Coventry Health Care

www.chcde.com

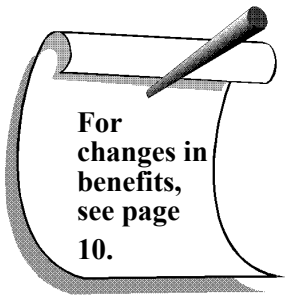
COVENTRY Health Care

2011

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

Serving: *All of Maryland*

Enrollment in this Plan is limited. You must live or work in the State of Maryland. See page 8 for requirements



Maryland:
IG1 High Option – Self Only
IG2 High Option – Self and Family
IG4 Standard Option – Self Only
IG5 Standard Option – Self and Family
GZ1 HDHP Option – Self Only
GZ2 HDHP Option – Self and Family

FEHB
Federal Employees Health Benefits Program

Authorized for distribution by the:

United States Office of Personnel Management

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

RI 73-836

Important Notice from Coventry Health Care About

Our Prescription Drug Coverage and Medicare

OPM has determined that the Coventry Health Care prescription drug coverage is, on average, comparable to Medicare Part D prescription drug coverage; thus you do not need to enroll in Medicare Part D and pay extra for prescription drug benefits. If you decide to enroll in Medicare Part D later, you will not have to pay a penalty for late enrollment as long as you keep your FEHB coverage.

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

Remember: If you are an annuitant and you 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).

Table of Contents

Introduction

This brochure describes the benefits of Coventry Health Care under our contract (CS 2892) with the United States Office of Personnel Management, as authorized by the Federal Employees Health Benefits law. The address for Coventry's administrative offices is:

Coventry Health Care
750 Prides Crossing, Suite 300
Newark, DE 19713

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 9. Rates are shown at the end of this brochure.

Plain Language

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

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

- Don't give your plan identification (ID) number over the telephone or to people you do not know, except for your health care providers, authorized health benefits plan, or OPM representative.
- Let only the appropriate medical professionals review your medical record or recommend services.
- Avoid using health care providers who say that an item or service is not usually covered, but they know how to bill us to get it paid.
- Carefully review explanations of benefits (EOBs) 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 800-833-7423 and explain the situation.
  - If we do not resolve the issue:

CALL - THE HEALTH CARE FRAUD HOTLINE

202-418-3300

OR WRITE TO:

United States Office of Personnel Management
Office of the Inspector General Fraud Hotline
1900 E Street NW Room 6400
Washington, DC20415-1100

- Do not maintain as a family member on your policy:
  - Your former spouse after a divorce decree or annulment is final (even if a court order stipulates otherwise); or
  - Your child age 26 (unless he/she is disabled and incapable of self-support prior to age 26).
- If you have any questions about the eligibility of a dependent, check with your personnel office if you are employed, with your retirement office (such as OPM) if you are retired, or with the National Finance Center if you are enrolled under Temporary Continuation of Coverage.
- 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 the provider. You may be prosecuted for fraud for knowlingly using health insurance benefits for which you have not paid premiums. It is your responsiblity 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 tests or procedures.
- Don't assume the results are fine if you do not get them when expected, be it in person, by phone, or by mail.
- Call your doctor and ask for your results.
- Ask what the results mean for your care.

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

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

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

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

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 Covnetry participating 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 on 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 patient 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 you nor your FEHB plan will incur costs to correct the medical error.

Section 1. Facts about this HMO Plan

General features of our High and Standard Options

The High and Standard Options are individual practice Open Access health maintenance organization (HMO) plans. This means you can receive coverred services from a participating provider without a required referral from your primary care physician or by another participating provider in the network. 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.

Non-grandfathered Plan

This plan is a "non-grandfathered" plan under the Affordable Care Act. A non-grandfathered plan must meet immedicate health care reforms legislated by the Act. Specifically, these plans 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). Information regarding what protections apply may be directed to our website at www.chcde.com. You can also read additional information from the U.S. Department of Health and Human Services at www.healthcare.gov.

How we pay providers

Payment for Covered Services will be made by Us directly to the Participating Provider. For Medical Emergency and Urgent Care services, payment will be made by us directly to the Provider or may, at our discretion, be made to you. Participating Providers may not, under any circumstances, seek payment from you except for Copayments, Coinsurance, and payments for Non-authorized or non-Covered Services.

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 HDHP's also offer health savings accounts or health reimbursement arrangements. Please see below of more information about these savings features.

Preventive care services

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

Annual deductible

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

Health Savings Account (HSA)

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

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

Health Reimbursement Arrangement (HRA)

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

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

Catastrophic protection

We protect you against catastrophic out-of-pocket expenses for covered services. Your annual out-of-pocket expenses for covered services, including deductibles and copayments, cannot exceed $4,000 for Self Only enrollment, or $8,000 family coverage.

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 Web site (www.opm.gov/insure) lists the specific types of information that we must make available to you. Some of the required information is listed below.

- Years in existence
- Profit status

If you want more information about us, call 302-283-6500 in Delaware or 800-833-7423 outside of Delaware or write to Coventry Health Care at 750 Prides Crossing, Suite 300, Newark, DE 19713. You may also contact us by fax at 866-858-1522 or visit our Web site at www.chcde.com.

Your medical and claims records are confidential:

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

Service Area

To enroll in this Plan, you must **live or work in the State of Maryland**. You can receive services in our service area. This is where our providers practice. Our service area is all of Maryland, Delaware and certain counties in Pennsylvania and New Jersey.

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 the 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 another plan that has agreements with affiliates in other areas. If you or a family member moves, you do not have to wait until Open Season to change plans. Contact your employing or retirement office.

Section 2. 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 FEHP Progam and the 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.
- We have reorganized Mental health and substance abuse benefits to clarify coverage.

Changes to High Option, Standard Option, and High Deductible Health Plan (HDHP)

- Smoking Cessation coverage has been added subject to no member cost sharing. The program includes two quit attempts per year with up to four smoking cessation counseling sessions of at least 30 minutes each, including proactive telephone counseling, group counseling, and individual counseling. FDA approved over-the-counter (OTC) and prescribed medications are covered without cost sharing.
- Preventive cost sharing has been eliminated. You now pay nothing for this benefit. Previously, the cost sharing was as follows: High and Standard Options-$20 per primary card doctor's office visit and $40 per specialist office visit; HDHP-$15 per visit.

Changes to High Option only

- Your share of the non-Postal premium has decreased for Self Only and will not increase for Self and Family. See page 127.
- Outpatient Mental Health/Substance Abuse benefit copayment is now nothing instead of $40 per visit.
- Outpatient Facility Mental Health/Substance Abuse benefit cost sharing is not nothing instead of member paying $200 copayment per day up to a maximum of $600.

Changes to Standard Option only

- Your share of the non-Postal premium will increase for Self Only and for Self and Family. See page 127.
- Outpatient Mental Health/Substance Abuse benefit copayment is now nothing instead of $40 per visit.
- Outpatient Facility Mental Health/Substance Abuse benefit cost sharing is now nothing instead of member paying 20% of charges.
- Outpatient laboratory visit copayments are now $10 per visit instead of nothing.
- Retail prescription drug copayments are now $15 tier one formulary, $30 name brand formulary, and $60 name brand non-formulary. Previously, the copayments were, respectively, $5/$25/$50.
- Mail Order prescription drug copayments are now $30 tier one formulary, $60 name brand formulary, and $120 name brand non-formulary. Previously, the copayments were, respectively, $10/$50/$100.

Changes to High Deductible Health Plan

- Your share of the non-Postal premium will increase for Self Only and for Self and Family. See page 127.
- The penalty for withdrawals from an HSA for non-medical expenses increases from 10% to 20% after January 1, 2011.

- 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.
- Retail prescription drug copayment is now $15 tier one formulary instead of $5. Name brand formulary and name brand non-formulary copayments will remain, respectively, $30 and $60.
- Mail Order prescription drug copayment is now $30 tier one formulary instead of $10. Name brand formulary and name brand non-formulary copayments will remain, respectively, $60 and $120.

Section 3. How you get care

Identification cards

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

If you do not receive your ID card within 30 days after the effective date of your enrollment, or if you need replacement cards, call us at 800-833-7423 or write to us

COVENTRY HEALTH CARE
750 Prides Crossing
Suite 300
Newark, DE 19713

You may also request replacement cards through our Web site at www.chcde.com through My Online Services.

Where you get covered care

You get care from "Plan providers" and "Plan facilities." You will only pay copayments, deductibles, and/or coinsurance, if you use our Open Access programs you can receive covered services from a participating provider without a required referral from your primary care physician or by another participating provider in the network. If you go to a non-Participating Provider, benefits will be denied, except for Emergency Services and Urgent Care Services outside the Service Area and certain referrals as provided for below.

- **Network providers and facilities**

Plan providers are physicians and other health care professionals in our service area that we contract with to provide covered services to our members. Members are responsible for verifying provider participation.

