All charges</i>

Benefit Description	You pay After the calendar year deductible. . .	
	High Option	Standard Option
Speech therapy		
60 visits per condition	15% of our allowance	20% of our allowance
Hearing services (testing, treatment, and supplies)	High Option	Standard Option
<ul style="list-style-type: none"> Hearing testing for children through age 17, as shown in <i>Preventive care, children</i>; Hearing aids, as shown in <i>Orthopedic and prosthetic devices</i>. 		
Vision services (testing, treatment, and supplies)	High Option	Standard Option
<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>) 	\$20 per visit to a primary care physician, No Deductible \$50 per visit to a specialist, No Deductible	\$30 per visit to a primary care physician, No Deductible \$60 per visit to a specialist, No Deductible
<ul style="list-style-type: none"> Annual eye refraction exam for all members 	\$20 per visit to a primary care physician, No Deductible \$50 per visit to a specialist, No Deductible	\$30 per visit to a primary care physician, No Deductible \$60 per visit to a specialist, No Deductible
<i>Not covered</i> <ul style="list-style-type: none"> <i>Eyeglasses or contact lenses; or contact lens exam</i> <i>Exams of fitting fees for contact lenses</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	High Option	Standard Option
Routine foot care when you are under active treatment for a metabolic or peripheral vascular disease, such as diabetes. Note: See Orthopedic and prosthetic devices for information on podiatric shoe inserts.	\$20 per visit to a primary care physician, No Deductible \$50 per visit to a specialist, No Deductible	\$30 per visit to a primary care physician, No Deductible \$60 per visit to a specialist, No Deductible
<i>Not covered:</i> <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>

Benefit Description	You pay After the calendar year deductible. . .	
	High Option	Standard Option
<ul style="list-style-type: none"> • Orthopedic devices such as braces • Artificial limbs and eyes; stump hose • Hearing aids and testing to fit them • Externally worn breast prostheses and surgical bras, including necessary replacements following a mastectomy. External prosthetic devices, except those associated with reconstructive surgery after a mastectomy are limited to two per member per calendar year. • Internal prosthetic devices, such as artificial joints, pacemakers, 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. • Foot Orthotics and Ankle Foot Orthotics are covered for members who have diabetes with demonstrated peripheral neuropathy or the insert is needed for a shoe that is part of a covered brace. 	50% of our allowance, No Deductible	50% of our allowance, No Deductible
<ul style="list-style-type: none"> • Hearing aid devices are limited to conventional, programmable, digital, and BAHA - we limit coverage to one (1) device per ear per every 24 months, not to exceed \$5,000 combined maximum plan benefit every 24 month period. 	\$500 copayment per eligible device, No Deductible	\$500 copayment per eligible device, No Deductible
<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>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>DOC Bands (Dynamic Orthotic Cranial Bands)</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>Orthotics (regular or custom, including but not limited to ankle foot orthotics or podiatric orthotics)</i> 	<i>All charges</i>	<i>All charges</i>

Orthopedic and prosthetic devices - continued on next page

Benefit Description	You pay After the calendar year deductible. . .	
Orthopedic and prosthetic devices (cont.)	High Option	Standard Option
<ul style="list-style-type: none"> • <i>Repair and replacement of orthopedic and prosthetic devices, unless necessiated by normal growth</i> • <i>Hearing aid batteries</i> • <i>Replacement hearing aid devices within the same 24 month period</i> • <i>Hearing devices that are not specifically listed in the covered services section</i> 	<i>All charges</i>	<i>All charges</i>
Durable medical equipment (DME)	High Option	Standard Option
<ul style="list-style-type: none"> • Rental or purchase, at our option, including repair and adjustment, of durable medical equipment prescribed by your Plan physician, such as oxygen and dialysis equipment. Under this benefit, we also cover: • Hospital beds; • Wheelchairs; • Crutches; • Walkers; • Audible prescription reading devices; • Speech generating devices (limited to \$1,000 per device per year); • Enteral feeding pumps; • Insulin pumps, and syringes for insulin pumps; • Apnea monitor; • Cane; • Ostomy and urological supplies; • Prosthetic and orthotic supplies; • Replacement due to anatomical growth; • Repair and replacement of DME determined to be medically necessary. 	50% of our allowance, No Deductible	50% of our allowance, No Deductible
<ul style="list-style-type: none"> • Blood glucose monitors for members with diabetes <p>Note: Prior authorization is required for non-preferred blood glucose monitors and supplies.</p>	Nothing, if you obtain our preferred brand. You pay 50% of our allowance if you receive a non-preferred brand or replacement device, No Deductible	Nothing, if you obtain our preferred brand. You pay 50% of our allowance if you receive a non-preferred brand or replacement device, No Deductible
<p>Note: Call us at 1-800-969-3343 as soon as your Plan physician prescribes this equipment. We will arrange with a health care provider to rent or sell you durable medical equipment at discounted rates and will tell you more about this service when you call.</p>		
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Motorized wheelchairs</i> 	<i>All charges</i>	<i>All charges</i>

Durable medical equipment (DME) - continued on next page

Benefit Description	You pay After the calendar year deductible. . .	
Durable medical equipment (DME) (cont.)	High Option	Standard Option
<ul style="list-style-type: none"> • Oral supplements and/or enteral feeding, either by mouth or by tube • Comfort, convenience, or luxury items or features • Electric monitors of bodily functions, except for apnea monitors • Devices to perform medical testing of bodily fluids, excretions or substances • Disposable supplies • Replacement of lost equipment • Repair, adjustment, or replacement necessitated by wear, tear or misuse • More than one piece of durable medical equipment serving essentially the same function, except for replacement due to anatomical growth; spare equipment or alternate use equipment is not provided 	<i>All charges</i>	<i>All charges</i>
Home health services	High Option	Standard Option
<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 or home health aide. • Services include intravenous therapy and medications (oxygen is covered under DME). 	15% of our allowance	20% of our allowance
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • Home care requested by, or the convenience of, the patient or the patient's family; • Services primarily for hygiene, feeding, exercising, moving the patient, homemaking, companionship or giving oral medication; • Home care that could appropriately be rendered in a Plan medical office, affiliated hospital, or skilled nursing facility; • Home care that can be performed safely and effectively by people whom, in order to provide the care do not require medical licenses or certificates, or the presence of a supervising licensed nurse • Home care primarily for personal assistance that does not include a medical component and is not diagnostic, therapeutic, or rehabilitative. 	<i>All charges</i>	<i>All charges</i>

Benefit Description	You pay After the calendar year deductible. . .	
	High Option	Standard Option
<p>Chiropractic</p> <ul style="list-style-type: none"> Coverage limited to subluxation and manipulation 60 visits per condition (visit limit includes physical and occupational therapies. See Physical and Occupational therapies) <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>	15% of our allowance	20% of our allowance
<p>Alternative treatments</p> <p><i>No benefit</i></p>	<p>High Option</p> <p><i>All charges</i></p>	<p>Standard Option</p> <p><i>All charges</i></p>
<p>Educational classes and programs</p> <p>Coverage is limited to:</p> <ul style="list-style-type: none"> Diabetes self- management educational classes, as referred by your Plan physician One nutritional counseling visit with a registered dietician, for all other covered conditions Up to six (6) nutritional counseling visits with a registered dietician for the following conditions: <ul style="list-style-type: none"> High cholesterol Obesity High blood pressure Diabetes <p>Smoking cessation program, through QuitNet, including individual/group/telephone counseling, and for physician prescribed over the counter (OTC) and prescription drugs approved by the FDA to treat tobacco dependence.</p> <p>Enroll online at www.quitnet.com/coventrywellbeing or call 1-866-577-8210. A representative will ask you for your Authentication code which is your 11 digit Coventry ID number - and will then assist you in the completion of the registration process.</p>	<p>High Option</p> <p>Nothing</p> <p>Nothing for the counseling for up to two quit attempts per year.</p> <p>Nothing for physician prescribed OTC and prescription drugs approved by the FDA to treat tobacco dependence.</p>	<p>Standard Option</p> <p>Nothing</p> <p>Nothing for the counseling for up to two quit attempts per year.</p> <p>Nothing for physician prescribed OTC and prescription drugs approved by the FDA to treat tobacco dependence.</p>

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

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan physicians must provide or arrange your care.
- High Option: The calendar year deductible is \$500 Self Only and \$1,500 Self and Family. The calendar year deductible applies to almost all benefits in this Section. We added ("No Deductible") to show when the calendar year deductible does not apply.
- Standard Option: The calendar year deductible is \$1,500 Self Only and \$4,500 Self and Family. The calendar year deductible applies to almost all benefits in this Section. We added ("No Deductible") to show when the calendar year deductible does not apply.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost-sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- The amounts listed below are for the charges billed by a physician or other health care professional for your surgical care. Look in Section 5(c) for charges associated with the facility (i.e. hospital, surgical center, etc.).
- **YOUR PHYSICIAN MUST GET PRECERTIFICATION FOR SOME SURGICAL PROCEDURES.** Please refer to the precertification information shown in Section 3 to be sure which services require precertification.

Benefit Description	You pay After the calendar year deductible. . .	
	High Option	Standard Option
Surgical procedures		
A comprehensive range of services, such as:	15% of our allowance	20% of our allowance
<ul style="list-style-type: none"> • Operative procedures • Circumcision of a newborn • Treatment of fractures, including casting • Normal pre- and post-operative care by the surgeon 		
<ul style="list-style-type: none"> • Correction of amblyopia and strabismus • Endoscopy procedures • Biopsy procedures • Removal of tumors and cysts • Correction of congenital anomalies (see Reconstructive surgery) 		
<ul style="list-style-type: none"> • Minor surgery in physician office 	\$20 per visit to a primary care physician or OB/GYN, No Deductible \$50 per visit to a specialist, No Deductible	20% of our allowance
	15% of our allowance	20% of our allowance

Surgical procedures - continued on next page

Benefit Description	You pay After the calendar year deductible. . .	
Surgical procedures (cont.)	High Option	Standard Option
<ul style="list-style-type: none"> • Surgical treatment of morbid obesity (bariatric surgery) Roux-en-Y Gastric Bypass, Laparoscopic Gastric Banding, and Vertical Banded Gastroplasty. <ul style="list-style-type: none"> - a condition in which an individual weighs 100 pounds or 100% over his or her normal weight according to current underwriting standards; eligible members must be age 18 or over - the patient is an adult (≥ 18 years of age) with morbid obesity that has persisted for at least 3 years, and for which there is no treatable metabolic cause for the obesity; - there is presence of morbid obesity, defined as a body mass index (BMI) exceeding 40, or greater than 35 with documented co-morbid conditions (cardiopulmonary problems e.g., severe apnea, Pickwickian Syndrome, and obesity-related cardiomyopathy, severe diabetes mellitus, hypertension, or arthritis). (BMI is calculated by dividing a patient's weight (in kilograms) by height (in meters) squared. To convert pounds to kilograms, multiply pounds by 0.45. To convert inches to meters, multiply inches by .0254); - The patient has failed to lose weight (approximately 10% from baseline) or has regained weight despite participation in a three month physician-supervised multidisciplinary program within the past six months that included dietary therapy, physical activity and behavior therapy and support; - The patient has been evaluated for restrictive lung disease and received surgical clearance by a pulmonologist, if clinically indicated; has received cardiac clearance by a cardiologist if there is a history of prior phen-fen or redux use, and the patient has agreed, following surgery, to participate in a multidisciplinary program that will provide guidance on diet, physical activity and social support; and, - The patient has completed a psychological evaluation and has been recommended for bariatric surgery by a licensed mental health professional (this must be documented in the patient's medical record) and the patient's medical record reflects documentation by the treating psychotherapist that all psychosocial issues have been identified and addressed; and the psychotherapist indicates that the patient is likely to be compliant with the post-operative diet restrictions; 	<p>15% of our allowance</p>	<p>20% of our allowance</p>

Surgical procedures - continued on next page

Benefit Description	You pay After the calendar year deductible. . .	
	High Option	Standard Option
Surgical procedures (cont.)		
<ul style="list-style-type: none"> • 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>	15% of our allowance	20% of our allowance
Voluntary sterilization (e.g., Tubal ligation, Vasectomy)	15% of our allowance	20% of our allowance
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Surgical treatment of morbid obesity (bariatric surgery) Jujunoileal Bypass, Gastric Stapling, Duodenal Switch, and Bilopancreatic Diversion.</i> • <i>Reversal of voluntary sterilization</i> • <i>Routine treatment of conditions of the foot; see Foot care</i> 	<i>All charges</i>	<i>All charges</i>
Reconstructive surgery	High Option	Standard Option
<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>	15% of our allowance	20% of our allowance
<i>Not covered:</i>	<i>All charges</i>	<i>All charges</i>

Reconstructive surgery - continued on next page
High and Standard Option Section 5(b)

Benefit Description	You pay After the calendar year deductible. . .	
Reconstructive surgery (cont.)	High Option	Standard Option
<ul style="list-style-type: none"> • <i>Cosmetic surgery – any surgical procedure (or any portion of a procedure) performed primarily to improve physical appearance through change in bodily form, except repair of accidental injury</i> • <i>Surgeries related to sex transformation</i> 	<i>All charges</i>	<i>All charges</i>
Oral and maxillofacial surgery	High Option	Standard Option
<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; • Other surgical procedures that do not involve the teeth or their supporting structures; and • Treatment of TMJ (non-dental). 	15% of our allowance	20% of our allowance
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Oral implants and transplants</i> • <i>Procedures that involve the teeth or their supporting structures (such as the periodontal membrane, gingiva, and alveolar bone)</i> • <i>TMJ related dental work</i> 	<i>All charges</i>	<i>All charges</i>
Organ/tissue transplants	High Option	Standard Option
<p>These solid organ transplants are subject to medical necessity and experimental /investigational review by the Plan. Refer to Other Services in Section 3 for prior authorization procedures. Transplant services must be performed at a participating Center of Excellence. We approve and designate where all transplants must be performed including hospitals for specific transplant procedures. If you would like to know about a specific facility, please contact Customer Service.</p> <p>Solid organ transplants limited to:</p> <ul style="list-style-type: none"> • Cornea • Heart • Heart/lung • Kidney • Liver • Pancreas* • Kidney/Pancreas 	15% of our allowance	20% of our allowance

Organ/tissue transplants - continued on next page

Benefit Description	You pay After the calendar year deductible. . .	
	High Option	Standard Option
<p>Organ/tissue transplants (cont.)</p> <ul style="list-style-type: none"> • Lung: single, double, lobar • Intestinal transplants <ul style="list-style-type: none"> - small intestine - small intestine with the liver - small intestine with multiple organs such as the liver, stomach, and pancreas • Autologous pancreas islet cell transplant (as an adjunct to total or near total pancreatectomy) only for patients with chronic pancreatitis. <p>* We limit the coverage for pancreas (only) transplants to patients who have insulin dependent (or Type 1) diabetes mellitus when we find that exogenous treatment with insulin is ineffective.</p>	15% of our allowance	20% of our allowance
<p>These tandem blood or marrow stem cell transplants for covered transplants are subject to medical necessity review by the Plan. Refer to <i>Other services</i> in Section 3 for prior authorization procedures.</p> <ul style="list-style-type: none"> • Autologous tandem transplants for <ul style="list-style-type: none"> - AL Amyloidosis - Multiple myeloma (de novo and treated) - Recurrent germ cell tumors (including testicular cancer) 	15% of our allowable	20% of our allowable
<p>Blood or marrow stem cell transplants limited to the stages of the following diagnoses. For the diagnoses listed below, the medical necessity limitation is considered satisfied if the patient meets the staging description.</p> <p>Allogeneic (donor) transplants for:</p> <ul style="list-style-type: none"> • Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia • Advanced Hodgkin’s lymphoma with reoccurrence (relapsed) • Advanced non-Hodgkin’s lymphoma with reoccurrence (relapsed) • Acute myeloid leukemia • Advanced Myeloproliferative Disorder (MPDs) • Advanced Neuroblastoma • Amyloidosis • Chronic lymphocytic lymphoma /small lymphocytic lymphoma (CLL/SLL) • Hemoglobinopathy • Infant malignant osteopetrosis 	15% of our allowance	20% of our allowance

Organ/tissue transplants - continued on next page

Benefit Description	You pay After the calendar year deductible. . .	
	High Option	Standard Option
<p>Organ/tissue transplants (cont.)</p> <ul style="list-style-type: none"> • Kostmann’s syndrome • Leukocyte adhesion deficiencies • Marrow Failure and Related Disorders (i.e. Fanconi’s, PNH, Pure Red Cell Aplasia) • Mucopolysaccharidosis (e.g. Gaucher’s disease, metachromatic leukodystrophy, adrenoleukodystrophy) • Mucopolysaccharidosis (e.g. Hunter’s Syndrome, Hurler’s syndrome, Sanfillippo’s syndrome, Maroteauxlamy syndrome variants) • Myelodysplasia/Myelodysplastic syndromes • Paroxysmal Nocturnal Hemoglobinuria • Phagocytic / Hemophagocytic deficiency diseases (e.g. Wiskott-Aldrich syndrome) • Severe combined immuno-deficiency disease • Severe or very severe aplastic anemia • Sickle cell anemia <p>Autologous transplants for:</p> <ul style="list-style-type: none"> • Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia • Advanced Hodgkin’s lymphoma with reoccurrence (relapsed) • Advanced non-Hodgkin’s lymphoma with reoccurrence (relapsed) • Amyloidosis • Advanced Neuroblastoma • Multiple Myeloma • Testicular, Mediastinal, Retroperitoneal, and ovarian germ cell tumors 	15% of our allowance	20% of our allowance
<p>Mini Transplants performed in a clinical trial setting (non-myeloblastic, reduced intensity conditioning or RIC) for members with a diagnosis listed below are subject to medical necessity review by the Plan. Refer to Other Services in Section 3 for prior authorization procedures:</p> <p>Allogeneic transplants for:</p> <ul style="list-style-type: none"> • Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia • Advanced Hodgkin’s lymphoma with reoccurrence (relapsed) • Advanced non-Hodgkin’s lymphoma with reoccurrence (relapsed) • Acute myeloid leukemia 	15% of our allowable	20% of our allowable

Organ/tissue transplants - continued on next page

Benefit Description	You pay After the calendar year deductible. . .	
Organ/tissue transplants (cont.)	High Option	Standard Option
<ul style="list-style-type: none"> • Advanced Myeloproliferative Disorder (MPDs) • Amyloidosis • Chronic lymphocytic lymphoma /small lymphocytic lymphoma (CLL/SLL) • Hemoglobinopathy • Marrow Failure and Related Disorders (i.e. Fanconi's, PNH, Pure Red Cell Aplasia) • Myelodysplasia/Myelodysplastic syndromes • Paroxysmal Nocturnal Hemoglobinuria • Severe combined immuno-deficiency disease • Severe or very severe aplastic anemia <p>Autologous transplants for:</p> <ul style="list-style-type: none"> • Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia • Advanced Hodgkin's lymphoma with reoccurrence (relapsed) • Advanced non-Hodgkin's lymphoma with reoccurrence (relapsed) • Amyloidosis • Neuroblastoma • Breast cancer • Epithelial ovarian cancer 	<p>15% of our allowable</p>	<p>20% of our allowable</p>
<p>These blood or marrow stem cell transplants are covered only in a National Cancer Institute or National Institutes of health approved clinical trial or a Plan-designated center of excellence and if approved by the Plan's medical director in accordance with the Plan's protocols.</p> <p>If you are a participant in a clinical trial, the Plan will provide benefits for related routine care that is medically necessary (such as doctor visits, lab tests, x-rays and scans, and hospitalization related to treating the patient's condition) if it is not provided by the clinical trial. Section 9 has additional information on costs related to clinical trials. We encourage you to contact the Plan to discuss specific services if you participate in a clinical trial.</p> <p>Allogeneic transplants for:</p> <ul style="list-style-type: none"> • Advanced Hodgkin's lymphoma • Advanced non-Hodgkin's lymphoma • Early stage (indolent or non-advanced) small cell lymphocytic lymphoma 	<p>15% of our allowance</p>	<p>20% of our allowance</p>

Organ/tissue transplants - continued on next page

Benefit Description	You pay After the calendar year deductible. . .	
	High Option	Standard Option
Organ/tissue transplants (cont.) Mini-transplants (non-myeloblastic allogeneic, reduced intensity conditioning or RIC) for <ul style="list-style-type: none"> • Acute lymphocytic or non-lymphocytic leukemia • Advanced Hodgkin’s lymphoma • Advanced non-Hodgkin’s lymphoma • Breast Cancer • Chronic lymphocytic leukemia • Chronic myelogenous leukemia • Colon cancer • Chronic lymphocytic lymphoma /small lymphocytic lymphoma (CLL/SLL) • Early stage (indolent or non-advanced) small cell lymphocytic lymphoma • Multiple Myeloma • Multiple sclerosis • Myeloproliferative Disorder (MPDs) • Non-small lung cancer • Ovarian cancer • Prostate cancer • Renal cell carcinoma • Sarcomas • Sickle cell anemia (pediatric only) Mini-transplants (non-myeloblastic autologous, reduced intensity conditioning or RIC) for <ul style="list-style-type: none"> • Advanced Hodgkin’s lymphoma • Advanced non-Hodgkin’s lymphoma • Chronic myelogenous leukemia • Chronic lymphocytic lymphoma /small lymphocytic lymphoma (CLL/SLL) • Early stage (indolent or non-advanced) small cell lymphocytic lymphoma • Multiple sclerosis • Small cell lung cancer • Systemic lupus erythematosus • Systemic sclerosis • Scleroderma • Scleroderma – SSc (severe, progressive) 	15% of our allowance	20% of our allowance

Organ/tissue transplants - continued on next page

Benefit Description	You pay After the calendar year deductible. . .	
Organ/tissue transplants (cont.)	High Option	Standard Option
<ul style="list-style-type: none"> • NOTE: We cover related medical and hospital expenses of the donor when we cover the recipient. We cover donor testing for the actual solid organ or up to four bone marrow /stem cell transplant donors in addition to the testing of family members. • After referral to a transplant facility, the following will apply: <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><i>Not covered:</i></p> <ul style="list-style-type: none"> • Donor screening tests and donor search expenses, except as shown above. • Any related conditions or complications for a member who is donating an organ or tissue when the recipient is not a member • Outpatient immunosuppressive agents • Any transplant procedure that is performed in a facility that has not been designated by the Medical Director as a approved transplant facility • Implants of non-human or artificial organs • Transplants not listed as covered 	<i>All charges</i>	<i>All charges</i>
Anesthesia	High Option	Standard Option
Professional services provided in – <ul style="list-style-type: none"> • Hospital (inpatient) 	15% of our allowance	20% of our allowance
Professional services provided in – <ul style="list-style-type: none"> • Hospital outpatient department • Skilled nursing facility • Ambulatory surgical center 	15% of our allowance	20% of our allowance

Anesthesia - continued on next page

High and Standard Option

Benefit Description	You pay After the calendar year deductible. . .	
Anesthesia (cont.)	High Option	Standard Option
• Office	\$20 per visit to a primary care physician or OB/GYN, No Deductible \$50 per visit to a specialist, No Deductible	20% of our allowance

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

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan physicians must provide or arrange your care and you must be hospitalized in a Plan facility.
- High Option: The calendar year deductible is \$500 Self Only and \$1,500 Self and Family. The calendar year deductible applies to almost all benefits in this Section. We added ("No Deductible") to show when the calendar year deductible does not apply.
- Standard Option: The calendar year deductible is \$1,500 Self Only and \$4,500 Self and Family. The calendar year deductible applies to almost all benefits in this Section. We added ("No Deductible") to show when the calendar year deductible does not apply.
- Be sure to read Section 4, *Your costs for covered services* for valuable information about how cost-sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- The amounts listed below are for the charges billed by the facility (i.e., hospital or surgical center) or ambulance service for your surgery or care. Any costs associated with the professional charge (i.e., physicians, etc.) are in Sections 5(a) or (b).
- **YOUR PHYSICIAN MUST GET PRECERTIFICATION FOR HOSPITAL STAYS.** Please refer to Section 3 to be sure which services require precertification.

Benefit Description	You pay After the calendar year deductible. . .	
	High Option	Standard Option
Inpatient hospital		
Room and board, such as <ul style="list-style-type: none"> • Ward, semiprivate, or intensive care accommodations; • General nursing care; and • Meals and special diets. • Special duty nursing Note: If you want a private room when it is not medically necessary, you pay the additional charge above the semiprivate room rate.	15% of our allowance	20% of our allowance
Other hospital services and supplies, such as: <ul style="list-style-type: none"> • Operating, recovery, maternity, and other treatment rooms • Prescribed drugs and medicines • Diagnostic laboratory tests and X-rays • Administration of blood and blood products • Blood or blood plasma, if not donated or replaced • Dressings, splints, casts, and sterile tray services • Medical supplies and equipment, including oxygen 	15% of our allowance	20% of our allowance

Inpatient hospital - continued on next page

Benefit Description	You pay After the calendar year deductible. . .	
	High Option	Standard Option
<p>Inpatient hospital (cont.)</p> <ul style="list-style-type: none"> Anesthetics, including nurse anesthetist services Medical supplies, appliances, medical equipment, and any covered items billed by a hospital for use at home <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>We must authorize benefits for the administration of general anesthesia and for hospital services related to dental care, when the following members receive these services:</p> <ul style="list-style-type: none"> A dependent child age five and under; A member who is severely disabled; or A member who has a medical behavioral condition which requires hospitalization or general anesthesia when dental care is provided. <p>A participating provider must administer the general anesthesia whether or not the dental services are provided in a hospital, surgical center or office.</p>	15% of our allowance	20% of our allowance
<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>Take home items</i> 	<i>All charges</i>	<i>All charges</i>
<p>Outpatient hospital or ambulatory surgical center</p> <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 	15% of our allowance	20% of our allowance

Outpatient hospital or ambulatory surgical center - continued on next page

Benefit Description	You pay After the calendar year deductible. . .	
Outpatient hospital or ambulatory surgical center (cont.)	High Option	Standard Option
<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>We must authorize benefits for the administration of general anesthesia and for hospital services related to dental care, when the following members receive these services:</p> <ul style="list-style-type: none"> • A dependent child age five and under; • A member who is severely disabled; or • A member who has a medical behavioral condition which requires hospitalization or general anesthesia when dental care is provided. <p>A participating provider must administer the general anesthesia whether or not the dental services are provided in a hospital, surgical center or office.</p>	15% of our allowance	20% of our allowance
High Tech Diagnostics - including, but not limited to CAT, PET, MRI, MRA, and EEGs	\$250 per visit, No Deductible	\$250 per visit, No Deductible
<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	High Option	Standard Option
<p>A comprehensive range of benefits covered for 60 days per calendar year when full-time skilled nursing care is necessary and confinement in a skilled nursing facility is medically appropriate as determined by a Plan doctor and approved by the Plan. All necessary services are covered, including:</p> <ul style="list-style-type: none"> • Bed, board and general nursing care • Drugs, biologicals, supplies, and equipment ordinarily provided and arranged by the skilled nursing facility when prescribed by a Plan doctor. 	15% of our allowance	20% of our allowance
<i>Not covered: Custodial care</i>	<i>All charges</i>	<i>All charges</i>
Hospice care	High Option	Standard Option
<p>Supportive and Palliative care for a terminally ill member is covered in the home or hospice facility. Services include inpatient and outpatient care and family counseling. These services are provided under the direction of 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.</p>	15% of our allowance	20% of our allowance
<i>Not covered:</i>	<i>All charges</i>	<i>All charges</i>

Hospice care - continued on next page

High and Standard Option

Benefit Description	You pay After the calendar year deductible. . .	
Hospice care (cont.)	High Option	Standard Option
<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	High Option	Standard Option
<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. 	15% of our allowance	20% of our allowance

Section 5(d). Emergency services/accidents

Important things to keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- High Option: The calendar year deductible is \$500 Self Only and \$1,500 for Self and Family. The calendar year deductible applies to almost all benefits in this Section. We added ("No Deductible") to show when the calendar year deductible does not apply.
- Standard Option: The calendar year deductible is \$1,500 Self Only and \$4,500 for Self and Family. The calendar year deductible applies to almost all benefits in this Section. We added ("No Deductible") to show when the calendar year deductible does not apply.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost-sharing works. Also read Section 9 about Coordinating benefits with other coverage, including with Medicare.

What is a medical emergency?

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

What to do in case of emergency:

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

Emergencies within our service area:

If your symptoms are not life-threatening, contact your physician, who is on call 24 hours a day, seven days a week. During after hours or weekends, your physician 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 access to Take Care Clinics (Walgreens), Minute Clinics (CVS Pharmacy), and several urgent care centers which are open on evenings, weekends and holidays, and are designed to give our members fast, effective quality care for non-emergent conditions such as: sprains, influenza, sore throats, ear infections, minor lacerations, and upper respiratory infections.

Emergencies outside our service area:

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

High and Standard Option

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

Benefit Description	You pay After the calendar year deductible. . .	
	High Option	Standard Option
Emergency within our service area		
<ul style="list-style-type: none"> • Emergency care at a doctor’s office (consultation only) 	\$20 per visit to a primary care physician or OB/GYN, No Deductible \$50 per visit to a specialist, No Deductible	\$30 per visit to a primary care physician, No Deductible \$60 per visit to a specialist, No Deductible
<ul style="list-style-type: none"> • Emergency care at an urgent care center • Take Care Clinic (Walgreens) • Minute Clinic (CVS Pharmacy) 	\$75 per urgent care visit, No Deductible \$20 per visit, No Deductible	\$75 per urgent care visit, No Deductible \$30 per visit, No Deductible
<ul style="list-style-type: none"> • Emergency care at a hospital 	\$250 for facility and physician per visit, No Deductible; waived if admitted to hospital	\$350 for facility and physician per visit, No Deductible; 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 (consultation only) 	\$20 per visit to a primary care physician or OB/GYN, No Deductible \$50 per visit to a specialist, No Deductible	\$30 per visit to a primary care physician or OB/GYN, No Deductible \$60 per visit to a specialist, No Deductible
<ul style="list-style-type: none"> • Emergency care at an urgent care center • Take Care Clinic (Walgreens) • Minute Clinic (CVS Pharmacy) 	\$75 per urgent care visit, No Deductible \$20 per visit, No Deductible	\$75 per urgent care visit, No Deductible \$20 per visit, No Deductible
<ul style="list-style-type: none"> • Emergency care at a hospital 	\$250 for facility and physician per visit, No Deductible; waived if admitted to hospital	\$350 for facility and physician per visit, No Deductible; 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>

High and Standard Option

Benefit Description	You pay After the calendar year deductible. . .	
Ambulance	High Option	Standard Option
<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>	15% of our allowance	20% of our allowance

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

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

Important things to keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- High Option: The calendar year deductible is \$500 Self Only and \$1,500 Self and Family. The calendar year deductible applies to almost all benefits in this Section. We added ("No Deductible") to show when the calendar year deductible does not apply
- Standard Option: The calendar year deductible is \$1,500 Self Only and \$4,500 Self and Family. The calendar year deductible applies to almost all benefits in this Section. We added ("No Deductible") to show when the calendar year deductible does not apply
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost-sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

YOU MUST GET PREAUTHORIZATION FOR THESE SERVICES. Benefits are payable only when we determine the care is clinically appropriate to treat your condition and only when you receive the care as part of a treatment plan that we approve. The treatment plan may include services, drugs, and supplies described elsewhere in this brochure. To be eligible to receive full benefits, you must follow the preauthorization process and get Plan approval of your treatment plan with MHNet Behavioral Health at 1-866-607-5970. They can be reached 24 hours a day, 7 days a week to answer questions and assist you in choosing appropriate services. Your mental health provider will obtain subsequent authorizations for treatment.