A member may get information about our participating provider network by checking the Provider Directory; calling our Customer Service Department at 302-283-6500 within our service area or 800-833-7423; or logging on to our website at www.chcde.com. We reserve the right to make changes in our participating provider network as is appropriate or necessary.

We credential plan providers according to national standards. Coventry has been awarded full accreditation under the Health Plan standards of URAC (American Accreditation HealthCare Commission), including provider credentialing.

When services are rendered by a Plan Provider, payment will be made to the Provider for services rendered. Members are responsible for any copayment, deductible, or coinsurance and payment of an unauthorized or non-covered Service.

When a Covered Service is rendered to a Member by a Non-Plan Provider, We shall pay the Out-of-Network Plan Allowance for Covered Services within 30 days after the receipt of a claim. We shall determine, in Our sole discretion, whether to accept assignment of payment of the claim. Therefore, We reserve the right to pay either You or the Non-Plan Provider. In addition, if a Member is covered as a Dependent child under a Qualified Medical Child Support Order or other court or administrative order applicable to the Group, who is not the Subscriber/Member, receives covered expenses on the Dependent child's behalf, We reserve the right to make payment for these covered expenses to the non-Subscriber/Member parent or the Provider. Payment will, in either case, be full and complete satisfaction of benefit and payment obligations under this Plan.

Plan facilities are hospitals and other facilities in our service area that we contract with to provide covered services to our members. Members are responsible for verifying provider participation. A member may get information about our participating provider network by checking the Provider Directory; calling our Customer Service Department at 302-283-6500 within our service area or 800-833-7423; or logging on to our website at http://www.CHCDE.com/. As noted above, we reserve the right to make changes in our participating network as is appropriate or neccessary.

- **Out-of-network providers and facilities**

Your benefit plan does not have coverage for out of network facilities or providers without prior authorization from Us, or if in the case on an Emergency situation and Urgent Care Services outside the Service Area.

What you must do to get covered care

Carry your Identification Card at all times; this is your proof of coverage. Always seek care from Participating Providers. The fact that a participating physician may prescribe, order, recommend, or approve a service or supply does not by itself make the charge a covered service. We will not cover a service or supply that is not medically necessary or that is not a covered service, even if it is not specifically listed or described under an exclusion or limitation, unless approved by Us.

To obtain benefits provided by this agreement, the member is subject to all terms, conditions, limitations, and exclusions in this agreement. The member is also subject to all of our rules and regulations. We retain the right to make all final decisions concerning covered services.

- **Primary care**

Our plan does not require you to pick a primary care physician, however you will need to use a physician in the Coventry Health Care network.

Some participating provider services require authorization by us. See "Services Requiring Our Approval" below for more information.

- **Specialty care**

Our plan does not require you to obtain referrals to see specialists, however the provider must be in our network. If you go to a non-participating provider, benefits will be denied, except for Emergency Services and Urgent Care Services outside the Service Area and certain referrals as provided for below.

Members may be covered for services rendered by a Non-Plan Provider if:

- The Member is diagnosed with a condition or disease that requires specialist medical care and we do not have a Plan Provider with the professional training and expertise to treat the condition or disease; and
- The Non-Plan Provider agrees to accept the same reimbursement as would be provided to a Provider who is part of our provider panel.

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

- If you need to see a specialist frequently because of a chronic, complex, or serious medical condition, your primary care physician will develop a treatment plan that allows you to see your specialist for a certain number of visits without additional referrals. Your primary care physician will use our criteria when creating your treatment plan (the physician may have to get an authorization or approval beforehand).
- If you are seeing a specialist when you enroll in our Plan, talk to your primary care physician. Your primary care physician will decide what treatment you need. If he or she decides to refer you to a specialist, ask if you can see your current specialist. If your current specialist does not participate with us, you must receive treatment from a specialist who does. Generally, we will not pay for you to see a specialist who does not participate with our Plan.

- If you are seeing a specialist and your specialist leaves the Plan, call your primary care physician, who will arrange for you to see another specialist. You may receive services from your current specialist until we can make arrangements for you to see someone else.
- If you have a chronic and disabling condition and lose access to your specialist because we:

  - Terminate our contract with your specialist for other than cause; or

  - Drop out of the Federal Employees Health Benefits (FEHB) Program and you enroll in another FEHB program Plan; or

  - Reduce our service area and you enroll in another FEHB Plan.

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

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

- **Hospital care**

If hospitalization is required, a Participating Physician will arrange admission to one of our Participating Hospitals. A Participating Physician will care for you, or you will be referred to a Participating Provider who will manage your care. **All non-emergency Hospital admissions must be Authorized by a Participating Physician and Coventry Health Care <u>prior</u> to admission.**

- **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 800-833-7423. 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.

Circumstances beyond our control

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

Services requiring our prior approval

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

We call this review and approval process precertification. Your physician must obtain approval for the following list of services:

- Ambulance Transport (except for emergency situations)
- Certain Prescription Drugs

- Chemotherapy
- Computed Tomography Scans (CT Scans)
- Durable Medical Equipment purchase price greater than $200 – all rentals require authorization (personal, comfort and convenience items are a benefit exclusion)
- Eye Glasses or Corrective Lenses Required after Cataract Surgery
- Genetic Counseling
- Habilitative Services for Children under age 19
- Hair Prosthesis
- Hearing Aids
- Home Health Care
- Home Infusion Therapy
- Hospice
- Infertility Services
- Injectables other than those covered under CHCDE's Formulary
- Inpatient Admission (i.e., Hospitals, Rehabilitation, Surgery, Skilled Nursing Facilities and Sub-Acute Facilities)
- In Vitro Fertilization
- Magnetic Resonance Angiography (MRA)
- Magnetic Resonance Imaging (MRI)
- Maternity Care
- Mental Health and Substance Abuse Services
- Morbid Obesity Treatment
- Non-Participating Providers (except for Emergency Services)
- Nutritional Counseling performed by Providers other than Participating Physicians
- Outpatient procedures and surgical services performed in a hospital
- Plastic/Cosmetic Surgery and Procedures
- Positron Emission Tomography (PET Scans)
- Therapies (i.e., Speech Therapy, Physical Therapy, Occupational Therapy, Cardiac Rehabilitation/Therapy and Pulmonary Rehabilitation)
- Transplant and Transplant Evaluation

AuthorizationProcess

The Participating Provider calls us for an Authorization within 10 days of the scheduled admission or service. The Health Plan will:

- inform the Member's Provider within 3 calendar days of the Authorization request when we do not have enough information to make a decision;
- make a decision for a scheduled admission or service within 2 working days of receiving the necessary information;
- make a decision for an extended stay in a health care facility within one working day after receiving the necessary information;
- make a decision to provide additional services or extend the time for such services within one working day after receiving the necessary information; and
- promptly notify the Member and the Member's Provider of the decision.

If we do not authorize the care, we will notify the Member and the Member's Provider of the decision within 5 days after the decision has been made. If the Member's Provider disagrees with the decision, he or she may ask us to reconsider. We will give the Provider the opportunity to speak with the physician who made the decision, by telephone, within 24 hours of when the Provider asked for reconsideration.

We will waive the prior authorization requirements for emergency admissions and urgent care. However, the Member, a family member or the Provider needs to call us within 48 hours or as soon as possible to advise us of an emergency hospital admission.

Mental Health Admissions

Emergency mental health admissions do not require Authorization. We will not deny a mental health admission during the first 24 hours of the inpatient admission when

- The Member is admitted because he or she is a danger to self or others;
- The Member's Physician or psychologist consults with a medical staff member of the facility who has admitting privileges and they determine the admission is necessary; and
- The hospital notifies us immediately that the Member has been admitted and the reason for the admission.

Emergency Admissions

For emergency inpatient admissions, we will not render an adverse decision solely because the hospital did not notify us of the emergency admission within 48 hours after that admission if the patient's medical condition prevented the hospital from determining:

- the patient's insurance status; and
- our emergency admission notification requirements.

Retroactive Adverse Decisionsfor Authorized Care

- Except as provided in the bullets below, if a course of treatment has been authorized for a Member, we will not make an adverse decision for the authorized services.
- We may retrospectively render an adverse decision for authorized services if:
- the information submitted to us regarding the Member's services was fraudulent or intentionally misrepresentative;
- critical information requested by us regarding the Member's services was omitted and our determination would have been different had we known the critical information; or
- the Provider did not substantially follow the approved treatment plan for the Member.

Section 4. Your costs for covered services

You must share the cost of some service. You are responsible for:

Copayments

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

High Option and Standard Option: Example: when you see your primary care physician you pay a copayment of $20 per office visit – and when you visit a specialist the copayment is $40 per visit. Preventive services do not require a copayment.

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 amount you must incur for certain covered services and supplies before we pay benefits for them. Copayments do not count toward any deductible.

High Option: There is no plan deductible.