We will provide medical review criteria or reasons for treatment plan denials to enrollees, patient or providers upon request or as otherwise required.

OPM will base its review of disputes about treatment plans on the treatment plan’s clinical appropriateness. OPM will generally not order us to pay or provide one clinically appropriate treatment plan in favor of another.

Benefit Description	You pay After the calendar year deductible. . .	
	High Option	Standard Option
<p>Mental health and substance abuse benefits</p> <p>All diagnostic and treatment services recommended by a Plan provider and contained in a treatment plan that we approve. The treatment plan may include services, drugs, and supplies described elsewhere in this brochure.</p> <p>Note: Plan benefits are payable only when we determine the care is clinically appropriate to treat your condition and only when you receive the care as part of a treatment plan that we approve.</p>	<p>Your cost-sharing responsibilities are no greater than for other illnesses or conditions.</p>	<p>Your cost-sharing responsibilities are no greater than for other illnesses or conditions.</p>
<p>Diagnostic and treatment of psychiatric conditions, mental illness and mental disorders. Services include:</p> <ul style="list-style-type: none"> • Diagnostic evaluation 	<p>\$0 per visit, No Deductible</p>	<p>\$0 per visit, No Deductible</p>

Mental health and substance abuse benefits - continued on next page

Benefit Description	You pay After the calendar year deductible. . .	
	High Option	Standard Option
Mental health and substance abuse benefits (cont.)		
<ul style="list-style-type: none"> • Professional services, including individual or group therapy by providers such as psychiatrists, psychologists, or clinical social workers • Crisis intervention for acute episodes • Medication management 	\$0 per visit, No Deductible	\$0 per visit, No Deductible
<ul style="list-style-type: none"> • Psychological testing necessary to determine the appropriate treatment 	\$0 per visit, No Deductible	\$0 per visit, No Deductible
<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 a primary care physician. However, before you continue a treatment plan with a mental health provider, you must obtain authorization for the visit from MHNNet 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>	\$0 per visit, No Deductible	\$0 per visit, No Deductible
<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 	15% of our allowance	20% of our 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. 	\$0 per visit, No Deductible	\$0 per visit, No Deductible
<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.

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

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

Limitation

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

Section 5(f). Prescription drug benefits

Important things 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 for prescription drug 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.

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. **Medco's Customer Service number for Coventry Health Care of Kansas' Plan members 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 the Customer Service Department at 1-800-969-3343. If your Plan 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.

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 Medco, our mail order prescription drug program, and may be dispensed with three (3) applicable copayment(s) for a ninety-three (93) day supply. To order prescriptions or refills please contact Medco's Customer Service number for Coventry Health Care of Kansas' Plan members at 1-800-378-7040 or visit the web site www.rxrequest.com. Available 24 hours a day – 7 days a week.
- To promote appropriate utilization, or following manufacturer's recommendations, certain plan approved medications may have a quantity limit on the amount of medication dispensed and Prior Authorization must be obtained prior to dispensing.
- We reserve the right to include only one dosage or form of a drug on our Formulary when the same drug (i.e., a drug with the same active ingredient) is available in different dosages or forms (i.e., dissolvable tablets, capsules, etc) from the same or different manufacturers. The product, in the dosage or form, that is listed on the Formulary will be Covered at the applicable Member Responsibility. The drug, product or products, in different forms or dosages or from the same or different manufacturers, not listed on the Formulary will be excluded from coverage.
- Coverage of Prescription Drugs, therapeutic devices or supplies requiring a Prescription Order and prescribed by a Prescribing Provider is limited to Plan approved drugs, devices, supplies, or spacers for metered dose inhalers.

Members called to active military duty in a time of national or other emergency who need to obtain a greater-than-normal supply of prescribed medications should call us at 1-800-969-3343.

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

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

When you do have to file a 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	
	High Option	Standard Option
<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 • Diabetic supplies, including insulin syringes, needles, glucose test tablets and test tape* • Disposable needles and syringes for the administration of covered medications. • Drugs for sexual dysfunction • Contraceptive drugs and devices • Injectable contraceptive drugs (such as Depo Provera) • Immunosuppressant drugs required after a covered transplant* • Growth hormones and other self-administered injectables* <p>*Note: Non-formulary Diabetic supplies, etc., Immunosuppressants, and GHT require prior authorization.</p> <p>To find Your Prescription Drug, its applicable Tier and any Prior Authorization requirements, visit Our searchable Formulary on Our website www.chckansas.com, in the Participating Provider’s office, or by contacting the Customer Service Department.</p>	<p>Retail Pharmacy</p> <p>Tier 1A - \$3 Copayment (No Deductible) per prescription</p> <p>Tier 1B - \$12 Copayment (No Deductible) per prescription</p> <p>Tier 2 - \$40 Copayment (No Deductible) per prescription</p> <p>Tier 3 - \$65 Copayment (No Deductible) per prescription</p> <p>Tier 4 - 20% Coinsurance or \$65 Copayment, which ever is greater up to \$200 maximum per individual prescription. A separate catastrophic maximum of \$2,500 per covered individual applies to Tier 4.</p> <p>Mail Order (93 day supply)</p> <p>Tier 1A - \$9 Copayment (No Deductible) per prescription</p> <p>Tier 1B - \$36 Copayment (No Deductible) per prescription</p> <p>Tier 2 - \$120 Copayment (No Deductible) per prescription</p> <p>Tier 3 - \$195 Copayment (No Deductible) per prescription</p> <p>Tier 4 - Not Available</p>	<p>Retail Pharmacy</p> <p>Tier 1A - \$3 Copayment (No Deductible) per prescription</p> <p>Tier 1B - \$12 Copayment (No Deductible) per prescription</p> <p>Tier 2 - \$40 Copayment (No Deductible) per prescription</p> <p>Tier 3 - \$65 Copayment (No Deductible) per prescription</p> <p>Tier 4 - 20% Coinsurance or \$65 Copayment, which ever is greater up to \$200 maximum per individual prescription. A separate catastrophic maximum of \$2,500 per covered individual applies to Tier 4.</p> <p>Mail Order (93 day supply)</p> <p>Tier 1A - \$9 Copayment (No Deductible) per prescription</p> <p>Tier 1B - \$36 Copayment (No Deductible) per prescription</p> <p>Tier 2 - \$120 Copayment (No Deductible) per prescription</p> <p>Tier 3 - \$195 Copayment (No Deductible) per prescription</p> <p>Tier 4 - Not Available</p>

Covered medications and supplies - continued on next page

Benefit Description	You pay	
Covered medications and supplies (cont.)	High Option	Standard Option
	<p>Note: If there is no Tier 1 equivalent available, you will still have to pay the Tier 2 copayment. If there is a Tier 1 equivalent and you choose the Tier 2 drug, you will pay the Tier 2 copayment plus the difference in the average wholesale price between the Tier 1 and Tier 2 drug. The Ancillary charge does not apply to any deductible or catastrophic maximum. This applies to both formulary and non-formulary drugs.</p>	<p>Note: If there is no Tier 1 equivalent available, you will still have to pay the Tier 2 copayment. If there is a Tier 1 equivalent and you choose the Tier 2 drug, you will pay the Tier 2 copayment plus the difference in the average wholesale price between the Tier 1 and Tier 2 drug. The Ancillary charge does not apply to any deductible or catastrophic maximum. This applies to both formulary and non-formulary drugs.</p>
<ul style="list-style-type: none"> • Insulin – Under retail pharmacy benefit, you can obtain up to a 3 month supply of insulin. • Diabetic supplies* – Under retail pharmacy benefit, you can obtain up to a 3 month supply of diabetic supplies (non-formulary supplies requires prior-authorization). • Oral and injectable contraceptive drugs – Under retail pharmacy benefit, you can obtain up to a 3 month supply. 	<p>Retail Pharmacy</p> <p>Tier 1A - \$9 Copayment (No Deductible) per prescription</p> <p>Tier 1B - \$36 Copayment (No Deductible) per prescription</p> <p>Tier 2 - \$120 Copayment (No Deductible) per prescription</p> <p>Tier 3 - \$195 Copayment (No Deductible) per prescription</p> <p>Tier 4 - 20% Coinsurance or \$195 Copayment, which ever is greater up to \$600 maximum per individual prescription. Out-of-pocket maximum is \$2,500 per covered individual.</p>	<p>Retail Pharmacy</p> <p>Tier 1A - \$9 Copayment (No Deductible) per prescription</p> <p>Tier 1B - \$36 Copayment (No Deductible) per prescription</p> <p>Tier 2 - \$120 Copayment (No Deductible) per prescription</p> <p>Tier 3 - \$195 Copayment (No Deductible) per prescription</p> <p>Tier 4 - 20% Coinsurance or \$195 Copayment, which ever is greater up to \$600 maximum per individual prescription. Out-of-pocket maximum is \$2,500 per covered individual.</p>
<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>Medications used for cosmetic purposes or to enhance work or athletic performance (i.e. Nuvigil or Provigil for shift work, anabolic steroids and minoxidil lotion, retin A (tretinoin) for aging skin). Also excluded are drugs, oral or injectable, used to slow or reverse normal aging processes (i.e. growth hormone, testosterone, etc.).</i> • <i>Fertility drugs</i> • <i>Drugs obtained at a non-Plan pharmacy; except for out-of-area emergencies</i> 	<p><i>All charges</i></p>	<p><i>All charges</i></p>

Covered medications and supplies - continued on next page

Benefit Description	You pay	
Covered medications and supplies (cont.)	High Option	Standard Option
<ul style="list-style-type: none"> • <i>Vitamins, nutrients and food supplements even if a physician prescribes or administers them, except as specified on the Formulary</i> • <i>Drugs available without a prescription or for which there is a non-prescription equivalent; except those designated by the plan</i> • <i>Appetite suppressants and other drugs to assist in weight control (except for the treatment of morbid obesity when authorized by us).</i> • <i>Nonprescription medicines; except those designated by the plan</i> • <i>Dosage forms of natural estrogen or progesterone; or any natural hormone replacement product, including but not limited to oral capsules, suppositories, creams and troches</i> • <i>Prescription drugs for non-covered services</i> • <i>Drugs for hair restoration</i> <p>Note: Physician prescribed over-the-counter and prescription drugs approved by the FDA to treat tobacco dependence are covered under the Smoking cessation benefit. (See page 31).</p>	<p><i>All charges</i></p>	<p><i>All charges</i></p>

Section 5(g). Dental benefits

Important things to keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable when we determine they are dentally necessary.
- If you are enrolled in a Federal Employees Dental/Vision Insurance Program (FEDVIP) Dental Plan, your FEHB Plan will be First/Primary payor of any Benefit payments and your FEDVIP Plan is secondary to your FEHB Plan. See Section 9 Coordinating benefits with other coverage.
- We have no calendar year deductible for diagnostic and preventative services.
- Locate a Coventry Dental Provider at www.chckansas.com, under Member page, click on "Find a dentist" to search for a provider in your area or call customer service toll-free at 1-866-433-6391. If you are unable to locate a network provider in your area, you may seek covered dental service from a non-participating provider at no additional cost.
- There are no benefits for any service which is not specifically listed in this brochure.
- Some procedures and treatments may have specific age and frequency limitations as noted below.
- We cover hospitalization for dental procedures only when a non-dental physical impairment which makes hospitalization necessary to safeguard the health of the patient. Section 5(c) for inpatient benefits. We do not cover the dental procedure unless it is described below.
- Important Note: **IT IS YOUR RESPONSIBILITY TO BE INFORMED ABOUT YOUR DENTAL COVERAGE.**

Benefit Description	You Pay After the calendar year deductible. . .	
Accidental injury benefit	High Option	Standard Option
We cover restorative services and supplies necessary to promptly repair (but not replace) sound natural teeth. The need for these services must result from an accidental injury.	The remaining cost after a 20% reduction of participating specialist fees	The remaining cost after a 20% reduction of participating specialist fees
Dental Benefits	You Pay	
Service	High Option	Standard Option
Diagnostic: Oral examinations: once each twelve (12) months Diagnostic x-rays: bitewings once each twelve (12) months Full mouth x-rays: once each five (5) years	Nothing, No Deductible	Nothing, No Deductible
Preventive: Prophylaxis (cleanings) once every (12) months Topical Fluoride: once every (12) months for dependent children under age (19) Space maintainers for dependent children under age (14) and only for premature loss of primary molars	Nothing, No Deductible	Nothing, No Deductible

Service - continued on next page

High and Standard Option

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

Section 5(h). 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. If we identify a less costly alternative, we will ask you to sign an alternative benefits agreement that will include all of the following terms. Until you sign and return the agreement, regular contract benefits will continue. • Alternative benefits will be made available for a limited time period and are subject to our ongoing review. You must cooperate with the review process. • By approving an alternative benefit, we cannot guarantee you will get it in the future. • The decision to offer an alternative benefit is solely ours, and except as expressly provided in the agreement, we may withdraw it at any time and resume regular contract benefits. • If you sign the agreement, we will provide the agreed-upon alternative benefits for the stated time period (unless circumstances change). You may request an extension of the time period, but regular benefits will resume if we do not approve your request. <p>Our decision to offer or withdraw alternative benefits is not subject to OPM review under the disputed claims process.</p>
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 hours a day, 7 days a week and are trained to handle your questions. Any member who visits an emergency room or urgent care center as a result of advice from FirstHelp will automatically have associated claims approved. With FirstHelp authorization, you will know in advance if medical services will be covered. You may call 1-800-622-9528 or for the hearing impaired call 1-800-735-2966.</p>
Services for deaf and hearing impaired	<p>The Kansas TDD relay number is 1-800-766-3777. 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>

High Deductible Health Plan Benefits

See page 11 for how our benefits changed this year and page 127 for a benefits summary.

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Section 5. High Deductible Health Plan Benefits Overview

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

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

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

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

With this Plan, preventive care is covered in full. As you receive other non-preventive medical care, you must meet the Plan's deductible before we pay benefits according to the benefits described on page 72. You can choose to use funds available in your HSA to make payments toward the deductible or you can pay toward your deductible entirely out-of-pocket, allowing your savings to continue to grow.

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

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

Covered services include:

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

Health Savings Accounts (HSA)

By law, HSAs are available to members who are not enrolled in Medicare, cannot be claimed as a dependent on someone else’s tax return, have not received VA benefits within the last three months, or do not have other health insurance coverage other than another high deductible health plan. In 2011, for each month you are eligible for an HSA premium pass through, we will contribute to your HSA \$66.66 per month for a Self-Only enrollment or \$133.33 per month for a Self and Family enrollment. In addition to our monthly contribution, you have the option to make additional tax-free contributions to your HSA, so long as total contributions do not exceed the limit established by law, which is \$3,050 for an individual and \$6,150 for family - see maximum contribution information in HDHP Section 5(c). You can use funds in your HSA to help pay your health plan deductible. You own your HSA, so the funds can go with you if you change plans or employment.

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

HSA features include:

- Your HSA is administered by Coventry Consumer Advantage (C3).
- Your contributions to the HSA are tax deductible
- You may establish pre-tax HSA deductions from your paycheck to fund your HSA up to IRS limits using the same method that you use to establish other deductions (i.e., Employee Express, MyPay, etc.)
- You can make tax-free withdrawals for qualified medical expenses for you, your spouse and dependents. (See IRS publication 502 for a complete list of eligible expenses.)
- Your unused HSA funds and interest accumulate from year to year
- It’s portable - the HSA is owned by you and is yours to keep, even when you leave Federal employment or retire
- When you need it, funds up to the actual HSA balance are available
- Smart Payment features as described on page 9.

Important consideration if you want to participate in a Health Care Flexible Spending Account (HCFSA): If you are enrolled in this HDHP with a Health Savings Account (HSA), and start or become covered by a HCFSA health care flexible spending account (such as FSAFEDS offers – see Section 12), this HDHP cannot continue to contribute to your HSA. Similarly, you cannot contribute to an HSA if your spouse enrolls in an HCFSA. Instead, when you inform us of your coverage in an HCFSA, we will establish an HRA for you.