Standard Option: The deductible amount for this plan is $300 for individual coverage and $600 for family coverage. The Plan will not pay benefits until the deductible is met. The time period for accumulating amounts applied to the deductible is a Calendar or Contract Year.

When the Member incurs expenses in the last three (3) months of a year which are applied to the Member's deductible for that year, the deductible amounts are also applied to the Member's deductible amount due for the following year, if the prior year deductible has not been satisfied in full.

High Deductible Health Plan: The deductible amount for this plan is $2,000 for individual coverage (subscribers covering no spouse or dependents) and $4,000 for family coverage (subscribers covering spouse and/or family).

The Plan will not pay benefits until the deductible is met. The time period for accumulating amounts applied to the deductible is a Calendar or Contract Year. The entire family deductible must be met before individual family members are eligible for benefits.

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.

Coinsurance

Coinsurance is the percentage of our allowance that you must pay for your care. Coinsurance does not begin until you meet your deductible.

High Option: Example: you pay 20% of our allowance for durable medical equipment.

Standard Option: Example: you pay 20% of our allowance after your deductible for speech therapy.

High Deductible Health Plan: Example: you pay nothing for durable medical equipment after you have met the deductible in network and 30% of our allowance for durable medical equipment after you have met the deductible out of network.

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

For example, if your physician ordinarily charges $100 for a service but routinely waives your 15% coinsurance, the actual charge is $70. We will pay $59.50 (85% of the actual charge of $70).

Differences between our Plan allowance and the bill

In-network providers agree to limit what they will bill you. Because of that, when you use a network provider, your share of covered charges consists only of your deductible and coinsurance or copayment. Here is an example about coinsurance: You see a network physician who charges $150, but our allowance is $100. If you have met your deductible, you are only responsible for your coinsurance. That is, you pay just – 15% of our $100 allowance ($15). Because of the agreement, your network physician will not bill you for the $50 difference between our allowance and his bill.

Your catastrophic protection out-of-pocket maximum

High Option: After your copayments and coinsurances total $1,000 per person or $3,000 per family enrollment in any calendar year, you do not have to pay any more for covered services. The calendar year out-of-pocket maximum does not include any copayments except those for emergency room or urgent care center. In addition, coinsurances for infertility treatment do not count toward your catastrophic protection out-of-pocket maximum, and you must continue to pay coinsurance for these services.

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

Standard Option: After your coinsurances total $3,000 per person or $9,000 per family enrollment in any calendar year, you do not have to pay any more for covered services. The calendar year out-of-pocket maximum does not include any deductibles or copayments except those for emergency room or urgent care center. In addition, coinsurances for infertility treatment do not count toward your catastrophic protection out-of-pocket maximum, and you must continue to pay coinsurance for these services.

High Deductible Health Plan: Your out-of pocket maximum for this plan is $4,000 per individual and $8,000 per family.

The individual Out-of-Pocket Maximum is a limit on the amount you must pay out of Your pocket for specific Covered Services in a calendar year. The family Out-of-Pocket Maximum is the limit on the total amount Members of the same family must pay for specific Covered Services in a calendar year. Once the Out-of-Pocket Maximum is met, Covered Services are paid at 100% for the remainder of the calendar year.

The out of pocket maximum includes all deductibles, copayments and coinsurance as applied by this plan.

Carryover

If you changed to this Plan during open season from a plan with a catastrophic protection benefit and the effective date of the change was after January 1, any expenses that would have applied to that plan's catastrophic protection benefit during the prior year will be covered by your old plan if they are for care you received in January before your effective date of coverage in this Plan. If you have already met your old plan's catastrophic protection benefit level in full, it will continue to apply until the effective date of your coverage in this Plan. If you have not met this expense level in full, your old plan will first apply your covered out-of-pocket expenses until the prior year's catastrophic level is reached and then apply the catastrophic protection benefit to covered out-of-pocket expenses incurred from that point until the effective date of your coverage in this Plan. Your old plan will pay these covered expenses according to this year's benefits; benefit changes are effective January 1.

Note: If you change options in this Plan during the year, we will credit the amount of covered expenses already accumulated toward the catastrophic out-of-pocket limit of your old option to the catastrophic protection limit of your new option.

When Government facilities bill us

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

High and Standard Option Benefits

See page 10 for how our benefits changed this year. Page 123 and page 124 are a benefits summary of each option. Make sure that you review the benefits that are available under the option in which you are enrolled.

Section 5. High and Standard Option Benefits Overview

This Plan offers both a High and Standard Option. Our benefit package is described in Section 5. Make sure that you review the benefits carefully.

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 Option benefits, contact us at 800-833-7423 or at our Web site at www.chcde.com.

Our benefit package offers the following unique features:

- **High Option** — The High Option is an individual practice health maintenance organization (HMO) plan. 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.

- **Standard Option** — The Standard Option HMO works similarly to the High Option plans, however the benefits are not as rich, but the premiums are lower. Members use the same provider network and preventive care is emphasized. However, some services will be subject to a deductible and coinsurance. Basic care, such as, office visits, laboratory and x-rays, are not subject to the deductible and have only a minimal copayment.

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: We have no deductible.
- Standard Option: The calendar year deductible is: $300 per person ($600 per family). The calendar year deductible applies to almost all benefits in this section. Copayments do not count toward your deductible. **Note: 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		
Diagnostic and treatment services	**High Option**	**Standard Option**
Professional services of physicians • In physician's office	$20 copayment per visit to a primary care physician (PCP) $40 copayment per visit to a specialist	$20 copayment per visit to a primary care physician (PCP) (No deductible) $40 copayment per visit to a specialist (No deductible)
Professional services of physicians • In an urgent care center • During a hospital stay • In a skilled nursing facility • Office medical consultation • Second surgical opinion	Nothing Nothing Nothing $20 PCP; $40 Specialist $40 for specialist visit	Nothing Nothing Nothing $20 PCP; $40 Specialist (No deductible) $40 for specialist visit (No deductible)
At home	Nothing	Nothing
Not covered: • *Immunizations needed for travel.*	*All charges*	*All charges*

Benefit Description		
Lab, X-ray and other diagnostic tests	**High Option**	**Standard Option**
Tests, such as: • Blood tests • Urinalysis • Non-routine Pap tests • Pathology • X-rays	Nothing if you receive any of these services during your office visit; otherwise, $10 per office visit	Nothing if you receive any of these services during your office visit; otherwise, $10 copayment for lab tests (No deductible)/$20 copayment for x-rays (No deductible)
• CAT Scans/MRI • Ultrasound • Electrocardiogram and EEG	$50 copayment for high-tech radiology services (i.e. MRI, MRA, PET, and CAT scans)	20% coinsurance for specialized radiology (MRI, MRA, CAT & PET Scans)
Preventive care, adult	**High Option**	**Standard Option**
Routine physical every year which includes: Routine screenings, such as: • Total Blood Cholesterol • Colorectal Cancer Screening, including - Fecal occult blood test - Sigmoidoscopy, screening – every five years starting at age 50 - Double contrast barium enema – every five years starting at age 50 - Colonoscopy screening – every ten years starting at age 50	Nothing	Nothing
Routine Prostate Specific Antigen (PSA) test – one annually for men age 40 and older Annual Chlamydia Screening Test for women who are younger than 20 years old who are sexually active, and at least 20 years old who have multiple risk factors; and men who have multiple risk factors.	Nothing	Nothing
Routine Pap test	Nothing	Nothing
Routine mammogram – covered for women age 35 and older, as follows: • From age 35 through 39, one during this five year period • From age 40 through 64, one every calendar year • At age 65 and older, one every two consecutive calendar years	Nothing	Nothing
• Adult routine immunizations endoresed by the Centers for Disease Control and Prevention (CDC)	Nothing	Nothing
Not covered: Physical exams and immunizations required for obtaining or continuing employment or insurance, attending schools or camp, or travel.	*All charges*	*All charges*

Benefit Description		
Preventive care, children	**High Option**	**Standard Option**
• Childhood immunizations recommended by the American Academy of Pediatrics	Nothing	Nothing
• Well-child care charges for routine examinations, immunizations and care (up to age 22) • Examinations, such as: - Eye exams through age 17 to determine the need for vision correction - Hearing exams through age 17 to determine the need for hearing correction - Examinations done on the day of immunizations (up to age 22)	Nothing	Nothing
Maternity care	**High Option**	**Standard Option**
Complete maternity (obstetrical) care, such as: • Prenatal care • Delivery • Postnatal care Note: Here are some things to keep in mind: • You do not need to precertify your normal delivery; see below for other circumstances, such as extended stays for you or your baby. • You may remain in the hospital up to 48 hours after a regular delivery and 96 hours after a cesarean delivery. We will extend your inpatient stay if medically necessary; however, you will need to get preauthorization for extended days. • For a mother and newborn child who have a Hospital stay of less than 48 hours for vaginal delivery or 96 hours for cesarean section, benefits are provided for one home visit to occur within 24 hours after discharge and an additional home visit if prescribed by the attending provider. • For a mother and newborn child who remain in the Hospital for at least 48 or 96 hours of inpatient hospitalization, we shall provide coverage for a home visit if prescribed by the attending provider.	$20 copayment for the initial office visit; Nothing for all visits thereafter.	$20 copayment for the initial office visit; Nothing for all visits thereafter (No deductible).