Health Reimbursement Arrangements (HRA)

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

In 2011, we will give you an HRA credit of \$66.66 per month, up to \$800 per year, for a Self-Only enrollment and \$133.33 per month, up to \$1,600 per year, for a Self and Family enrollment. You can use funds in your HRA to help pay your health Plan deductible and/or for certain expenses that don’t count toward the deductible.

HRA features include:

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

- Tax-free credit can be used to pay for qualified medical expenses for you and any individuals covered by this HDHP
- Unused credits carryover from year to year
- HRA credit does not earn interest
- HRA credit is forfeited if you leave Federal employment or switch health insurance plans
- Smart Pay features as described on page 9.
- An HRA does not affect your ability to participate in an FSAFEDS Health Care Flexible Spending Account (HCFSA). However, you must meet FSAFEDS eligibility requirements.

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

When you use network providers, your annual maximum for out-of-pocket expenses (deductibles and copayments) for covered services is limited to \$3,500 Self Only or \$6,500 Self and Family. However, certain expenses do not count toward your out-of-pocket maximum and you must continue to pay these expenses once you reach your out-of-pocket maximum (such as expenses in excess of the Plan’s benefit limit). Refer to Section 4 *Your catastrophic protection out-of-pocket maximum*, HDHP Section 5(b) *Traditional medical coverage subject to the deductible* for more details.

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

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

Section 5. Savings – HSAs and HRAs

Feature Comparison	Health Savings Account (HSA)	Health Reimbursement Arrangement (HRA) Provided when you are ineligible for an HSA
Administrator	<p>The Plan will establish an HSA for you with Coventry Consumer Advantage (C3), this HDHP’s fiduciary (an administrator, trustee or custodian as defined by Federal tax code and approved by IRS).</p> <p>Coventry Consumer Advantage (C3) PO BOX 7758 London, KY 40742 1-800-969-3343 or https://www.chkansas.com</p>	<p>Coventry Consumer Advantage (C3) PO BOX 7758 London, KY 40742 1-800-969-3343 or https://www.chkansas.com</p>
Fees	<p>Set-up fee, and monthly maintenance fee are paid by the HDHP as long as you are enrolled in the HDHP.</p>	<p>Set-up fee paid by the HDHP.</p>
Eligibility	<p>You must:</p> <ul style="list-style-type: none"> • Enroll in this HDHP • Have no other health insurance coverage (does not apply to specific injury, accident, disability, dental, vision or long-term care coverage) • Not be enrolled in Medicare • Not be claimed as a dependent on someone else’s tax return • Not have received VA benefits in the last three months • Complete and return all banking paperwork. 	<p>You must enroll in this HDHP.</p> <p>Eligibility is determined on the first day of the month following your effective day of enrollment and will be prorated for length of enrollment.</p>
Funding	<p>If you are eligible for HSA contributions, a portion of your monthly health plan premium is deposited to your HSA each month. Premium pass through contributions are based on the effective date of your enrollment in the HDHP.</p>	<p>Eligibility for the annual credit will be determined on the first day of the month and will be prorated for length of enrollment. The entire amount of your HRA will be available to you upon your enrollment.</p>

	In addition, you may establish pre-tax HSA deductions from your paycheck to fund your HSA up to IRS limits using the same method that you use to establish other deductions (i.e. Employee Express, MyPay, etc.).	
• Self Only enrollment	For 2011, a monthly premium pass through of \$66.66 will be made by the HDHP directly into your HSA each month.	For 2011, your HRA annual credit is \$800 (prorated for mid-year enrollment).
• Self and Family enrollment	For 2011, a monthly premium pass through of \$133.33 will be made by the HDHP directly into your HSA each month.	For 2011, your HRA annual credit is \$1,600 (prorated for mid-year enrollment).
Contributions/credits	<p>The maximum that can be contributed to your HSA is an annual combination of HDHP premium pass through and enrollee contribution funds, which when combined, do not exceed the maximum contribution amount set by the IRS of \$3,050 for an individual and \$6,150 for a family.</p> <p>If you enroll during Open Season, you are eligible to fund your account up to the maximum contribution limit set by the IRS. To determine the amount you may contribute, subtract the amount the Plan will contribute to your account for the year from the maximum allowable contribution.</p> <p>You are eligible to contribute up to the IRS limit for partial year coverage as long as you maintain your HDHP enrollment for 12 months following the last month of the year of your first year of eligibility. To determine the amount you may contribute, take the IRS limit and subtract the amount the Plan will contribute to your account for the year.</p> <p>If you do not meet the 12 month requirement, the maximum contribution amount is reduced by 1/12 for any month you were ineligible to contribute to an HSA. If you exceed the maximum contribution amount, a portion of your tax reduction is lost and a 10% penalty is imposed. There is an exception for death or disability.</p>	The full HRA credit will be available, subject to proration, on the effective date of enrollment. The HRA does not earn interest.

	<p>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).</p> <p>HSAs earn tax-free interest (does not affect your annual maximum contribution).</p> <p>Catch-up contribution discussed on page 65.</p>	
<ul style="list-style-type: none"> • Self Only enrollment 	<p>You may make an annual maximum contribution of \$3,050.</p>	<p>You cannot contribute to the HRA.</p>
<ul style="list-style-type: none"> • Self and Family enrollment 	<p>You may make an annual maximum contribution of \$6,150</p>	<p>You cannot contribute to the HRA.</p>
<p>Access funds</p>	<p>You can access your HSA by the following methods:</p> <ul style="list-style-type: none"> • Debit Card • Withdrawal form • Smart Payment through www.chckansas.com, My Online Services 	<p>You can access your HRA by the following methods:</p> <ul style="list-style-type: none"> • Withdrawal form • Smart Payment through www.chckansas.com, My Online Services
<p>Distributions/withdrawals</p> <ul style="list-style-type: none"> • Medical 	<p>You can pay the out-of-pocket expenses for yourself, your spouse or your dependents (even if they are not covered by the HDHP) from the funds available in your HSA.</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 HSA.</p> <p>See IRS Publication 502 for a list of eligible medical expenses. Medicare premiums and other types of medical insurance premiums are also reimbursable.</p> <p>If you have signed up for EFT you can request reimbursement for any amount. Paper checks require \$25.00 minimum before funds will be issued.</p>	<p>You can pay 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 list of eligible medical expenses. Medicare premiums and ther types of medical insurance premiumsare also reimbursable.</p> <p>If you have signed up for EFT you can request reimbursement for any amount. Paper checks require \$25.00 minimum before funds will be issued.</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 20% income tax penalty in addition to any other income taxes you may owe on the accumulated funds.</p>	<p>Not applicable – distributions will not be made for anything other than non-reimbursed qualified medical expenses</p>

	When you turn age 65, distributions can be used for any reason without being subject to the 20% penalty, however they will be subject to ordinary income tax.	
Availability of funds	<p>Funds are not available for withdrawal until all the following steps are completed:</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. • The fiduciary sends you HSA paperwork for you to complete and the fiduciary receives the completed paperwork back from you. 	The entire amount of your HRA will be available to you upon your enrollment in the HDHP.
Account owner	FEHB enrollee	HDHP
Portable	<p>You can take this account with you when you change plans, separate or retire.</p> <p>If you do not enroll in another HDHP, you can no longer contribute to your HSA. See page 59 for HSA eligibility.</p>	<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.

If you have an HSA

• **Contributions**

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

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

• **Catch-up contributions**

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

• **If you die**

If you do not have a named beneficiary, if you are married, it becomes your spouse’s HSA; otherwise, it becomes part of your taxable estate.

• **Qualified expenses**

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

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

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

• **Non-qualified expenses**

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

• **Tracking your HSA balance**

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

• **Minimum reimbursements from your HSA**

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

If you have an HRA

- **Why an HRA is established**

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

- **How an HRA differs**

Please review the chart on page 64 which details the differences between an HRA and an HSA. The major differences are:

 - You cannot make contributions to an HRA
 - Funds are forfeited if you leave the HDHP
 - An HRA does not earn interest, and
 - HRAs can only pay for qualified medical expenses, such as deductibles, copayments, and coinsurance expenses, for individuals covered by the HDHP. FEHB law does not permit qualified medical expenses to include services, drugs, or supplies related to abortions, except when the life of the mother would be endangered if the fetus were carried to term, or when the pregnancy is the result of an act of rape or incest.

Section 5. Preventive care

Important things you should keep in mind about these benefits:

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

Benefit Description	You pay HDHP
Preventive care, adult	HDHP
Professional services, such as: <ul style="list-style-type: none"> • Routine physicals • Blood tests • Urinalysis • Total Blood Cholesterol • Routine Prostate Specific Antigen (PSA) test – one annually for men age 50 and older • Colorectal Cancer Screening, including <ul style="list-style-type: none"> - Fecal occult blood test yearly starting at age 50, - Sigmoidoscopy screening – every five years starting at age 50; - Colonoscopy screening – every 10 years starting at age 50 • Routine annual digital rectal exam (DRE) for men age 40 and older • Routine well-woman exam including Pap test • Routine mammogram – covered for woman 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, No Deductible
<ul style="list-style-type: none"> • 1 routine eye exam every 12 months • 1 routine hearing exam every 24 months 	Nothing, No Deductible
<i>Not covered:</i> <ul style="list-style-type: none"> • <i>Physical exams and immunizations required for obtaining or continuing employment or insurance, attending schools or camp, athletic exams or travel.</i> • <i>Immunizations, boosters, and medications for travel.</i> 	<i>All charges</i>
Preventive care, children	HDHP
Professional services, such as: <ul style="list-style-type: none"> • Well-child visits for routine examinations and care 	Nothing, No Deductible
<ul style="list-style-type: none"> • Pediatric routine immunizations endorsed by the Centers for Disease Control and Prevention (CDC) and recommended by the American Academy of Pediatrics: 	Nothing, No Deductible
<ul style="list-style-type: none"> • Routine eye exam through age 17 • Routine hearing exam through age 17 	Nothing, No Deductible

Preventive care, children - continued on next page

Benefit Description	You pay
Preventive care, children (cont.)	HDHP
<i>Not covered</i> <ul style="list-style-type: none">• <i>Physical exams and immunizations 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. Traditional medical coverage subject to the deductible

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- The deductible is \$3,500 Self Only or \$6,500 Self and Family enrollment. The family deductible can be satisfied by one or more family members. The deductible applies to almost all benefits in Section 5. You must pay your deductible before your Traditional Medical Coverage may begin.
- Under Traditional Medical Coverage, you are responsible for your deductible for covered expenses.
- When you use network providers, you are protected by an annual catastrophic maximum on out-of-pocket expenses for covered services. After your copayments and deductibles total \$3,500 Self Only or \$6,500 Self and Family enrollment in any calendar year, you do not have to pay any more for covered services from network providers. However, certain expenses do not count toward your out-of-pocket maximum and you must continue to pay these expenses once you reach your out-of-pocket maximum (such as expenses in excess of the Plan’s benefit limits, and payments for dental care services).
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost-sharing works. Also read Section 9 about coordinating benefits with other coverage including with Medicare.

Benefit Description	You pay After the calendar year deductible...
Deductible before Traditional medical coverage begins	HDHP
<p>The deductible applies to almost all benefits in this Section. In the You Pay column, we say “No Deductible” when it does not apply. When you receive covered services from network providers, you are responsible for paying the allowable charges until you meet the deductible.</p> <p>After you meet the deductible and catastrophic out-of-pocket maximum, we pay the allowable charge for covered services.</p>	<p>100% of allowable charges until you meet the deductible of \$3,500 for Self-Only or \$6,500 for Self and family.</p>

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

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- You must use providers that are part of our network.
- The deductible is \$3,500 Self Only or \$6,500 Self and Family enrollment. The family deductible can be satisfied by one or more family members. The deductible applies to almost all benefits in this Section, unless we indicate differently.
- After you have satisfied your deductible, coverage begins for traditional medical services.
- Under Traditional Medical Coverage, you will be responsible for your deductible and copayments for eligible medical expenses and prescriptions.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost-sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

Benefit Description	You pay After the calendar year deductible...
Diagnostic and treatment services	HDHP
Professional services of physicians <ul style="list-style-type: none"> • In physician’s office • Adult routine immunizations endorsed by the Centers for Disease Control and Prevention (CDC) 	Nothing
<ul style="list-style-type: none"> • In an urgent care center for routine services 	Nothing
<ul style="list-style-type: none"> • During a hospital stay 	Nothing
<ul style="list-style-type: none"> • In a skilled nursing facility 	Nothing
<ul style="list-style-type: none"> • At home 	Nothing
Lab, X-ray and other diagnostic tests	HDHP
Tests, such as: <ul style="list-style-type: none"> • Blood tests • Urinalysis • Non-routine Pap tests • Pathology • X-rays • Non-routine mammograms • CAT Scans/MRI • Ultrasound • Electrocardiogram and EEG 	Nothing

Benefit Description	You pay After the calendar year deductible...
Maternity care	HDHP
<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 below for other circumstances, such as extended stays for you or your baby. • You may remain in the hospital up to 48 hours after a regular delivery and 96 hours after a cesarean delivery. We will cover an extended inpatient stay if medically necessary but you, your representatives, your doctor, or your hospital must recertify the extended stay. • We cover routine nursery care of the newborn child during the covered portion of the mother’s maternity stay. We will cover other care of an infant who requires non-routine treatment only if we cover the infant under a Self and Family enrollment. Surgical benefits, not maternity benefits, apply towards circumcision the newborn. • We pay hospitalization and surgeon services for non-maternity care the same as for illness and injury. 	Nothing
<i>Not covered: Routine sonograms to determine fetal age, size or sex.</i>	<i>All charges</i>
Family planning	HDHP
<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>	Nothing
<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>
Infertility services	HDHP
<p>Diagnosis and treatment of infertility such as:</p> <ul style="list-style-type: none"> • Artificial insemination: <ul style="list-style-type: none"> - intravaginal insemination (IVI) - intracervical insemination (ICI) - intrauterine insemination (IUI) 	Nothing
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Assisted reproductive technology (ART) procedures, such as:</i> 	<i>All charges</i>

Infertility services - continued on next page

Benefit Description	You pay After the calendar year deductible...
Infertility services (cont.)	HDHP
<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	HDHP
<ul style="list-style-type: none"> • Testing and treatment 	Nothing
<ul style="list-style-type: none"> • Allergy injections 	Nothing
<ul style="list-style-type: none"> • Allergy serum 	Nothing
<i>Not covered: Provocative food testing and sublingual allergy desensitization</i>	<i>All charges</i>
Treatment therapies	HDHP
<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 84.</p>	Nothing
Respiratory and inhalation therapy – limited to 60 visits per condition	Nothing
Dialysis – hemodialysis and peritoneal dialysis	Nothing
Intravenous (IV) Infusion Therapy – Home IV and antibiotic therapy	Nothing
<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	HDHP
<p>60 visits per condition for the each of the following services:</p> <ul style="list-style-type: none"> • qualified physical therapists and • occupational therapists <p>(Chiropractors coverage included in the visit limit, See Chiropractic)</p> <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>	Nothing

Physical and occupational therapies - continued on next page

Benefit Description	You pay After the calendar year deductible...
Physical and occupational therapies (cont.)	HDHP
Cardiac rehabilitation following a heart transplant, bypass surgery or a myocardial infarction is provided for up to 60 sessions.	Nothing
<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	HDHP
60 visits per condition	Nothing
Hearing services (testing, treatment, and supplies)	HDHP
<ul style="list-style-type: none"> • Hearing exams for children through age 17, <i>as shown in Preventive care, children;</i> • Hearing aids, as shown in <i>Orthopedic and prosthetic devices.</i> 	
Vision services (testing, treatment, and supplies)	HDHP
<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) 	Nothing
<ul style="list-style-type: none"> • Annual eye refractions <p>Note: See Preventive care</p>	Nothing
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Eyeglasses or contact lenses; or contact lens exams</i> • <i>Eye exercises and orthoptics</i> • <i>Radial keratotomy and other refractive surgery</i> 	<i>All charges</i>
Foot care	HDHP
<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>	Nothing
<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>

Benefit Description	You pay After the calendar year deductible...
Orthopedic and prosthetic devices	HDHP
<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 two per member per calendar year. • 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. • Foot orthotics and ankle foot orthotics are covered for members who have diabetes with demonstrated peripheral neuropathy or the insert is needed for a shoe that is part of a covered brace. 	Nothing
<ul style="list-style-type: none"> • Hearing aid devices are limited to conventional, programmable, digital, and BAHA - we limit coverage to one (1) device per ear per every 24 months, not to exceed \$5,000 combined maximum plan benefit every 24 month period. 	Nothing
<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 othotics 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>Hearing aid batteries</i> • <i>Replacement hearing aid devices within the same 24 month period</i> • <i>Hearing devices that are not specifically listed in the covered services section</i> 	<i>All charges</i>

Benefit Description	You pay After the calendar year deductible...
<p>Durable medical equipment (DME)</p> <ul style="list-style-type: none"> • Rental or purchase, at our option, including repair and adjustment, of durable medical equipment prescribed by your Plan physician, such as oxygen and dialysis equipment. Under this benefit, we also cover: • Hospital beds; • Wheelchairs; • Crutches; • Walkers; • Audible prescription reading devices; • Ostomy and urological supplies; • Prosthetic and orthotic supplies; • Blood glucose monitors; • Enteral feeding pumps; • 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 1-800-969-3343 as soon as your Plan physician prescribes this equipment. We will arrange with a health care provider to rent or sell you durable medical equipment at discounted rates and will tell you more about this service when you call.</p>	<p>HDHP</p> <p>Nothing</p>
<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>Speech generating devices</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>Oral supplements and/or enteral feeding, either by mouth or by tube</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>

Benefit Description	You pay After the calendar year deductible...
Home health services	HDHP
<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, or home health aide. • Services include intravenous therapy and medications (oxygen is covered under DME). 	Nothing
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Home care requested by, or 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>Home care that could appropriately be rendered in a Plan medical office, affiliated hospital, or skilled nursing facility</i> • <i>Home care that can be performed safely and effectively by people whom, in order to provide the care do not require medical licenses or certificates, or the presence of a supervising licensed nurse</i> • <i>Home care primarily for personal assistance that does not include a medical component and is not diagnostic, therapeutic, or rehabilitative.</i> 	<i>All charges</i>
Chiropractic	HDHP
<ul style="list-style-type: none"> • Coverage limited to subluxation and manipulation • 60 visits per condition (visit limit includes physical and occupational therapies. See Physical and Occupational therapies) <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>	Nothing
Alternative treatments	HDHP
<i>No benefit</i>	<i>All charges</i>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Naturopathic services</i> • <i>Hypnotherapy</i> • <i>Biofeedback</i> 	<i>All charges</i>
Educational classes and programs	HDHP
<p>Coverage is limited to:</p> <ul style="list-style-type: none"> • Diabetes self-management educational classes, as referred by your Plan physician • One nutritional counseling visit with a registered dietician, for all other conditions • Up to six (6) nutritional counseling visits with a registered dietician for the following conditions: <ul style="list-style-type: none"> - High cholesterol 	Nothing, No Deductible

Educational classes and programs - continued on next page

Benefit Description	You pay After the calendar year deductible...
Educational classes and programs (cont.)	HDHP
<ul style="list-style-type: none">- Obesity- High blood pressure- Diabetes	Nothing, No Deductible
Smoking cessation program, through QuitNet, including individual/group/ telephone counseling, and for physician prescribed over the counter (OTC) and prescription drugs approved by the FDA to treat tobacco dependence. Enroll online at www.quitnet.com/coventrywellbeing or call 1-866-577-8210. A representative will ask you for your Authentication code which is your 11 digit Coventry ID number - and will then assist you in the completion of the registration process.	Nothing for the counseling for up to two quit attempts per year. Nothing for physician prescribed OTC and prescription drugs approved by the FDA to treat tobacco dependence.

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

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- You must use providers that are part of our network.
- The deductible is \$3,500 Self Only or \$6,500 Self and Family enrollment. The Self and Family deductible can be satisfied by one or more family members. The deductible applies to almost all benefits in this Section, unless we indicate differently.
- After you have satisfied your deductible, coverage begins for traditional medical services.
- Under Traditional Medical Coverage, you will be responsible for your deductible for eligible covered services.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost-sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- **YOU MUST GET PRECERTIFICATION FOR SOME SURGICAL PROCEDURES.** Please refer to the precertification information in Section 3 to be sure which services require precertification.

Benefit Description	You pay After the calendar year deductible...
Surgical procedures	HDHP
<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). 	Nothing
<ul style="list-style-type: none"> • Surgical treatment of morbid obesity (bariatric surgery) Roux-en-Y Gastric Bypass, Laparoscopic Gastric Banding, and Vertical Banded Gastroplasty <ul style="list-style-type: none"> - a condition in which an individual weighs 100 pounds or 100% over his or her normal weight according to current underwriting standards; eligible members must be age 18 or over - the patient is an adult (≥ 18 years of age) with morbid obesity that has persisted for at least 3 years, and for which there is no treatable metabolic cause for the obesity; 	Nothing

Surgical procedures - continued on next page

Benefit Description	You pay After the calendar year deductible...
Surgical procedures (cont.)	HDHP
<ul style="list-style-type: none"> - there is presence of morbid obesity, defined as a body mass index (BMI) exceeding 40, or greater than 35 with documented co-morbid conditions (cardiopulmonary problems e.g., severe apnea, Pickwickian Syndrome, and obesity-related cardiomyopathy, severe diabetes mellitus, hypertension, or arthritis). (BMI is calculated by dividing a patient’s weight (in kilograms) by height (in meters) squared. To convert pounds to kilograms, multiply pounds by 0.45. To convert inches to meters, multiply inches by .0254); - The patient has failed to lose weight (approximately 10% from baseline) or has regained weight despite participation in a three month physician-supervised multidisciplinary program within the past six months that included dietary therapy, physical activity and behavior therapy and support; - The patient has been evaluated for restrictive lung disease and received surgical clearance by a pulmonologist, if clinically indicated; has received cardiac clearance by a cardiologist if there is a history of prior phen-fen or redux use, and the patient has agreed, following surgery, to participate in a multidisciplinary program that will provide guidance on diet, physical activity and social support; and, - The patient has completed a psychological evaluation and has been recommended for bariatric surgery by a licensed mental health professional (this must be documented in the patient’s medical record) and the patient’s medical record reflects documentation by the treating psychotherapist that all psychosocial issues have been identified and addressed; and the psychotherapist indicates that the patient is likely to be compliant with the post-operative diet restrictions. <ul style="list-style-type: none"> • Insertion of internal prosthetic devices. See 5(a) – Orthopedic and prosthetic devices for device coverage information • Treatment of burns • Voluntary sterilization (e.g., tubal ligation, vasectomy) <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>	Nothing
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Surgical treatment of morbid obesity (bariatric surgery) Jujunoileal Bypass, Gastric Stapling, Duodenal Switch, and Biliopancreatic Diversion</i> • <i>Reversal of voluntary sterilization</i> • <i>Routine treatment of conditions of the foot; see Foot care</i> 	<i>All charges</i>

Benefit Description	You pay After the calendar year deductible...
Reconstructive surgery	HDHP
<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>	Nothing
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Cosmetic surgery – any surgical procedure (or any portion of a procedure) performed primarily to improve physical appearance through change in bodily form, except repair of accidental injury</i> • <i>Surgeries related to sex transformation</i> 	<i>All charges</i>
Oral and maxillofacial surgery	HDHP
<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; • Other surgical procedures that do not involve the teeth or their supporting structures; and • Treatment of TMJ (non-dental). 	Nothing
<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> 	<i>All charges</i>

Benefit Description	You pay After the calendar year deductible...
Organ/tissue transplants	HDHP
<ul style="list-style-type: none"> • These solid organ transplants are subject to medical necessity and experimental /investigational review by the Plan. Refer to Other Services in Section 3 for prior authorization procedures. Transplant services must be performed at a participating Center of Excellence. We approve and designate where all transplants must be performed including hospitals for specific transplant procedures. If you would like to know about a specific facility, please contact Customer Service. <p>Solid organ transplants limited to:</p> <ul style="list-style-type: none"> * We limit the coverage for pancreas (only) transplants to patients who have insulin dependent (or Type 1) diabetes mellitus when we find that exogenous treatment with insulin is ineffective. - Cornea - Heart - Heart/lung - Kidney - Liver - Pancreas* - Kidney/Pancreas - Lung: single, double, lobar - Intestinal transplants <ul style="list-style-type: none"> • small intestine • small intestine with the liver • small intestine with multiple organs such as the liver, stomach, and pancreas - Autologous pancreas islet cell transplant (as an adjunct to total or near total pancreatectomy) only for patients with chronic pancreatitis. 	Nothing
<p>These tandem blood or marrow stem cell transplants for covered transplants are subject to medical necessity review by the Plan. Refer to <i>Other services</i> in Section 3 for prior authorization procedures.</p> <p>Autologous tandem transplants for</p> <ul style="list-style-type: none"> • AL Amyloidosis • Multiple myeloma (de novo and treated) • Recurrent germ cell tumors (including testicular cancer) 	Nothing
<p>Blood or marrow stem cell transplants limited to the stages of the following diagnoses. For the diagnoses listed below, the medical necessity limitation is considered satisfied if the patient meets the staging description.</p> <p>Allogeneic (donor) transplants for:</p> <ul style="list-style-type: none"> • Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia • Advanced Hodgkin’s lymphoma with reoccurrence (relapsed) 	Nothing

Organ/tissue transplants - continued on next page

Benefit Description	You pay After the calendar year deductible...
Organ/tissue transplants (cont.)	HDHP
<ul style="list-style-type: none"> • Advanced non-Hodgkin’s lymphoma with reoccurrence (relapsed) • Acute myeloid leukemia • Advanced Myeloproliferative Disorder (MPDs) • Advanced Neuroblastoma • Amyloidosis • Chronic lymphocytic lymphoma /small lymphocytic lymphoma (CLL/SLL) • Hemoglobinopathy • Infant malignant osteopetrosis • Kostmann’s syndrome • Leukocyte adhesion deficiencies • Marrow Failure and Related Disorders (i.e. Fanconi’s, PNH, Pure Red Cell Aplasia) • Mucopolysaccharidosis (e.g. Gaucher’s disease, metachromatic leukodystrophy, adrenoleukodystrophy) • Mucopolysaccharidosis (e.g. Hunter’s Syndrome, Hurler’s syndrome, Sanfillippo’s syndrome, Maroteauxlamy syndrome variants) • Myelodysplasia/Myelodysplastic syndromes • Paroxysmal Nocturnal Hemoglobinuria • Phagocytic / Hemophagocytic deficiency diseases (e.g. Wiskott-Aldrich syndrome) • Severe combined immuno-deficiency disease • Severe or very severe aplastic anemia • Sickle cell anemia <p>Autologous transplants for:</p> <ul style="list-style-type: none"> • Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia • Advanced Hodgkin’s lymphoma with reoccurrence (relapsed) • Advanced non-Hodgkin’s lymphoma with reoccurrence (relapsed) • Amyloidosis • Advanced Neuroblastoma • Multiple Myeloma • Testicular, Mediastinal, Retroperitoneal, and ovarian germ cell tumors 	Nothing
<p>Mini Transplants performed in a clinical trial setting (non-myeloblastic, reduced intensity conditioning or RIC) for members with a diagnosis listed below are subject to medical necessity review by the Plan.</p> <p>Refer to Other Services in Section 3 for prior authorization procedures:</p> <p>Allogeneic transplants for:</p> <ul style="list-style-type: none"> • Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia • Advanced Hodgkin’s lymphoma with reoccurrence (relapsed) 	Nothing

Benefit Description	You pay After the calendar year deductible...
Organ/tissue transplants (cont.)	HDHP
<ul style="list-style-type: none"> • Advanced non-Hodgkin’s lymphoma with reoccurrence (relapsed) • Acute myeloid leukemia • Advanced Myeloproliferative Disorder (MPDs) • Amyloidosis • Chronic lymphocytic lymphoma /small lymphocytic lymphoma (CLL/SLL) • Hemoglobinopathy • Marrow Failure and Related Disorders (i.e. Fanconi's, PNH, Pure Red Cell Aplasia) • Myelodysplasia/Myelodysplastic syndromes • Paroxysmal Nocturnal Hemoglobinuria • Severe combined immuno-deficiency disease • Severe or very severe aplastic anemia <p>Autologous transplants for:</p> <ul style="list-style-type: none"> • Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia • Advanced Hodgkin’s lymphoma with reoccurrence (relapsed) • Advanced non-Hodgkin’s lymphoma with reoccurrence (relapsed) • Amyloidosis • Neuroblastoma • Breast cancer • Epithelial ovarian cancer 	Nothing
<p>These blood or marrow stem cell transplants are covered only in a National Cancer Institute or National Institutes of health approved clinical trial or a Plan-designated center of excellence and if approved by the Plan’s medical director in accordance with the Plan’s protocols.</p> <p>If you are a participant in a clinical trial, the Plan will provide benefits for related routine care that is medically necessary (such as doctor visits, lab tests, x-rays and scans, and hospitalization related to treating the patient’s condition) if it is not provided by the clinical trial. Section 9 has additional information on costs related to clinical trials. We encourage you to contact the Plan to discuss specific services if you participate in a clinical trial.</p> <p>Allogeneic transplants for:</p> <ul style="list-style-type: none"> • Advanced Hodgkin’s lymphoma • Advanced non-Hodgkin’s lymphoma • Early stage (indolent or non-advanced) small cell lymphocytic lymphoma <p>Mini-transplants (non-myeloblastic allogeneic, reduced intensity conditioning or RIC) for</p> <ul style="list-style-type: none"> • Acute lymphocytic or non-lymphocytic leukemia • Advanced Hodgkin’s lymphoma • Advanced non-Hodgkin’s lymphoma 	Nothing

Organ/tissue transplants - continued on next page

Benefit Description	You pay After the calendar year deductible...
Organ/tissue transplants (cont.)	HDHP
<ul style="list-style-type: none"> • Breast Cancer • Chronic lymphocytic leukemia • Chronic myelogenous leukemia • Colon cancer • Chronic lymphocytic lymphoma /small lymphocytic lymphoma (CLL/SLL) • Early stage (indolent or non-advanced) small cell lymphocytic lymphoma • Multiple Myeloma • Multiple sclerosis • Myeloproliferative Disorder (MPDs) • Non-small lung cancer • Ovarian cancer • Prostate cancer • Renal cell carcinoma • Sarcomas • Sickle cell anemia (pediatric only) <p>Mini-transplants (non-myeloblative autologous, reduced intensity conditioning or RIC) for</p> <ul style="list-style-type: none"> • Advanced Hodgkin’s lymphoma • Advanced non-Hodgkin’s lymphoma • Chronic myelogenous leukemia • Chronic lymphocytic lymphoma /small lymphocytic lymphoma (CLL/SLL) • Early stage (indolent or non-advanced) small cell lymphocytic lymphoma • Multiple sclerosis • Small cell lung cancer • Systemic lupus erythematosus • Systemic sclerosis • Scleroderma • Scleroderma – SSc (severe, progressive) 	Nothing
<p>NOTE: We cover related medical and hospital expenses of the donor when we cover the recipient. We cover donor testing for the actual solid organ or up to four bone marrow /stem cell transplant donors in addition to the testing of family members.</p> <p>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 	Nothing

Organ/tissue transplants - continued on next page

Benefit Description	You pay After the calendar year deductible...
Organ/tissue transplants (cont.)	HDHP
<ul style="list-style-type: none"> • 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
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Donor screening tests and donor search expenses, except as shown above.</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> 	<i>All charges</i>
Anesthesia	HDHP
<p>Professional services provided in –</p> <ul style="list-style-type: none"> • Hospital (inpatient) • Hospital outpatient department • Skilled nursing facility • Ambulatory surgical center • Office 	Nothing

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

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan physicians must provide or arrange your care and you must be hospitalized in a Plan facility.
- The deductible is \$3,500 for Self Only enrollment and \$6,500 for Self and Family enrollment each calendar year. The Self and Family deductible can be satisfied by one or more family members. The deductible applies to all benefits in this Section.
- After you have satisfied your deductible, your Traditional medical coverage begins.
- Under your Traditional medical coverage, you will be responsible for your deductible for eligible covered services.
- Be sure to read Section 4, *Your costs for covered services* for valuable information about how cost-sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- The amounts listed below are for the charges billed by the facility (i.e., hospital or surgical center) or ambulance service for your surgery or care. Any costs associated with the professional charge (i.e., physicians, etc.) are in HDHP Sections 5(a) or (b).
- **YOUR PHYSICIAN MUST GET PRECERTIFICATION FOR HOSPITAL STAYS.** Please refer to the precertification information shown in Section 3.