Maternity care - continued on next page

Benefit Description		
Maternity care (cont.)	**High Option**	**Standard Option**
• We cover routine nursery care of the newborn child during the covered portion of the mother's maternity stay. We will cover other care of an infant who requires non-routine treatment for the first 31 days after birth. An enrollment form must be completed to cover the infant under a Self and Family enrollment after the 31 days if you do not already have Self and Family coverage. Surgical benefits, not maternity benefits, apply to circumcision. • If a mother is required to remain hospitalized after childbirth for medical reasons and the mother requests that the newborn remain in the Hospital, we shall provide as part of the hospitalization services, payment for the cost of additional hospitalization for the newborn for up to 4 days. • We pay hospitalization and surgeon services for non-maternity care the same as for illness and injury.	$20 copayment for the initial office visit; Nothing for all visits thereafter.	$20 copayment for the initial office visit; Nothing for all visits thereafter (No deductible).
Not covered: • *Newborn home delivery* • *Surrogate motherhood services and supplies, including, but not limited to, all services and supplies relating to the conception and pregnancy of a Member acting as a surrogate mother.*	*All charges*	*All charges*
Family planning	**High Option**	**Standard Option**
A range of voluntary family planning services, limited to: • Voluntary sterilization (See Surgical procedures Section 5 (b)) • Surgically implanted contraceptives • Injectable contraceptive drugs (such as Depo provera) • Intrauterine devices (IUDs) • Diaphragms Note: We cover oral contraceptives under the prescription drug benefit.	50% coinsurance	50% coinsurance
Not covered: • *Reversal of voluntary surgical sterilization.* • *Surrogate motherhood services and supplies, including, but not limited to, all services and supplies relating to the conception and pregnancy of a Member acting as a surrogate mother* • *Genetic counseling*	*All charges*	*All charges*

Benefit Description		
Infertility services	**High Option**	**Standard Option**
Diagnosis and treatment of infertility such as: • Artificial insemination: - intravaginal insemination (IVI) - intracervical insemination (ICI) - intrauterine insemination (IUI) • Invitrofertilization - Limited to three attempts per live birth and a maximum plan lifetime benefit of $100,000 • Fertility drugs Note: We cover injectible fertility drugs under medical benefits and oral fertility drugs under the prescription drug benefit.	50% coinsurance	50% coinsurance
Not covered: • *Assisted reproductive technology (ART) procedures, such as:* *- Intracytoplasmic sperm injection (ICSI), unless authorized as part of an approved IVF procedure* *- in vivo fertilization in vivo fertilization including but not limited to all forms of artificial insemination procedures, such as Artificial Insemination Donor (AID), Artificial Insemination Homologous/ Husband (AIH) and Interuterine Insemination (IUI); and cryopreservation and storage of sperm, eggs and embryos.* • *Cost of donor egg* • *Cost of donor sperm*	*All charges*	*All charges*
Allergy care	**High Option**	**Standard Option**
• Testing and treatment Allergy injections	$20 copayment per PCP visit $40 copayment per specialist visit	$20 copayment per PCP visit (No deductible) $40 copayment per specialist visit (No deductible)
Allergy serum	Nothing	Nothing
Not covered: Provocative food testing and sublingual allergy desensitization	*All charges*	*All charges*
Treatment therapies	**High Option**	**Standard Option**
• Chemotherapy and radiation therapy Note: High dose chemotherapy in association with autologous bone marrow transplants is limited to those transplants listed under Organ/Tissue Transplants on page 35. • Respiratory and inhalation therapy • Dialysis – hemodialysis and peritoneal dialysis • Intravenous (IV)/Infusion Therapy – Home IV and antibiotic therapy • Growth hormone therapy (GHT)	$40 copayment per specialist visit or outpatient visit Nothing per visit during covered inpatient admission	$40 copayment per specialist office visit (No deductible) 20% coinsurance per outpatient facility service

Treatment therapies - continued on next page

Benefit Description		
Treatment therapies (cont.)	**High Option**	**Standard Option**
Note: • Growth hormone therapy medications listed on the Self-Administered Injectable (SAI) formulary are covered under the prescription drug benefit. All other growth hormone therapy will be covered under the medical benefit. We only cover GHT when we preauthorize the treatment. Call 877-215-4100 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 *Services requiring our prior approval* in Section 3.	$40 copayment per specialist visit or outpatient visit Nothing per visit during covered inpatient admission	$40 copayment per specialist office visit (No deductible) 20% coinsurance per outpatient facility service
Physical and occupational therapies	**High Option**	**Standard Option**
60 visits per condition per calendar year for the services of each of the following: • qualified physical therapists and • occupational therapists 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. Cardiac rehabilitation following a heart transplant, bypass surgery or a myocardial infarction is provided for up to 60 sessions.	$40 copayment per visit Nothing per visit during covered inpatient admission	20% coinsurance per visit
Not covered: • *Long-term rehabilitative therapy* • *Exercise programs*	*All charges*	*All charges*
Speech therapy	**High Option**	**Standard Option**
60 visits per condition	$40 copayment per visit Nothing per visit during covered inpatient admission	20% coinsurance per visit
Habilitative services	**High Option**	**Standard Option**
Habilitative services for the treatment of a child with congenital or genetic birth defects to enhance the child's ability to function are covered for children under the age of 19 if preauthorized by us. Services include • occupational, • physical, and • speech therapy	$40 copayment per visit	20% coinsurance per visit

Habilitative services - continued on next page

Benefit Description		
Habilitative services (cont.)	**High Option**	**Standard Option**
Not covered • *Habilitative services delivered through early intervention or school services*	*All charges*	*All charges*
Hearing services (testing, treatment, and supplies)	**High Option**	**Standard Option**
First hearing aid and testing only when necessitated by accidental injury	$20 copayment PCP visit $40 copayment specialist visit	$20 copayment PCP visit (No deductible) $40 copayment specialist visit (No deductible)
Hearing testing for children through age 17, which include; (see *Preventive care, chrildren)*	Nothing	Nothing
• Hearing aids for minor children up to a maximum Plan benefit of $1,400 per hearing aid per every 36 months when a hearing aid is prescribed, fitted and dispensed by a licensed audiologist. • Hearing aids for adults up to a maximum Plan benefit of $500 per hearing aid per every 5 years when a hearing aid is prescribed, fitted and dispensed by a licensed audiologist.	20% coinsurance	20% coinsurance
Vision services (testing, treatment, and supplies)	**High Option**	**Standard Option**
• Eye exam to determine the need for vision correction for children though age 17 • First pair of eyeglasses or corrective lenses required following cataract surgery Note: See *Preventive care, children* for eye exams for children.	Nothing 20% coinsurance for eyeglasses or corrective lenses	Nothing 20% coinsurance for eyeglasses or corrective lenses
Not covered: • *Eyeglasses or contact lenses, except as shown above* • *Eye exercises and orthoptics* • *Radial keratotomy and other refractive surgery* • *Annual Refraction*	*All charges*	*All charges*
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. Visits to a podiatrist are limited to 10 visits per calendar year.	$40 copayment per specialist visit	$40 copayment per specialist visit (No deductible)
Not covered: • *Cutting, trimming or removal of corns, calluses, or the free edge of toenails, and similarroutine treatment of conditions of the foot, except as stated above*	*All charges*	*All charges*

Foot care - continued on next page

Benefit Description		
Foot care (cont.)	**High Option**	**Standard Option**
• *Treatment of weak, strained or flat feet or bunions or spurs; and of any instability, imbalance or subluxation of the foot (unless the treatment is by open cutting surgery)*	*All charges*	*All charges*
Orthopedic and prosthetic devices	**High Option**	**Standard Option**
• Artificial limbs and eyes; stump hose • Externally worn breast prostheses and surgical bras, including necessary replacements following a mastectomy • Hearing aids and testing to fit them (for details refer to Hearing Services, page 28) • 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. • Internal prosthetic devices, such as artificial joints, pacemakers, cochlear implants, and surgically implanted breast implant following mastectomy. Note: Internal prosthetic devices are paid as hospital benefits; see Section 5(c) for payment information. Insertion of the device is paid as surgery; see Section 5(b) for coverage of the surgery to insert the device. • Corrective orthopedic appliances for non-dental treatment of temporomandibular joint (TMJ) pain dysfunction syndrome. • Prosthetic replacements are provided when preauthorized.	20% coinsurance	20% coinsurance
Not covered: • *Orthopedic and corrective shoes* • *Arch supports* • *Foot orthotics* • *Heel pads and heel cups* • *Lumbosacral supports* • *Corsets, trusses, elastic stockings, support hose, and other supportive devices* • *Prosthetic replacements that are not preauthorized.* • *Braces and supports needed for athletic participation or employment.*	*All charges*	*All charges*

Benefit Description		
Durable Medical Equipment (DME)	**High Option**	**Standard Option**
Rental or purchase, at our option, including repair and adjustment, of durable medical equipment prescribed by your Plan physician, such as oxygen and dialysis equipment. Under this benefit, we also cover: • Hospital beds; • Wheelchairs (see note below regarding motorized wheelchairs); • Crutches; • Walkers; • Ostomy and disposable diabetic supplies; • Hair prosthesis as prescribed by the attending oncologist for a member who hair loss is a result of chemotherapy or radiation treatment for cancer (Coverage is limited to a maximum Plan benefit of $350 for one hair prosthesis); • Blood glucose monitors; and • Insulin pumps	20% coinsurance	20% coinsurance
Not covered: Motorized wheelchair, wigs (except as noted above), and upgrades to equipment.	*All charges*	*All charges*
Home health services	**High Option**	**Standard Option**
• Home health care ordered by a Plan physician and provided by a registered nurse (R.N.), licensed practical nurse (L.P.N.), licensed vocational nurse (L.V.N.), or home health aide. • Home visits following a mastectomy or removal of a testicle if the hospital stay is less than 48 hours. • Services include oxygen therapy, intravenous therapy and medications.	Nothing	20% coinsurance
Not covered: • *Nursing care requested by, or for the convenience of, the patient or the patient's family;* • *Home care primarily for personal assistance that does not include a medical component and is not diagnostic, therapeutic, or rehabilitative.*	*All charges*	*All charges*
Chiropractic	**High Option**	**Standard Option**
• Coverage is limited to 20 visits per calendar year. Services include consultation, diagnosis, and treatment of diseases relating to subluxations of the articulations of the spine and adjacent tissues.	$40 copayment per visit	20% coinsurance

Benefit Description		
Alternative treatments	**High Option**	**Standard Option**
No benefit	*All charges*	*All charges*
Educational classes and programs	**High Option**	**Standard Option**
• Diabetic outpatient self-management training and education • Health Education such as instructions on achieving and maintaining physical and mental health, and preventing illness and injury and childhood obesity education. • Nutritional counseling provided by a Registered Dietician or Participating Physician in connection with diabetes, coronary artery disease and hyperlipidemia.	Nothing	Nothing
Smoking cessation programs, including individual/group/telephone counseling, and for over the counter (OTC) and prescription drugs approved by the FDA to treat tobacco dependence.	You pay nothing for up to four counseling sessions for up to two quit attempts per year. Nothing for OTC and prescription drugs approved by the FDA to treat tobacco dependence.	You pay nothing for up to four counseling sessions for up to two quit attempts per year. Nothing for OTC and prescription drugs approved by the FDA to treat tobacco dependence.
Medical Clinical Trial	**High Option**	**Standard Option**
If you are a participant in a clinical trial, we will provide related care if it is not provided by the clinical trial, as follows: We provide coverage for Routine Patient Care Cost to a Member in a Medical Clinical Trial for randomized and controlled Phase III treatment of a life threatening disease, if such expenses are covered under this agreement, and we authorize them in advance. We provide coverage for Phase I and Phase II clinical trials and any randomized and controlled clinical trial for treatment of cancer that are sanctioned by the National Cancer Institute (NCI), or for the cost of any investigational drug. Treatment in a Medical Clinical Trial must be authorized in advance by us.	See coverage limitations based on setting (Inpatient, page 40; Outpatient, page 41; Home, page 22 and Office, page 22, etc.), and type of provider (Specialist care in office, hospital, etc.)	See coverage limitations based on setting (Inpatient, page 40; Outpatient, page 41; Home, page 22 and Office, page 22, etc.), and type of provider (Specialist care in office, hospital, etc.)

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: We have no deductible.
- Standard Option: The calendar year deductible is: $300 per person ($600 per family). The calendar year deductible only applies to the Standard Option Plan. Copayments do not apply towards the deductible. **Note: The calendar year deductible applies to almost all benefits in this Section. We say "(No deductible)" when it 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 and identify which surgeries require precertification.

Benefit Description		
Surgical procedures	**High Option**	**Standard Option**
A comprehensive range of services, such as: • Operative procedures • Treatment of fractures, including casting • Normal pre- and post-operative care by the surgeon • Correction of amblyopia and strabismus • Endoscopy procedures • Biopsy procedures • Removal of tumors and cysts • Correction of congenital anomalies (see Reconstructive surgery) • Treatment of burns	$20 copayment for surgeries in a primary care physician office $40 copayment for surgeries in a specialist office Nothing for facility visits	$20 copayment for surgeries in a primary care physician office (No deductible) $40 copayment for surgeries in a specialist office (No deductible) 20% for facility visits

Surgical procedures - continued on next page

Benefit Description		
Surgical procedures (cont.)	**High Option**	**Standard Option**
• Surgical treatment of morbid obesity (Bariatric Surgery), see *Services requiring our prior approval* on page 11. - 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. - When we approve, we provide coverage for treatment of morbid obesity through gastric bypass surgery or another surgical method that is recognized by the National Institutes of Health as effective for the long-term reversal of morbid obesity and consistent with criteria approved by the National Institutes of Health. - We provide benefits like any other medically necessary surgical procedure for Members whose body mass index is greater than 40 kilograms per meter squared, or equal to or greater than 35 kilograms per meter squared with a comorbid medical condition including hypertension, cardiopulmonary condition, sleep apnea or diabetes. - Body mass index is calculated by dividing the Member's weight in kilograms by the Member's height in meters squared. • Insertion of internal prosthetic devices. See 5(a) - *Orthopedic and prosthetic devices* for device coverage information Note: Generally, we pay for internal prostheses (devices) according to where the procedure is done. For example, we pay Hospital benefits for a pacemaker and Surgery benefits for insertion of the pacemaker.	$20 copayment for surgeries in a primary care physician office $40 copayment for surgeries in a specialist office Nothing for facility visits	$20 copayment for surgeries in a primary care physician office (No deductible) $40 copayment for surgeries in a specialist office (No deductible) 20% for facility visits
• Voluntary sterilization (e.g. tubal ligation, vasectomy)	50% coinsurance	50% coinsurance
Not covered: • *Reversal of voluntary sterilization* • *Routine treatment of conditions of the foot; see Foot care*	*All charges*	*All charges*

Benefit Description		
Reconstructive surgery	**High Option**	**Standard Option**
• Surgery to correct a condition that existed at or from birth and is a significant deviation from the common form or norm. Examples of congenital anomalies are protruding ear deformities; cleft lip; cleft palate; birthmarks; and webbed fingers and toes. • Surgery to correct a functional defect • Surgery to correct a condition caused by injury or illness if: - the condition produced a major effect on the member's appearance and - the condition can reasonably be expected to be corrected by such surgery • All stages of breast reconstruction surgery following a mastectomy, such as: - surgery to produce a symmetrical appearance of breasts; - treatment of any physical complications, such as lymphedemas;breast prostheses and surgical bras and replacements (see *Prosthetic devices*) Note: If you need a mastectomy, you may choose to have the procedure performed on an inpatient basis and remain in the hospital up to 48 hours after the procedure.	$20 copayment for surgeries in a primary care physician office; $40 copayment for surgeries in a specialist office When you have surgery in an inpatient or outpatient facility there is no copayment for the physician's services; however, copayments and coinsurance apply to the facility's charges.	$20 copayment for surgeries in a primary care physician office (No deductible) $40 copayment for surgeries in a specialist office (No deductible) 20% coinsurance for surgeries in a free-standing surgi-center or outpatient hospital
Not covered: • *Cosmetic surgery – any surgical procedure (or any portion of a procedure) performed primarily to improve physical appearance through change in bodily form, except repair of accidental injury* • *Surgeries related to sex transformation*	*All charges*	*All charges*
Oral and maxillofacial surgery	**High Option**	**Standard Option**
Oral surgical procedures, limited to: • Reduction of fractures of the jaws or facial bones; • Surgical correction of cleft lip, cleft palate or severe functional malocclusion; • Removal of stones from salivary ducts; • Excision of leukoplakia or malignancies; • TMJ related services (non-dental); • Excision of cysts and incision of abscesses when done as independent procedures; and • Other surgical procedures that do not involve the teeth or their supporting structures.	$20 copayment for surgeries in a primary care physician office; $40 copayment for surgeries in a specialist office When you have surgery in an inpatient or outpatient facility there is no copayment for the physician's services; however, copayments and coinsurance apply to the facility's charges.	$20 copayment for surgeries in a primary care physician office (No deductible) $40 copayment for surgeries in a specialist office (No deductible) 20% coinsurance for surgeries in a free-standing surgi-center or outpatient hospital