Benefit Description	You pay After the calendar year deductible. . .
Inpatient hospital	HDHP
Room and board, such as <ul style="list-style-type: none"> • Ward, semiprivate, or intensive care accommodations; • General nursing care; • Meals and special diets • Special duty nursing when medically necessary Note: If you want a private room when it is not medically necessary, you pay the additional charge above the semiprivate room rate.	Nothing
Other hospital services and supplies, such as: <ul style="list-style-type: none"> • Operating, recovery, maternity, and other treatment rooms • Prescribed drugs and medicines • Diagnostic laboratory tests and X-rays • Administration of blood and blood products • Blood or blood plasma, if not donated or replaced • Dressings, splints, casts, and sterile tray services • Medical supplies and equipment, including oxygen • Anesthetics, including nurse anesthetist services • Medical supplies, appliances, medical equipment, and any covered items billed by a hospital for use at home 	Nothing

Inpatient hospital - continued on next page

Benefit Description	You pay After the calendar year deductible. . .
Inpatient hospital (cont.)	HDHP
<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>We must authorize benefits for the administration of general anesthesia and for hospital services related to dental care, when the following members receive these services:</p> <ul style="list-style-type: none"> • A dependent child age five and under; • A member who is severely disabled; or • A member who has a medical behavioral condition which requires hospitalization or general anesthesia when dental care is provided. <p>A participating provider must administer the general anesthesia whether or not the dental services are provided in a hospital, surgical center or office.</p>	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, except when medically necessary</i> • <i>Take home items</i> 	<i>All charges</i>
Outpatient hospital or ambulatory surgical center	HDHP
<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>We must authorize benefits for the administration of general anesthesia and for hospital services related to dental care, when the following members receive these services:</p> <ul style="list-style-type: none"> • A dependent child age five and under; • A member who is severely disabled; or • A member who has a medical behavioral condition which requires hospitalization or general anesthesia when dental care is provided. 	Nothing

Outpatient hospital or ambulatory surgical center - continued on next page

Benefit Description	You pay After the calendar year deductible. . .
Outpatient hospital or ambulatory surgical center (cont.)	HDHP
A participating provider must administer the general anesthesia whether or not the dental services are provided in a hospital, surgical center or office.	Nothing
<i>Not covered: Blood and blood derivatives not replaced by the member</i>	<i>All charges</i>
Extended care benefits/Skilled nursing care facility benefits	HDHP
A comprehensive range of benefits covered for 60 days per calendar year when full-time skilled nursing care is necessary and confinement in a skilled nursing facility is medically appropriate as determined by a Plan doctor and approved by the Plan. All necessary services are covered, including: <ul style="list-style-type: none"> • Bed, board and general nursing care • Drugs, biologicals, supplies, and equipment ordinarily provided and arranged by the skilled nursing facility when prescribed by a Plan doctor. 	Nothing
<i>Not covered:</i> <ul style="list-style-type: none"> • <i>Custodial care</i> 	<i>All charges</i>
Hospice care	HDHP
<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
<i>Not covered:</i> <ul style="list-style-type: none"> • <i>Services 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	HDHP
<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. 	Nothing

Section 5(d). Emergency services/accidents

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- The deductible is \$3,500 for Self Only enrollment and \$6,500 for Self and Family enrollment each calendar year. The Self and Family deductible can be satisfied by one or more family members. The deductible applies to all benefits in this Section.
- After you have satisfied your deductible, your Traditional medical coverage begins.
- Under your Traditional medical coverage, you will be responsible for your deductible for your eligible covered services.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost-sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

What is a medical emergency?

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

What to do in case of emergency:

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

Emergencies within our service area:

If your symptoms are not life-threatening, contact a primary care physician, who is on call 24 hours a day, seven days a week. During after hours or weekends, your physician 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 access to Take Care Clinics (Walgreens), Minute Clinics (CVS Pharmacy), and several urgent care centers which are open on evenings, weekends and holidays, and are designed to give our members fast, effective quality care for non-emergent conditions such as: sprains, influenza, sore throats, ear infections, minor lacerations, and upper respiratory infections.

Emergencies outside our service area:

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

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

Benefit Description	You pay After the calendar year deductible...
Emergency within our service area	HDHP
<ul style="list-style-type: none"> • Emergency care at a doctors’ office • Emergency care at an urgent care center, Take Care Clinics (Walgreens), and Minute Clinics (CVS Pharmacy) • Emergency care as an outpatient at a hospital, including doctors’ services 	Nothing
<i>Not covered: Elective care or non-emergency care</i>	<i>All charges</i>
Emergency outside our service area	HDHP
<ul style="list-style-type: none"> • Emergency care at a doctors’ office • Emergency care at an urgent care center, Take Care Clinics (Walgreens), and Minute Clinics (CVS Pharmacy) • Emergency care as an outpatient at a hospital, including doctors’ services 	Nothing
<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	HDHP
<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. 	Nothing

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

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

Important things to keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- The deductible is \$3,500 for Self Only enrollment and \$6,500 for Self and Family enrollment each calendar year. The Self and Family deductible can be satisfied by one or more family members. The deductible applies to all benefits in this Section.
- After you have satisfied your deductible, your Traditional medical coverage begins.
- Under your Traditional medical coverage, you will be responsible for your deductible for eligible covered services.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost-sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

YOU MUST GET PREAUTHORIZATION FOR THESE SERVICES. Benefits are payable only when we determine the care is clinically appropriate to treat your condition and only when you receive the care as part of a treatment plan that we approve. The treatment plan may include services, drugs, and supplies described elsewhere in this brochure. To be eligible to receive full benefits, you must follow the preauthorization process and get Plan approval of your treatment plan with MHNNet Behavioral Health at 1-866-607-5970. They can be reached 24 hours a day, 7 days a week to answer questions and assist you in choosing appropriate services. Your mental health provider will obtain subsequent authorizations for treatment.

We will provide medical review criteria or reasons for treatment plan denials to enrollees, patient or providers upon request or as otherwise required.

OPM will base its review of disputes about treatment plans on the treatment plan’s clinical appropriateness. OPM will generally not order us to pay or provide one clinically appropriate treatment plan in favor of another.

Benefit Description	You pay After the calendar year deductible...
Mental health and substance abuse benefits	HDHP
<p>All diagnostic and treatment services recommended by a Plan provider and contained in a treatment plan that we approve. The treatment plan may include services, drugs, and supplies described elsewhere in this brochure.</p> <p>Note: Plan benefits are payable only when we determine the care is clinically appropriate to treat your condition and only when you receive the care as part of a treatment plan that we approve.</p>	<p>Your cost-sharing responsibilities are no greater than for other illnesses or conditions.</p>
<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 	<p>Nothing</p>

Mental health and substance abuse benefits - continued on next page

Benefit Description	You pay After the calendar year deductible...
Mental health and substance abuse benefits (cont.)	HDHP
<ul style="list-style-type: none"> Medication management 	Nothing
<ul style="list-style-type: none"> Psychological testing necessary to determine the appropriate treatment 	Nothing
<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 a primary care physician. However, before you continue a treatment plan with a mental health provider, you must obtain authorization for the visit from MHNNet 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>	Nothing
<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 	Nothing
<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. 	Nothing
<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.

MHNNet 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 MHNNet 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(f). Prescription drug benefits

Important things to keep in mind about these benefits:

- We cover prescribed drugs and medications, as described in the chart beginning on the next page.
- All benefits are subject to the definitions, limitations and exclusions in this brochure and are payable only when we determine they are medically necessary.
- The deductible is \$3,500 for Self Only enrollment and \$6,500 for Self and Family enrollment each calendar year. The Self and Family deductible can be satisfied by one or more family members. The deductible applies to all benefits in this Section.
- After you have satisfied your deductible, your Traditional medical coverage begins.
- Under your Traditional medical coverage, you will be responsible for your deductible for covered prescriptions.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost-sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

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

Who can write your prescription. A licensed physician, 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. **Medco’s Customer Service number for Coventry Health Care of Kansas’ Plan members 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 the Customer Service Department at 1-800-969-3343. If your Plan 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.

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

- Applicable cost share 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 Medco, our mail order prescription drug program, and may be dispensed up to a ninety-three (93) day supply. To order prescriptions or refills please contact Medco’s Customer Service number for Coventry Health Care of Kansas’ Plan members at 1-800-378-7040 or visit the web site www.rxrequest.com. Available 24 hours a day – 7 days a week.
- To promote appropriate utilization, or following manufacturer’s recommendations, certain plan approved medications may have a quantity limit on the amount of medication dispensed and Prior Authorization must be obtained prior to dispensing.
- We reserve the right to include only one dosage or form of a drug on our Formulary when the same drug (i.e., a drug with the same active ingredient) is available in different dosages or forms (i.e., dissolvable tablets, capsules, etc) from the same or different manufacturers. The product, in the dosage or form, that is listed on the Formulary will be Covered at the applicable Member Responsibility. The drug, product or products, in different forms or dosages or from the same or different manufacturers, not listed on the Formulary will be excluded from coverage.
- Coverage of Prescription Drugs, therapeutic devices or supplies requiring a Prescription Order and prescribed by a Prescribing Provider is limited to Plan approved drugs, devices, supplies, or spacers for metered dose inhalers.

Members called to active military duty in a time of national or other emergency who need to obtain a greater-than-normal supply of prescribed medications should call us at 1-800-969-3343. If a brand name prescription drug is dispensed, and an equivalent generic prescription is available, you pay an ancillary charge in addition to the formulary brand name copayment. The ancillary charge will be due whether or not the prescribing provider indicates that the pharmacy is to “Dispense as Written.” The ancillary charge is the difference between the average wholesale price of the brand name and the maximum allowable cost price of the generic prescription. Copayments and ancillary charges do not apply to the catastrophic protection out-of-pocket maximum.

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

When you do have to file a 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 After the calendar year deductible...
<p>Covered medications and supplies</p> <p>We cover the following medications and supplies prescribed by a Plan physician and obtained from a Plan pharmacy or through our mail order program:</p> <ul style="list-style-type: none"> • Drugs and medicines that by Federal law of the United States require a physician’s prescription for their purchase, except those listed as <i>Not covered</i>. • Insulin • Diabetic supplies, including insulin syringes, needles, glucose test tablets and test tape * • Disposable needles and syringes for the administration of covered medications. • Drugs for sexual dysfunction • Contraceptive drugs and devices • Injectable contraceptive drugs (such as Depo Provera) • Immunosuppressant drugs required after a covered transplant* • Growth hormones and other self-administered injectables* <p>To find Your Prescription Drug, its applicable Tier and any Prior Authorization requirements, visit Our searchable Formulary on Our website www.chckansas.com, in the Participating Provider’s office, or by contacting the Customer Service Department.</p> <p>*Note: Non-formulary diabetic supplies, etc., Immunosuppressants, and GHT require prior-authorization.</p>	<p>HDHP</p> <p>Retail Pharmacy</p> <p>Tier 1A - Nothing</p> <p>Tier 1B - Nothing</p> <p>Tier 2 - Nothing</p> <p>Tier 3 - Nothing</p> <p>Tier 4 - Nothing</p> <p>Mail Order (93 day supply)</p> <p>Tier 1A - Nothing</p> <p>Tier 1B - Nothing</p> <p>Tier 2 - Nothing</p> <p>Tier 3 - Nothing</p> <p>Tier 4 - Not Available</p> <p>Note: If there is no Tier 1 equivalent available, you will still have to pay the Tier 2 cost share. If there is a Tier 1 equivalent and you choose the Tier 2 drug, you will pay the Tier 2 cost share plus the difference in the average wholesale price between the Tier 1 and Tier 2 drug. Ancillary charges do not apply to your deductible or catastrophic maximum. This applies to both formulary and non-formulary drugs.</p>
<ul style="list-style-type: none"> • Insulin – Under retail pharmacy benefits, you can obtain up to a 3 month supply of insulin 	<p>Retail Pharmacy</p> <p>Nothing</p>

Covered medications and supplies - continued on next page

Benefit Description	You pay After the calendar year deductible...
Covered medications and supplies (cont.)	HDHP
<ul style="list-style-type: none"> • Diabetic supplies – Under retail pharmacy benefits, you can obtain up to a 3 month supply of diabetic supplies (non-formulary supplies requires prior-authorization) • Oral and injectable contraceptive drugs – Under retail pharmacy benefits, you can obtain up to a 3 month supply of oral contraceptive drugs 	<p>Retail Pharmacy</p> <p>Nothing</p>
<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>Medications used for cosmetic purposes or to enhance work or athletic performance (i.e. Nuvigil or Provigil for shift work, anabolic steroids and minoxidil lotion, retin A (tretinoin) for aging skin). Also excluded are drugs, oral or injectable, used to slow or reverse normal aging processes (i.e. growth hormone, testosterone, etc.).</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, except as specified on the Formulary</i> • <i>Drugs available without a prescription or for which there is a non-prescription equivalent; except those designated by the plan</i> • <i>Appetite suppressants and other drugs to assist in weight control (except for the treatment of morbid obesity when authorized by us).</i> • <i>Nonprescription medicines; except those designated by the plan</i> • <i>Dosage forms of natural estrogen or progesterone; or any natural hormone replacement product, including but not limited to oral capsules, suppositories, creams and troches</i> • <i>Prescription drugs for non-covered services</i> • <i>Drugs for hair restoration</i> <p>Note: Physician prescribed over-the-counter and prescription drugs approved by the FDA to treat tobacco dependence are covered under the Smoking cessation benefit. (See page 79)</p>	<p><i>All charges</i></p>

Section 5(g). Dental benefits

Important things to keep in mind about these benefits:

- This is summary of benefits only. All benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable when we determine they are dentally necessary.
- If you are enrolled in a Federal Employees Dental/Vision Insurance Program (FEDVIP), your FEHB Plan will be First Primary payor of any Benefit payments and your FEDVIP Plan is secondary to your FEHB Plan. See Section 9 Coordinating benefits with other coverage.
- Locate a Coventry Dental Provider at www.chckansas.com, under Member page, click on "Find a dentist" to search for a provider in your area or call customer service toll-free at 1-866-433-6391. If you are unable to locate a network provider in your area, you may seek covered dental services from a non-participating provider at no cost.
- The deductible is \$3,500 for Self Only enrollment and \$6,500 for Self and Family enrollment each calendar year. The Self and Family deductible can be satisfied by one or more family members. The deductible applies to almost all benefits in this Section unless we indicate differently.
- There are no benefits for any service which is not specifically listed in this brochure.
- Some procedures and treatments may have specific age and frequency limitations as noted below.
- We cover hospitalization for dental procedures only when a non-dental physical impairment which makes hospitalization necessary to safeguard the health of the patient. Section 5(c) for inpatient benefits. We do not cover the dental procedure unless it is described below.
- Important Note: **IT IS YOUR RESPONSIBILITY TO BE INFORMED ABOUT YOUR DENTAL COVERAGE.**