Oral and maxillofacial surgery - continued on next page

Benefit Description		
Oral and maxillofacial surgery (cont.)	**High Option**	**Standard Option**
Not covered: • *Oral implants and transplants* • *Procedures that involve the teeth or their supporting structures (such as the periodontal membrane, gingiva, and alveolar bone)*	*All charges*	*All charges*
Organ/tissue transplants	**High Option**	**Standard Option**
These solid organ transplants are subject to medical neccessity and experimental/investigational review by the Plan. Refer to *Other services* in Section 3 for prior authorization procedures. Transplant services must be performed at a participating Center of Excellence. We approve and designate where all transplants must be performed including hospitals for specific transplant procedures. If you would like to know about a specific facility, please contact Customer Service. Solid organ transplants limited to: • Cornea • Heart • Heart/lung • Single, double or lobar lung • Kidney • Kidney/Pancreas • Liver • Pancreas • Autologous pancreas islet cell transplant (as an adjunct to total or near total pancreatectomy) only for patients with chronic pancreatitis • Intestinal transplants - Small intestine - Small intestine with liver - Small intestine with multiple organs , such as the liver, stomach, and pancreas	Nothing	Nothing
Blood or marrow stem cell transplants limited to the stages of the following diagnoses: (the medical necessity limitation is considered satisfied if the patient meets the staging description) • Allogeneic transplants for - Acute lymphocytic or non-lymphocytic (i.e., myelogeneous) leukemia - Chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL) - Advanced Hodgkin's lymphoma with reoccurrence	Nothing	Nothing

Organ/tissue transplants - continued on next page

Benefit Description		
Organ/tissue transplants (cont.)	**High Option**	**Standard Option**
- Advanced non-Hodgkin's lymphoma with reoccurrence - Marrow Failure and Related disorders (i.e. Fanconi's PNH, pure red cell aplasia) - Chronic myleogenous leukemia - Hemoglobinopathies - Myelodysplasia/Myelodysplastic syndromes - Severe combined immunodeficiency - Severe or very severe aplastic anemia - Amyloidosis - Paroxysmal Nocturnal Hemoglobinuira • Autologous transplants for - Acute lymphocytic or nonlymphocytic (i.e., myelogenous) leukemia - Advanced Hodgkin's lymphoma with reoccurrence - Advanced non-Hodgkin's lymphoma with reoccurrence - Neuroblastoma - Amyloidosis • Autologous tandem transplants for - Recurrent germ cell tumors (including testicular cancer) - Multiple myeloma - Denovo myeloma Blood or marrow stem cell transplants for • Allogeneic transplants for - Phagocytic/Hemophagocytic deficiency diseases (e.g., Wiskott-Aldrich syndrome) - Advanced neuroblastoma - Infantile malignant osteopetrosis - Kostmann's syndrome - Leukocyte adhesion deficiencies - Mucolipidosis (e.g., Gaucher's disease, metachromatic leukodystrophy, adrenoleukodystrophy - Mucopolysaccharidosis (e.g., Hunter's syndrome, Hurler's syndrome, Sanfilippo's syndrome, Maroteaux-Lamy syndrome variants) - Myeloproliferative disorder - Sickle cell anemia	Nothing	Nothing

Organ/tissue transplants - continued on next page

Benefit Description		
Organ/tissue transplants (cont.)	**High Option**	**Standard Option**
- X-linked lymphoproliferative syndrome • Autologous transplants for - Multiple myeloma - Testicular, mediastinal, retroperitoneal, and ovarian germ cell tumors - Breast cancer - Epithelial ovarian cancer - Ependymoblastoma - Ewing's sarcoma - Medulloblastoma - Pineoblastoma - Waldenstrom's macroglobulinemia	Nothing	Nothing
Mini-transplants (nonmyeloblative, reduced intensity conditioning) for covered transplants: Subject to medical necessity. Refer to *Other Services* in Section 3 for prior authorization procedures.	Nothing	Nothing
Tandem transplants for covered transplants: Subject to medical necessity. Refer to *Other Services* in Section 3 for prior authorization procedures.	Nothing	Nothing
These Bone or marrow stem cell transplants covered only in a National Cancer Institute or National Institutes of Health approved clinical trial or a Plan-designated center of excellence and if approved by the Plan's medical director in accordance with the Plan's protocols. If you are a participant in a clinical trial, the Plan will provide benefits for related routine care that is medically neccessary (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 informaiton on costs related to clinical trials. We encourage you to contact the Plan to disucss specific services if you participate in a clinical trial. • Allogeneic transplants for - Chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL) - Hemoglobinopathies - Early stage (indolent or non-advanced) small cell lymphocytic lymphoma - Myelodysplasia/Myelodysplastic syndromes - Multiple myeloma - Multiple sclerosis • Nonmyeloablative allogeneic transplants or reduced intensity conditioning (RIC) for	Nothing	Nothing

Organ/tissue transplants - continued on next page

Benefit Description		
Organ/tissue transplants (cont.)	**High Option**	**Standard Option**
- Acute lymphocytic or non-lymphocytic (i.e., myelogeneous) leukemia - Myelodysplasia/Myelodysplastic syndromes - Advanced Hodgkin's lymphoma with reoccurrence - Advanced non-Hodgkin's lymphoma with reoccurence - Breast cancer - Chronic lymphocytic leukemia - Chronic myelogenous leukemia - Colon cancer - Early stage (indolent or non-advanced) small cell lymphocytic lymphoma - Chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL) - Multiple myeloma - Multiple sclerosis - Myeloproliferative disorder - Non-small cell lung cance - Ovarian cancer - Prostate cancer - Renal cell carcinoma - Sarcomas - Sickle Cell disease • Autologous transplants for - Chronic lymphocytic leukemia - Chronic myelogenous leukemia - Early stage (indolent or non-advanced) small cell lymphocytic lymphoma - Chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL) - Small cell lung cancer - Multiple sclerosis - Systemic lupus erythematosus - Systemic sclerosis • National Transplant Program (NTP) - 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 donor or up to four bone marrow/stem cell transplant donors in addition to the testing of family members.	Nothing	Nothing
Not covered:	*All charges*	*All charges*

Organ/tissue transplants - continued on next page

Benefit Description		
Organ/tissue transplants (cont.)	**High Option**	**Standard Option**
• *Implants of artificial organs* • *Transplants not listed as covered*	*All charges*	*All charges*
Anesthesia	**High Option**	**Standard Option**
Professional services provided in – • Hospital (inpatient)	Nothing	20% coinsurance
Professional services provided in – • Hospital outpatient department • Skilled nursing facility • Ambulatory surgical center • Office	Nothing	20% coinsurance for outpatient department of hospital, skilled nursing facility and ambulatory surgical-center Nothing for office service (No deductible)

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: We have no deductible.
- Standard Option: The calendar year deductible is: $300 per person ($600 per family). The calendar year deductible only applies to the Standard Option Plan. Copayments do not apply towards the deductible. Note: The calendar year deductible applies only when we say below "(calendar year deductible applies)".
- 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		
Inpatient hospital	**High Option**	**Standard Option**
Room and board, such as • Ward, semiprivate, or intensive care accommodations; • General nursing care; and • Meals and special diets. Note: If you want a private room when it is not medically necessary, you pay the additional charge above the semiprivate room rate.	$200 copayment per day up to a maximum of $600 per admission	$200 copayment per day up to a maximum of $600 per admission (No deductible)
Other hospital services and supplies, such as: • Operating, recovery, maternity, and other treatment rooms • Prescribed drugs and medicines • Diagnostic laboratory tests and X-rays • Dressings , splints , casts , and sterile tray services • Medical supplies and equipment, including oxygen	Nothing	Nothing
• Anesthetics, including nurse anesthetist services • Take-home items • Medical supplies, appliances, medical equipment, and any covered items billed by a hospital for use at home (Note: calendar year deductible applies.)	Nothing	Nothing
Not covered:	*All charges*	*All charges*

Inpatient hospital - continued on next page

Benefit Description		
Inpatient hospital (cont.)	**High Option**	**Standard Option**
• *Custodial care* • *Non-covered facilities, such as nursing homes, schools* • *Personal comfort items, such as telephone, television, barber services, guest meals and beds* • *Private nursing care*	*All charges*	*All charges*
Outpatient hospital or ambulatory surgical center	**High Option**	**Standard Option**
• Operating, recovery, and other treatment rooms • Prescribed drugs and medicines • Diagnostic laboratory tests, X-rays , and pathology services • Administration of blood, blood plasma, and other biologicals • Pre-surgical testing • Dressings, casts , and sterile tray services • Medical supplies, including oxygen • Anesthetics and anesthesia service Note: We cover hospital services and supplies related to dental procedures when necessitated by a non-dental physical impairment. We do not cover the dental procedures.	$150 per visit to an ambulatory surgical center Nothing for surgery in an outpatient department of a hospital	20% coinsurance (Calendar year deductible applies)
Not covered: Blood and blood derivatives not replaced by the member	*All charges*	*All charges*
Extended care benefits/Skilled nursing care facility benefits	**High Option**	**Standard Option**
Covered up to 100 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.	$200 copayment per day up to a maximum of $600 per admission	$200 copay per day up to a maximum of $600 per admission (No deductible)
Not covered: Custodial Care	*All charges*	*All charges*
Hospice care	**High Option**	**Standard Option**
Authorized within the service area for 30 days of inpatient care per member. Includes the following: • Part-time nursing care by or supervised by a registered graduate nurse; • Counseling, including dietary counseling, for the terminally ill Member, • Family counseling for the Immediate Family and the Family Caregiver before the death of the terminally ill Member;	Nothing	20% coinsurance

Hospice care - continued on next page

Benefit Description		
Hospice care (cont.)	**High Option**	**Standard Option**
• Bereavement counseling for the Immediate Family or Family Caregiver of the Member for at least the 6-month period following the Member's death or 15 visits, whichever occurs first; • Respite Care subject to the following: - The annual benefit shall be at least 14 days; and - The carrier may limit any one inpatient stay for Respite Care to 5 consecutive days; and Medical supplies, equipment, and medication required to maintain the comfort and manage the pain of the terminally ill Member.	Nothing	20% coinsurance
Not covered: Independent nursing, homemaker services	*All charges*	*All charges*
Ambulance	**High Option**	**Standard Option**
Local professional ambulance service when medically appropriate	Nothing	20% coinsurance

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.
- High Option: We have no deductible.
- Standard Option: The calendar year deductible is: $300 per person ($600 per family). The calendar year deductible applies only to the Standard Option Plan. Copayments do not apply towards the deductible. **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 you believe endangers your life or could result in serious injury or disability, and requires immediate medical or surgical care. Some problems are emergencies because, if not treated promptly, they might become more serious; examples include deep cuts and broken bones. Others are emergencies because they are potentially life-threatening, such as heart attacks, strokes, poisonings, gunshot wounds, or sudden inability to breathe. There are many other acute conditions that we may determine are medical emergencies – what they all have in common is the need for quick action.

What to do in case of emergency:

In a life-threatening emergency, call the local emergency system (e.g. the local 911-telephone system), or go to the nearest emergency facility. If an ambulance comes, tell the paramedics that the person who needs help is a Coventry Health Care member.

Emergencies within our service area:

When a need for Emergency Services occurs in the Service Area, a member should seek medical attention immediately from a hospital, physician's office or other emergency facility. The determination of covered benefits for services rendered in an emergency facility is based on our review of the member's emergency room medical records, along with those relevant symptoms and circumstances that preceded the provision of care. Services provided by an emergency facility for non-Emergency Services are not covered except if you are directed to an emergency room by us or a physician and the care is deemed not to be an emergency. Coverage will also be provided for Emergency Services in cases where you do not have 24-hour access to a physician, even if those services are deemed not to be an emergency.

Emergencies outside our service area:

The member may be transported from outside the service area to the service area for continued medical management of an emergency services condition at the option of the Medical Director or Medical Director's Designee. We will only exercise this option when the Medical Director or Medical Director's Designee decides that such action will not have a detrimental effect on the Member's medical condition. Ground ambulance transportation to return a member to a participating provider is covered when authorized by us. Refusal to be transferred may result in loss of benefits.

Benefit Description		
Emergency within our service area	**High Option**	**Standard Option**
Emergency care at a doctor's office	$20 copayment at primary care physician office $40 copayment at specialist office	$20 copayment at primary care physician office (No deductible) $40 copayment at specialist office (No deductible)
Emergency care at an urgent care center	$30 copayment per visit	20% coinsurance
Emergency Care as an outpatient at a hospital, including doctors' services Note: We waive the ER copay if you are admitted to the hospital	$150 copayment per visit	20% coinsurance
Not covered: Elective care or non-emergency care	*All charges*	*All charges*
Emergency outside our service area	**High Option**	**Standard Option**
Emergency care at a doctor's office	$20 copayment at primary care physician office $40 copayment at specialist office	$20 copayment at primary care physician office (No deductible) $40 copayment at specialist office (No deductible)
Emergency care at an urgent care center	$30 copayment per visit	20% coinsurance
Emergency care as an outpatient at a hospital, including doctors' services Note: We waive the ER copay if you are admitted to the hospital.	$150 copayment per visit	20% coinsurance
Not covered: • *Elective care or non-emergency care and follow-up care recommended by non-Plan providers that has not been approved by the Plan or provided by Plan providers* • *Emergency care provided outside the service area if the need for care could have been foreseen before leaving the service area* • *Medical and hospital costs resulting from a normal full-term delivery of a baby outside the service area*	*All charges*	*All charges*
Ambulance	**High Option**	**Standard Option**
Professional ambulance service when medically appropriate. Note: See 5(c) for non-emergency service.	Nothing	20% coinsurance

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

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

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- The calendar year deductible or, for facility care, the inpatient deductible, applies to almost all benefits in this Section. We added "(No deductible)" to show when a deductible does not apply.
- Be sure to read Section 4, *Your costs for covered services,* for valuable information about how cost-sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- **YOU MUST GET PREAUTHORIZATION FOR THESE SERVICES.** Benefits are payable only when we determine that care is clinically appropriate to treat your condition and only when you receive the care as part of a treatment plan that we approve. The treatment plan may include services, drugs, and supplies described elsewhere in this brochure. To be eligible to receive full benefits, you must follow the preauthorization process and get Plan approval of your treatment plan. We will provide medical review criteria or reasons for treatment plan denials to enrollees, members or providers upon request or as otherwise required.
- OPM will base its review of disputes about treatment plans on the treatment plan's clinical appropriateness. OPM will generally not order us to pay or provide one clinically appropriate treatment plan in favor of another.

Benefit Description	You Pay	
Professional Services	**High Option**	**Standard Option**
When part of a treatment plan we approve, we cover professional services by licensed professional mental health and substance abuse practioners when acting within the scope of their license, such as psychiatrists, psychologists, clinical social workers, licensed professional counselors, or marriage and family therapists. Diagnosis and treatment of psychiatric conditions, mental illness, or mental discorders. Services include: • Diagnostic evaluation • Crisis intervention and stabilization for acute episodes • Medication evaluation and management (pharmacotherapy) • Pyschological and neuropsychological testing necessary to determine the appropriate psychiatric treatment • Treatment and counseling (including individual or group therapy visits)	Your cost-sharing responsibilities are no greater than for other illnesses or conditions.	Your cost-sharing responsibilities are no greater than for other illnesses or conditions.

Professional Services - continued on next page

Benefit Description	You Pay	
Professional Services (cont.)	**High Option**	**Standard Option**
• Diagnostic and treatment of alcoholism and drug abuse, including detoxification, treatment and counseling • Professional charges for intensive outpatient treatment in a provider's office or other professional setting • Electroconvulsive therapy	Your cost-sharing responsibilities are no greater than for other illnesses or conditions.	Your cost-sharing responsibilities are no greater than for other illnesses or conditions.
Diagnostics	**High Option**	**Standard Option**
• Outpatient diagnostic tests provided and billed by a licensed mental health and substance abuse practitioner • Outpatient diagnostic tests provided and billed by a laboratory, hospital or other covered facility • Inpatatient diagnostic tests provided and billed by a hospital or other covered facility	$10 per test Nothing for inpatient tests	$10 copayment for lab tests (No deductible) Nothing for inpatient tests
Inpatient hospital and other covered facility	**High Option**	**Standard Option**
Inpatient services provided and billed by a hospital or other covered facility • Room and board, such as semiprivate or intensive accommodations, general nursing care, meals and special diets, and other hospital services	$200 copay per day up to a maximum of $600 per in-patient admission	$200 copay per day up to a maximum of $600 per in-patient admission
Outpatient hospital or other covered facility	**High Option**	**Standard Option**
Outpatient services provided and billed by a hospital or other covered facility • Services in approved treatment programs, such as partial hospitalization, half-way house, residential treatment, full-day hospitalization, or facility-based intensive outpatient treatment *Not covered: Services we have not approved*	Nothing for services provided in an out-patient setting	Nothing for services provided in an out-patient setting

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 CHCDE 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 by MHNet at 866-808-2808 or 800-862-2244 (for the deaf and hard of hearing).
Limitation	We may limit your benefits if you do not obtain a treatment plan.	

Section 5(f). Prescription drug benefits

Important things you should keep in mind about these benefits:

- We cover prescribed drugs and medications, as described in the chart beginning on the next page.
- Please remember that all benefits are subject to the definitions, limitations and exclusions in this brochure and are payable only when we determine they are medically necessary.
- High and Standard Option: We have no calendar year deductible.
- Be sure to read Section 4, *Your costs for covered services,* for valuable information about how cost-sharing works. Also, read Section 9 about coordinating benefits with other coverage, including with Medicare.