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

Dental Benefits - continued on next page

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

Section 5(h). 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. If we identify a less costly alternative, we will ask you to sign an alternative benefits agreement that will include all of the following terms. Until you sign and return the agreement, regular contract benefits will continue. • Alternative benefits will be made available for a limited time period and are subject to our ongoing review. You must cooperate with the review process. • By approving an alternative benefit, we cannot guarantee you will get it in the future. • The decision to offer an alternative benefit is solely ours, and except as expressly provided in the agreement, we may withdraw it at any time and resume regular contract benefits. • If you sign the agreement, we will provide the agreed-upon alternative benefits for the stated time period (unless circumstances change). You may request an extension of the time period, but regular benefits will resume if we do not approve your request. <p>Our decision to offer or withdraw alternative benefits is not subject to OPM review under the disputed claims process.</p>
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 hours a day, 7 days a week and are trained to handle your questions. Any member who visits an emergency room or urgent care center as a result of advice from FirstHelp will automatically have associated claims approved. With FirstHelp authorization, you will know in advance if medical services will be covered. You may call 1-800-622-9528 or for the hearing impaired call 1-800-735-2966.</p>
Services for deaf and hearing impaired	<p>The Kansas TDD relay number is 1-800-766-3777. 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(i). 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. <p>Prescription Drug educational materials are also accessible through our website, through a link to our pharmacy benefit manager, Medco. There, you will find:</p> <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 First Help. Experienced RNs are available through an inbound call center 24 hours a day, seven days per week, to assist you and help you to maximize your benefits, by providing clinical and economic information to make an informed decision on how to proceed with care.</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. <p>If you have an HSA,</p> <ul style="list-style-type: none"> • You will receive a quarterly statement from the HSA administrator outlining your account balance and activity for the month. • You may also access your account on-line at www.chckansas.com. • Smart Payment online tools at www.chckansas.com through My Online Services. <p>If you have an HRA,</p> <ul style="list-style-type: none"> • Your HRA balance will be available online through www.chckansas.com

	<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. Smart Payment online tools at www.chckansas.com through My Online Services.
<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>

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. These programs and materials are the responsibility of the Plan, and all questions must be directed to the Plan at, 1-800-969-3343 or visit their website at www.chckansas.com. Call **Coventry WellBeing** for a participating vision provider near you, **1-866-211-2417** or log onto www.eyemedvisioncare.com. Plan ID: 9240086 Name: Coventry Health Care of KS

*** Complete pair of glasses purchase (frame, lenses, and lens options) must be purchased in the same transaction to receive full discount. Items purchased separately will be discounted 20% off of the retail price. ***

Vision Care Services	Member Cost
Exam	
<ul style="list-style-type: none"> • includes Dialation, as necessary 	\$50
Standard Plastic Lenses	
Single Vision \ Bifocal \ Trifocal	\$50 \ \$70 \ \$105
Frames	
Any frame available at provider location	40% off retail price
Lense Options	
<ul style="list-style-type: none"> • UV Coating, Tint (Solid and Gradient), or Standard Scratch-Resistance • Standard Polycarbonate • Standard Progressive (add-on to Bifocal) • Standard anti-Reflective Coating • Other add-ons and services 	\$15 \$40 \$65 \$45 20% off retail prices
Contact Lenses	
<ul style="list-style-type: none"> • Disposable • Conventional <i>(Discount applied to materials only)</i> 	0% off retail price 15% off retail price
Limitations and Exclusions	
<i>Not Covered</i> <ul style="list-style-type: none"> • <i>Orthoptic or vision training, subnormal vision aids, and any associated supplemental testing</i> • <i>Medical and/or surgical treatment of the eye, eyes, or supporting structures</i> • <i>Corrective eyewear required by an employer as a condition of employment, and safety eyewear</i> • <i>Services provided as a result of any Worker's Compensation law</i> • <i>Discount is not available on those frames where the manufacturer prohibits a discount</i> 	<i>All charges</i>

THIS IS NOT INSURANCE

This is a discount vision service program and prices are subject to change with out notice. You will receive a 20% discount on those items purchased at participating Providers that are not specifically covered by this Discount design. The 20% discount may not be combined with any other discounts or promotional offers, and the discount does not apply to the EyeMed Provider's professional services, or contact lenses. Retail prices may vary by location. Lasik or PRK vision correction is an elective procedure, performed by specially trained providers, this discount may not always be available from a provider in your immediate location. For a location near you and the discount authorization, **please call 1-877-5LASER6.**

Section 6. General exclusions – things we don't cover

The exclusions in this section apply to all benefits. There may be other exclusions and limitations listed in Section 5 of this brochure. **Although we may list a specific service as a benefit, we will not cover it unless your Plan doctor determines it is medically necessary to prevent, diagnose, or treat your illness, disease, injury, or condition** (see specifics regarding transplants).

We do not cover the following:

- Care by non-Plan providers except for authorized referrals or emergencies (see Emergency services/accidents);
- Services, drugs, or supplies you receive while you are not enrolled in this Plan;
- Services, drugs, or supplies not medically necessary;
- Services, drugs, or supplies not required according to accepted standards of medical, dental, or psychiatric practice;
- Educational classes, programs, and other rehabilitative therapies not otherwise listed as covered;
- Experimental or investigational procedures, treatments, drugs or devices (see specifics regarding transplants);
- Services, drugs, or supplies related to abortions, except when the life of the mother would be endangered if the fetus were carried to term, or when the pregnancy is the result of an act of rape or incest ;
- Services, drugs, or supplies related to sex transformations;
- Services, drugs, or supplies you receive from a provider or facility barred from the FEHB Program;
- Services, drugs, or supplies you receive without charge while in active military service;
- Extra care costs related to taking part in a clinical trial such as additional tests that a patient may need as part of the trial, but not as part of the patient's routine care; or
- Research costs related to conducting the clinical trial such as research physician and nurse time, analysis of results, and clinical tests performed only for research purposes.

Section 7. Filing a claim for covered services

There are four types of claims. Three of the four types - Urgent care claims, Pre-service claims, and Concurrent review claims - usually involve access to care where you need to request and receive our advance approval to receive coverage for a particular service or supply covered under this Brochure. See Section 3 for more information on these claims/requests and Section 10 for the definitions of these three types of claims.

The fourth type - Post-service claims - is the claim for payment of benefits after services or supplies have been received.

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

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

Medical and hospital benefits

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

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

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

Submit your claims to:

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

Deadline for filing your claim

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

Urgent care claims procedures

If you have an urgent care claim, please contact Customer Service at 1-800-969-3343. Urgent care claims must meet the definition found in Section 10 of this brochure, and most urgent care claims will be claims for access to care rather than claims for care already received. We will notify you of our decision not later than 24 hours after we receive the claim as long as you provide us with sufficient information to decide the claim. If you or your authorized representative fails to provide sufficient information, we will inform you or your authorized representative of the specific information necessary to complete the claim not later than 24 hours after we receive the claim and a time frame for our receipt of this information. We will decide the claim within 48 hours of (i) receiving the information or (ii) the end of the time frame, whichever is earlier.

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

Concurrent care claims procedures

A concurrent care claim involves care provided over a period of time or over a number of treatments. We will treat any reduction or termination of our pre-approved course of treatment as an appealable decision. If we believe a reduction or termination is warranted we will allow you sufficient time to appeal and obtain a decision from us before the reduction or termination takes effect.

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

Pre-service claims

As indicated in Section 3, certain care requires Plan approval in advance. We will notify you of our decision within 15 days after the receipt of the pre-service claim. If matters beyond our control require an extension of time, we may take up to an additional 15 days for review and we will notify you before the expiration of the original 15-day period. Our notice will include the circumstances underlying the request for the extension and the date when a decision is expected.

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

If you fail to follow these pre-service claim procedures, then we will notify you of your failure to follow these procedures as long as (1) your request is made to our customer service department and (2) your request names you, your medical condition or symptom, and the specific treatment, service, procedure, or product requested. We will provide this notice within five days following the failure or 24 hours if your pre-service claim is for urgent care. Notification may be oral, unless you request written correspondence.

Post-service claims

We will notify you of our decision within 30 days after we receive the claim. If matters beyond our control require an extension of time, we may take up to an additional 15 days for review as long as we notify you before the expiration of the original 30-day period. Our notice will include the circumstances underlying the request for the extension and the date when a decision is expected.

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

When we need more information

Please reply promptly when we ask for additional information. We may delay processing or deny benefits for your claim if you do not respond. Our deadline for responding to your claim is stayed while we await all of the additional information needed to process your claim.

Authorized Representative

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

Section 8. The disputed claims process

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

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

To help you prepare your appeal, you may arrange with us to review and copy, free of charge, all relevant materials and Plan documents under our control relating to your claim, including those that involve any expert review(s) of your claim.

Step	Description
1	<p>Ask us in writing to reconsider our initial decision. You must:</p> <ul style="list-style-type: none">a) Write to us within six (6) months from the date of our decision; andb) Send your request to us at: Coventry Health Care of Kansas, Inc., Attn: Member Appeals, 8320 Ward Parkway, Kansas City, MO 64114 ; andc) Include a statement about why you believe our initial decision was wrong, based on specific benefit provisions in this brochure; andd) Include copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms.e) Your email address (optional), if you would like to receive our decision via email. Please note that by giving us your email, you may receive our decision more quickly.
2	<p>We have 30 days from the date we receive your request to:</p> <ul style="list-style-type: none">a) Pay the claim (or, if applicable, arrange for the health care provider to give you the care or precertify your hospital stay or grant your request for prior approval for a service, drug, or supply); orb) Write to you and maintain our denial - go to step 4; orc) Ask you or your provider for more information. If we ask your provider, we will send you a copy of our request—go to step 3.
3	<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> <p>In the case of an appeal of an urgent care claim, we will notify you of our decision not later than 72 hours after receipt of your reconsideration request. We will hasten the review process, which allows oral or written requests for appeals and the exchange of information by telephone, electronic mail, facsimile, or other expeditious methods.</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; or• 120 days after you first wrote to us - if we did not answer that request in some way within 30 days; or• 120 days after we asked for additional information.

Write to OPM at: United States Office of Personnel Management, Insurance Operations, Health Insurance 2
1900 E Street, NW, Washington, DC 20415-3630.

Send OPM the following information:

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

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

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

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

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OPM will review your disputed claim request and will use the information it collects from you and us to decide whether our decision is correct. OPM will send you a final decision within 60 days. There are no other administrative appeals.

If you do not agree with OPM's decision, your only recourse is to sue. If you decide to sue, you must file the suit against OPM in Federal court by December 31 of the third year after the year in which you received the disputed services, drugs, or supplies or from the year in which you were denied precertification or prior approval. This is the only deadline that may not be extended.

OPM may disclose the information it collects during the review process to support their disputed claim decision. This information will become part of the court record.

You may not sue until you have completed the disputed claims process. Further, Federal law governs your lawsuit, benefits, and payment of benefits. The Federal court will base its review on the record that was before OPM when OPM decided to uphold or overturn our decision. You may recover only the amount of benefits in dispute.

Note: **If you have a serious or life threatening condition** (one that may cause permanent loss of bodily functions or death if not treated as soon as possible), and you did not indicate that your claim was a claim for urgent care, then call us at -800-969-3343. We will hasten our review (if we have not yet responded to your claim); or we will inform OPM so they can quickly review your claim on appeal. You may call OPM's Health Insurance 2 at 202-606-3818 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 has coverage under any other health plan or has automobile insurance that pays health care expenses without regard to fault. This is called “double coverage.”

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

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

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

What is Medicare?

Medicare is a Health Insurance Program for:

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

Medicare has four parts:

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

Part B (Medical Insurance). Most people pay monthly for Part B. Generally, Part B premiums are withheld from your monthly Social Security check or your retirement check.

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

Part D (Medicare prescription drug coverage). There is a monthly premium for Part D coverage. If you have limited savings and a low income, you may be eligible for Medicare’s Low-Income Benefits. For people with limited income and resources, extra help in paying for a Medicare prescription drug plan is available. Information regarding this program is available through the Social Security Administration (SSA). For more information about this extra help, visit SSA online at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778). Before enrolling in Medicare Part D, please review the important disclosure notice from us about the FEHB prescription drug coverage and Medicare. The notice is on the first inside page of this brochure. The notice will give you guidance on enrolling in Medicare Part D.

• Should I enroll in Medicare?

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

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

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

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

- **The Original Medicare Plan (Part A or Part B)**

The Original Medicare Plan (Original Medicare) is available everywhere in the United States. It is the way everyone used to get Medicare benefits and is the way most people get their Medicare Part A and Part B benefits now. You may go to any doctor, specialist, or hospital that accepts Medicare. The Original Medicare Plan pays its share and you pay your share.

All physicians and other providers are required by law to file claims directly to Medicare for members with Medicare Part B, when Medicare is primary. This is true whether or not they accept Medicare

When you are enrolled in Original Medicare along with this Plan, you still need to follow the rules in this brochure for us to cover your care.

Claims process when you have the Original Medicare Plan – You will probably not need to file a claim form when you have both our Plan and the Original Medicare Plan.

When we are the primary payor, we process the claim first.

When Original Medicare is the primary payor, Medicare processes your claim first. In most cases, your claim will be coordinated automatically and we will then provide secondary benefits for covered charges. To find out if you need to do something to file your claim, call us at 1-866-969-3343 or see our Web site at www.chkansas.com.

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

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

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

You can find more information about how our plan coordinates benefits with Medicare in Medicare other health benefits: Your Guide to who pays first on Medicare's website at <http://www.medicare.gov/Publications/Pubs/pdf/02179.pdf>.

- **Tell us about your Medicare coverage**

You must tell us if you or a covered family member has Medicare coverage, and let us obtain information about services denied or paid under Medicare if we ask. You must also tell us about other coverage you or your covered family members may have, as this coverage may affect the primary/secondary status of this Plan and Medicare.
- **Medicare Advantage (Part C)**

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

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

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

This Plan and another plan's Medicare Advantage plan: You may enroll in another plan's Medicare Advantage plan and also remain enrolled in our FEHB plan. We will still provide benefits when your Medicare Advantage plan is primary, even out of the Medicare Advantage plan's network and/or service area (if you use our Plan providers), but we will not waive any of our copayments, coinsurance, or deductibles. If you enroll in a Medicare Advantage plan, tell us. We will need to know whether you are in the Original Medicare Plan or in a Medicare Advantage plan so we can correctly coordinate benefits with Medicare.

Suspended FEHB coverage to enroll in a Medicare Advantage plan: If you are an annuitant or former spouse, you can suspend your FEHB coverage to enroll in a Medicare Advantage plan, eliminating your FEHB premium. (OPM does not contribute to your Medicare Advantage plan premium.) For information on suspending your FEHB enrollment, contact your retirement office. If you later want to re-enroll in the FEHB Program, generally you may do so only at the next Open Season unless you involuntarily lose coverage or move out of the Medicare Advantage plan's service area.
- **Medicare prescription drug coverage (Part D)**

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

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

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

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

TRICARE and CHAMPVA

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

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

Workers' Compensation

We do not cover services that:

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

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

Medicaid

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

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

When other Government agencies are responsible for your care

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

When others are responsible for injuries

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

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

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

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

Clinical Trials

If you are a participant in a clinical trial, this health plan will provide for related care as follows, if it is not provided by the clinical trial:

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

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

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

Section 10. Definitions of terms we use in this brochure

Calendar year	January 1 through December 31 of the same year. For new enrollees, the calendar year begins on the effective date of their enrollment and ends on December 31 of the same year.
Clinical Trials Cost Categories	<ul style="list-style-type: none">• Routine care costs – costs for routine services such as doctor visits, lab tests, x-rays and scans, and hospitalizations related to treating the patient’s condition whether the patient is in a clinical trial or is receiving standard therapy• Extra care costs – costs related to taking part in a clinical trial such as additional tests that a patient may need as part of the trial, but not as part of the patient’s routine care• Research costs – costs related to conducting the clinical trial such as research physician and nurse time, analysis of results, and clinical tests performed only for research purposes
Coinsurance	Coinsurance is the percentage of our allowance that you must pay for your care. You may also be responsible for additional amounts. See Section 4.
Copayment	A copayment is a fixed amount of money you pay when you receive covered services. See Section 4.
Cost-sharing	Cost-sharing is the general term used to refer to your out-of-pocket costs (e.g., deductible, coinsurance, and copayments) for the covered care you receive.
Covered services	Care we provide benefits for, as described in this brochure.
Custodial care	Care that is primarily for meeting personal needs: such as walking, getting in and out of bed, bathing, dressing, shopping, eating and preparing meals, performing general household services, or taking medicine. Custodial care that lasts 90 days or more is sometimes know as Long term care.
Deductible	A deductible is a fixed amount of covered expenses you must incur for certain covered services and supplies before we start paying benefits for those services. See Section 4.
Experimental or investigational service	<p>A health product or service is deemed experimental if one or more of the following criteria are met:</p> <ul style="list-style-type: none">• Any drug not approved for use by the FDA; any FDA approved drug prescribed for an off-label use whose effectiveness is unproven based on clinical evidence reported in peer-reviewed medical literature; or, any drug that is classified as IND (investigational new drug) by the FDA. As used herein, off-label prescribing means prescribing prescription drugs for treatments other than those stated in the labeling approved by the FDA.• Any health product or service that is subject to Institutional Review Board (IRB) review or approval;• Any health product or service that is the subject of a clinical trial that meets criteria for Phase I, II, or III as set forth by FDA regulations;• Any health product or service whose effectiveness is unproven based on clinical evidence reported in peer-reviewed medical literature.
Group health coverage	Health care benefits that are available as a result of your employment, or the employment of your spouse, and that are offered by an employer or through membership in an employee organization. Health care coverage may be insured or indemnity coverage, self-insured or self-funded coverage, or coverage through health maintenance organizations or other managed care plans.
Health care professional	A physician or other health care professional licensed, accredited, or certified to perform specified health services consistent with state law.

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

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

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

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

1. Level 1: Randomized, controlled trial
2. Level 2: Cohort/Case Control Study
3. Level 3: Systematic Literature Review
4. Level 4: Large consecutive case series
5. Level 5: Small consecutive case series
6. Level 6: Textbook chapters (opinion of a respected authority)
7. Level 7: Case report

Effectiveness is evaluated using 4 measurements:

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

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

Post-service claims Any claims that are not pre-service claims. In other words, post-service claims are those claims where treatment has been performed and the claims have been sent to us in order to apply for benefits.

Pre-service claims Those claims (1) that require precertification, prior approval, or a referral and (2) where failure to obtain precertification, prior approval, or a referral results in a reduction of benefits.

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

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

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

If you believe your claim qualifies as an urgent care claim, please contact our Customer Service Department at 1-800-969-3343. You may also prove that your claim is an urgent care claim by providing evidence that a physician with knowledge of your medical condition has determined that your claim involves urgent care.

Us/We

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

You

You refers to the enrollee and each covered family member.

Section 11. FEHB Facts

Coverage information

- **No pre-existing condition limitation**

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

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

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

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

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

- When you may change your enrollment;
- How you can cover your family members;
- What happens when you transfer to another Federal agency, go on leave without pay, enter military service, or retire;
- What happens when your enrollment ends; 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. For information on your premium deductions, you must also contact your employing or retirement office.

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

Several provisions of the Affordable Care Act (ACA) affect the eligibility of family members under the FEHB Program effective January 1, 2011.

Children	Coverage
Between ages 22 and 26	Children between the ages of 22 and 26 are covered under their parent's Self and Family enrollment up to age 26.
Married Children	Married children (but NOT their spouse or their own children) are covered up to age 26. This is true even if the child is currently under age 22.
Children with or eligible for employer-provided health insurance	Children who are eligible for or have their own employer-provided health insurance are eligible for coverage up to age 26.
Stepchildren	Stepchildren do not need to live with the enrollee in a parent-child relationship to be eligible for coverage up to age 26.
Children Incapable of Self-Support	Children who are incapable of self-support because of a mental or physical disability that began before age 26 are eligible to continue coverage. Contact your human resources office or retirement system for additional information.
Foster Children	Foster children are eligible for coverage up to age 26.

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

Self Only coverage is for you alone. Self and Family coverage is for you, your spouse, and your dependent children under age 26, including any foster children or step-children your employing or retirement office authorizes coverage for. Under certain circumstances, you may also continue coverage for a disabled child 26 years of age or older who is incapable of self-support.

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

Your employing or retirement office will **not** notify you when a family member is no longer eligible to receive benefits, nor will we. Please tell us immediately when you add or remove family members from your coverage for any reason, including divorce, or when your child under age 26 turns age 26.

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

• **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 2011 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 2010 benefits until the effective date of your coverage with your new plan. Annuitants' coverage and premiums begin on January 1. If you joined at any other time during the year, your employing office will tell you the effective date of coverage.

If your enrollment continues after you are no longer eligible for coverage (i.e. you have separated from Federal service) and premiums are not paid, you will be responsible for all benefits paid during the period in which premiums were not paid. You may be billed for services received directly from your provider. You may be prosecuted for fraud for knowingly using health insurance benefits for which you have not paid premiums. It is your responsibility to know when you or a family member are no longer eligible to use your health insurance coverage.

• **When you retire**

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

When you lose benefits

• **When FEHB coverage ends**

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

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

Any person covered under the 31 day extension of coverage who is confined in a hospital or other institution for care or treatment on the 31st day of the temporary extension is entitled to continuation of benefits under the Plan during the continuance of the confinement but not beyond the 60th day after the end of the 31 day temporary extension.

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

- **Upon divorce**

If you are divorced from a Federal employee or annuitant, you may not continue to get benefits under your former spouse's enrollment. This is the case even when the court has ordered your former spouse to provide health coverage for you. However, you may be eligible for your own FEHB coverage under either the spouse equity law or Temporary Continuation of Coverage (TCC). If you are recently divorced or are anticipating a divorce, contact your ex-spouse's employing or retirement office to get RI 70-5, the *Guide to Federal Benefits for Temporary Continuation of Coverage and Former Spouse Enrollees*, or other information about your coverage choices. You can also download the guide from OPM's 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 26.

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 Benefits for Temporary Continuation of Coverage and Former Spouse Enrollees*, from your employing or retirement office or from www.opm.gov/insure. It explains what you have to do to enroll.

- **Converting to individual coverage**

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

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

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

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

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

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

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

Section 12. Three Federal Programs complement FEHB benefits

Important information

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

First, the **Federal Flexible Spending Account Program**, also known as FSAFEDS, lets you set aside pre-tax money from your salary to reimburse you for eligible dependent care and/or health care expenses. You pay less in taxes so you save money. The result can be a discount of 20% to more than 40% on services/products you routinely pay for out-of-pocket.

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

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

The Federal Flexible Spending Account Program – FSAFEDS

What is an FSA?

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

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

- **Health Care FSA (HCFSA)** – Reimburses you for eligible health care expenses (such as copayments, deductibles, insulin, products, physician prescribed over-the-counter medications and drugs, vision and dental expenses, and much more) for you and your tax dependents, including adult children (through the end of the calendar year in which they turn 26) which are not covered or reimbursed by FEHBP or FEDVIP coverage or any other insurance.
- **Limited Expense Health Care FSA (LEX HCFSA)** – Designed for employees enrolled in or covered by a High Deductible Health Plan with a Health Savings Account. Eligible expenses are limited to dental and vision care expenses for you and your tax dependents adult children (through the end of the calendar year in which they turn 26) which are not covered or reimbursed by FEHBP or FEDVIP coverage or any other insurance.
- **Dependent Care FSA (DCFSA)** – Reimburses you for eligible **non-medical** day care expenses for your child(ren) under age 13 and/or for any person you claim as a dependent on your Federal Income Tax return who is mentally or physically incapable of self-care. You (and your spouse if married) must be working, looking for work (income must be earned during the year), or attending school full-time to be eligible for a DCFSA.
- If you are a new or newly eligible employee you have 60 days from your hire date to enroll in HCFSA or LEX HCFSA and/or DCFSA, but you must enroll before October 1. If you are hired or become eligible on or after October 1, you must wait and enroll during the Federal Benefits Open Season held each fall.

Where can I get more information about FSAFEDS?

Visit www.FSAFEDS.com or call an FSAFEDS Benefits Counselor toll-free at 1-877-FSAFEDS (1-877-372-3337), Monday through Friday, 9 a.m. until 9 p.m., Eastern time. TTY: 1-800-952-0450.

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

Important Information

The Federal Employees Dental and Vision Insurance Program (FEDVIP) is separate and different from the FEHB Program, and was established by the Federal Employee Dental and Vision Benefits Enhancement Act of 2004. This Program provides comprehensive dental and vision insurance at competitive group rates with no pre-existing condition limitations.

FEDVIP is available to eligible Federal and Postal Service employees, retirees, and their eligible family members on an enrollee-pay-all basis. Employee premiums are withheld from salary on a pre-tax basis.

Dental Insurance

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

- Class A (Basic) services, which include oral examinations, prophylaxis, diagnostic evaluations, sealants and x-rays.
- Class B (Intermediate) services, which include restorative procedures such as fillings, prefabricated stainless steel crowns, periodontal scaling, tooth extractions, and denture adjustments.
- Class C (Major) services, which include endodontic services such as root canals, periodontal services such as gingivectomy, major restorative services such as crowns, oral surgery, bridges and prosthodontic services such as complete dentures.
- Class D (Orthodontic) services with up to a 24-month waiting period

Vision Insurance

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

Additional Information

You can find a comparison of the plans available and their premiums on the OPM website at www.opm.gov/insure/dental and www.opm.gov/insure/vision. These sites also provide links to each plan's website, where you can view detailed information about benefits and preferred providers.

How do I enroll?

You enroll on the Internet at www.BENEFEDS.com. For those without access to a computer, call 1-877-888-3337 (TTY 1-877-889-5680).

The Federal Long Term Care Insurance Program – FLTCIP

It's important protection

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

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

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Summary of benefits for the High Option of Coventry Health Care of Kansas, Inc. - 2011

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

High Option Benefits	You pay	Page
Medical services provided by physicians:		
Diagnostic and treatment services provided in the office	\$20 for PCP and OB/GYN; \$50 Specialist, No Deductible	22
Services provided by a hospital:		
• Inpatient	15% of our allowable, after Deductible	42
• Outpatient	15% of our allowable, after Deductible	43
Emergency benefits:		
• In-area	\$250 per visit, No Deductible; waived if admitted to hospital	47
• Out-of-area	\$250 per visit, No Deductible; waived if admitted to hospital	47
Mental health and substance abuse treatment:	Regular cost-sharing	49
Prescription drugs:		
• Retail pharmacy	\$3/\$12/\$40/\$65/20%, No Deductible	53
• Mail order	\$9/\$36/\$120/\$195, No Deductible	53
Dental care: (Preventive Care)	Nothing, No Deductible	56
Vision care: (Preventive Care)	Nothing, No Deductible	58
Special features: Flexible Benefits Option, 24 hour nurse line, Services for deaf and hearing impaired, Transplant Network		58
Protection against catastrophic costs (out-of-pocket maximum):	\$2,500 Self Only \$5,000 Self Only and Family	7
Deductible	\$500 Self Only \$1,500 Self and Family	7

Summary of benefits for the Standard Option of Coventry Health Care of Kansas, Inc. - 2011

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

Standard Option Benefits	You Pay	Page
Medical services provided by physicians:		
Diagnostic and treatment services provided in the office	\$30 for PCP and OB/GYN; \$60 Specialist, No Deductible	22
Services provided by a hospital:		
• Inpatient	20% of our allowance, after Deductible	42
• Outpatient	20% of our allowance, after Deductible	43
Emergency benefits:		
• In-area	\$350 per visit, No Deductible; waived if admitted to hospital	47
• Out-of-area	\$350 per visit, No Deductible; waived if admitted to hospital	47
Mental health and substance abuse treatment:	Regular cost-sharing	49
Prescription drugs:		
• Retail pharmacy	\$3/\$12/\$40/\$65/20%, No Deductible	53
• Mail order	\$9/\$36/\$120/\$195, No Deductible	53
Dental care: (Preventive Care)	Nothing, No Deductible	56
Vision care: (Preventive Care)	Nothing, No Deductible	58
Special features: Flexible Benefits Option, 24 hour nurse line, Services for deaf and hearing impaired, Transplant Network		58
Deductible	\$1,500 Self Only \$4,500 Self and Family	7
Protection against catastrophic costs (out-of-pocket maximum):	\$3,500 Self Only \$7,500 Self and Family	7

Summary of benefits for the HDHP of Coventry Health Care of Kansas, Inc. - 2011

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

In 2011 for each month you are eligible for the HSA, will deposit \$66.66 per month for Self Only enrollment or \$133.33 per month for Self and Family enrollment to your HSA. For the Health Savings Account (HSA), you must satisfy your calendar year deductible of \$3,500 for Self Only and \$6,500 for Self and Family before using your HSA. Once you satisfy your calendar year deductible and/or catastrophic out-of-pocket maximum, Traditional medical coverage begins.

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

HDHP Benefits	After the deductible, you pay	Page
Medical services provided by physicians:		
Diagnostic and treatment services provided in the office	Nothing	73
Preventive services:		
• Routine screenings, physicals and child immunizations	Nothing, No Deductible	70
Services provided by a hospital:		
• Inpatient	Nothing	89
• Outpatient	Nothing	90
Emergency benefits:		
• In-area	Nothing	47
• Out-of-area	Nothing	47
Mental health and substance abuse treatment:	Nothing	49
Prescription drugs:		
• Retail pharmacy	Nothing	52
• Mail order	Nothing	52
Dental care: (Preventive Services)	Nothing, No Deductible	99
Vision care: (Preventive Services)	Nothing, No Deductible	70
Special features: Flexible Benefits Option, 24 hour nurse line, Services for deaf and hearing impaired, Transplant Network		101
Deductible and Protection against catastrophic costs (your catastrophic out-of-pocket maximum):	\$3,500 Self Only \$6,500 Self and Family	8

2011 Rate Information for - Coventry Health Care of Kansas, Inc.

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

Postal rates apply to career Postal Service employees. Most employees should refer to the *Guide to Benefits for Career United States Postal Service Employees*. RI 70-2 and to the rates shown below.

The rates shown below do not apply to *Postal Service Inspectors*, Office of Inspector General (OIG) employees and Postal Service Nurses. Rates for members of these groups are published in special Guides. Postal Service Inspectors and OIG employees should refer to the *Guide to Benefits for United State Postal Inspectors and Office of Inspector General Employees* (RI 70-2IN). Postal Service Nurses should refer to the *Guide to Benefits for United States Postal Nurses* (RI 70-2NU)

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

Type of Enrollment	Enrollment Code	Non-Postal Premium				Postal Premium	
		Biweekly		Monthly		Biweekly	
		Gov't Share	Your Share	Gov't Share	Your Share	USPS Share	Your Share

Kansas City Metro Area

High Option Self Only	HA1	\$157.57	\$ 52.52	\$341.40	\$113.80	\$177.53	\$ 32.56
High Option Self and Family	HA2	\$395.66	\$131.88	\$857.25	\$285.75	\$445.77	\$ 81.77
Standard Option Self Only	HA5	\$134.27	\$ 44.75	\$290.91	\$ 96.97	\$151.27	\$ 27.75
Standard Option Self and Family	HA4	\$315.47	\$105.15	\$683.51	\$227.83	\$355.42	\$ 65.20
HDHP Option Self Only	9H1	\$129.85	\$ 43.28	\$281.34	\$ 93.78	\$146.29	\$ 26.84
HDHP Option Self and Family	9H2	\$305.15	\$101.72	\$661.16	\$220.39	\$343.81	\$ 63.06