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

- **Who can write your prescription.** You may obtain a prescription from a prescribing physician or other health care professional who is licensed and who, in the usual course of business, may legally prescribe prescription drugs.
- **Where you can obtain them.** You may fill the prescription at a participating pharmacy, including a participating mail order or specialty pharmacy, except for Emergency or Urgent Care Services, out of the service area. A "specialty pharmacy" is a pharmacy from which you may obtain self-administered injectable drugs. You may obtain maintenance medication through Medco Health Solutions, our mail order prescription program. Medco's Customer Service number is 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 may be included in the formulary. If you would like information on whether a specific drug is included in our drug formulary, please call our Customer Service Department at 302-283-6500 within our service area or 800-833-7423.
- **There are dispensing limitations.** These are the dispensing and quantity limitations. **Prescription drugs will be dispensed in the quantity determined by Us.** In order for Prescription Drugs to be covered in excess of the specific quantity limit, your physician must call Us before you fill the Prescription Order or Refill for a drug that exceeds the specific quantity limit.

Retail Drugs

In general, the quantity of a Prescription Drug dispensed by a Retail Pharmacy for each Prescription Order or Refill is limited to the lesser of:

- The amount determined by Us to be a 30-day supply
- The amount prescribed in the Prescription Order or Refill; or
- Depending on the form and packaging of the product, the following:
  - 100 tablets/capsules, or
  - 480 cc of oral liquids; or
  - A single commercially prepackaged item (including but not limited to inhalers, topicals, and vials).

Mail Order Drugs

The quantity of a Prescription Drug dispensed by the Mail Order Pharmacy for one Prescription Order or Refill for a Maintenance Drug is limited to the lesser of:

- The amount prescribed in the Prescription Order or Refill; or
- The amount determined by Us to be Medically Necessary; or
- The amount determined by Us to be a 90-day supply; or

- Depending on the form and packaging of the product, the following:
  - 300 tablets/capsules, or
  - 1,440 cc of oral liquids; or
  - three (3) single commercially prepackaged items (including but not limited to inhalers, topicals, and vials).

The following Member payments shall apply:

1. High Option: One (1) copayment (i.e. $5 for Tier One prescriptions; $30 for Tier Two preferred brand name prescriptions, $60 for Tier Three non-preferred brand name prescriptions) or the cost of the prescription drug, whichever is less, is due each time a prescription is filled or refilled at a retail or specialty pharmacy. Standard Option: One (1) copayment (i.e. $15 for Tier One prescriptions; $30 for Tier Two preferred brand name prescriptions, $60 for Tier Three non-preferred brand name prescriptions or the cost of the prescription drug, whichever is less, is due each time a prescription is filled or refilled at a retail or specialty pharmacy.
2. Formulary maintenance drugs obtained through a mail order pharmacy designated by the Health Plan may be dispensed with two (2) copayments for a ninety- (90) day's supply (i.e. High Option: $10 copayment for Tier One formulary prescriptions; $60 for Tier Two preferred brand name formulary prescriptions, $120 for Tier Three non-formulary prescriptions. Standard Option: $30 copayment for Tier One formulary prescriptions; $60 for Tier Two preferred brand name formulary prescriptions, and $120 for Tier Three non-formulary prescriptions). **To order prescription drugs or refills please contact Medco's Customer Service at 800-378-7040. This service is available 24 hours a day – 7 days a week.**
3. Total member payments shall not exceed the price of the prescription drug. Copayments and Ancillary Charges do not apply do the member's 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.

You can save money by using generic drugs. However, you and your physician have the option to request a name brand if a generic option is available. Using the most cost-effective medication saves money.

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. To file a pharmacy claim, call Medco at 800-378-7040.

Benefit Description	You pay	
Covered medications and supplies	**High Option**	**Standard Option**
We cover the following medications and supplies prescribed by a Plan physician and obtained from a Plan pharmacy or through our mail order program: • Drugs and medicines that by Federal law of the United States require a physician's prescription for their purchase, except those listed as *Not covered.* • Insulin • Disposable needles and syringes for the administration of covered medications • Drugs for sexual dysfunction (see prior authorization below) • Contraceptive drugs and devices • Self-Administered injectable Prescription that includes but are not limited to the following: multiple sclerosis agents, growth hormones, colony stimulating factors given more than once monthly, chronic medications for hepatitis C, certain rheumatoid arthritis medications, certain injectable HIV drugs, certain osteoporosis agents, and heparin products. Self-Administered Injectable drugs are only available through Specialty Pharmacies. The following are not considered Self-Administered Injectable Drugs because they are not obtained from a Specialty Pharmacy: insulin, glucagon, and bee sting kits, Imitrex and injectable contraceptives. Self-Administered injectable drugs are only available through a Specialty Pharmacy.	**Retail and Specialty Pharmacy:** $5 per prescription or refill for Tier One formulary drugs; $30 per prescription or refill for Tier Two formulary drugs (brand name drugs) $60 per prescription or refill for Tier Three non-formulary drugs (brand name drugs) **Mail Order (Maintenance Drugs only):** $10 per prescription or refill for a 90 consecutive day supply for maintenance Tier One drugs; $60 per prescription or refill for a 90 consecutive day supply for maintenance Tier Two preferred drugs (formulary brand name drugs). $120 per prescription or refill for a 90 consecutive day supply for maintenance Tier Three non-formulary (band name drugs)	**Retail and Specialty Pharmacy:** $15 per prescription or refill for Tier One formulary drugs; $30 per prescription or refill for Tier Two formulary drugs (brand name drugs) $60 per prescription or refill for Tier Three non-formulary drugs (brand name drugs) **Mail Order (Maintenance Drugs only):** $30 per prescription or refill for a 90 consecutive day supply for maintenance Tier One drugs; $60 per prescription or refill for a 90 consecutive day supply for maintenance Tier Two preferred drugs (formulary brand name drugs) $120 per prescription or refill for a 90 consecutive day supply for maintenance Tier Three non-formulary (band name drugs)
Not covered: • *Compounded prescriptions whose only ingredients do not require prescription* • *Legend drugs for which there is a non-prescription equivalent such as vitamins, except legend prenatal vitamins for pregnant/nursing females, liquid or chewable legend pediatric vitamins for children under age 13, and potassium supplements to prevent/treat low potassium* • *Prescription Drugs and supplies for cosmetic purposes* • *Drugs to enhance athletic performance* • *Dietary supplements, appetite suppressants, and other drugs used to treatment obesity or assist in weight reduction* • *Drugs obtained at a non-Plan pharmacy; except for out-of-area emergencies* • *Vitamins, nutrients and food supplements even if a physician prescribes or administers them, except as specified herein*	*All charges*	*All charges*

Covered medications and supplies - continued on next page

Benefit Description	You pay	
Covered medications and supplies (cont.)	**High Option**	**Standard Option**
• *Nonprescription medicines* • *Charges for special re-packaging of medications prepared by the pharmacy such as "unit dose" or "bubble pack"* • *Oral dental preparations, fluoride rinses, except fluoride tablets or drops* • *Refill prescriptions resulting from loss or theft* Note: Over-the-counter and prescription drugs approved by the FDA to treat tobacco dependence are covered under the Smoking cessation benefit. (see Educational classes and Programs, page 31).	*All charges*	*All charges*

Section 5(g). Dental benefits

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- If you are enrolled in a Federal Employees Dental Vision Insurance Program (FEDVIP) Dental Plan, your FEHB Plan will be First Primary payor of any Benefit Payments and your FEDVIP Plan is secondary to your FEHB Plan. See Section 9 Coordinating benefits with other coverage.
- Plan providers must provide or arrange your care.
- We cover hospitalization for dental procedures only when a non-dental physical impairment exists which makes hospitalization necessary to safeguard the health of the patient. See Section 5(c) for inpatient hospital benefits. We do not cover the dental procedure unless it is described below.
- Be sure to read Section 4, *Your costs for covered services,* for valuable information about how cost-sharing works. Also read Section 10 about coordinating benefits with other coverage, including with Medicare.

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.	$20 copayment to your primary care physician $40 copayment to a specialist You pay nothing if services received during an inpatient admission	$20 copayment to your primary care physician (No deductible) $40 copayment to a specialist (No deductible) You pay nothing if services received during an inpatient admission

Dental benefits	High Option	Standard Option
We have no other dental benefits.		

Section 5(h). Special features

Feature	Description
Flexible benefits option	
Flexible benefits option	Under the flexible benefits option, we determine the most effective way to provide services. • 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. Our decision to offer or withdraw alternative benefits is not subject to OPM review under the disputed claims process.
Wellness Programs	Coventry Health Care offers an on-line wellness program called Wellbeing. Wellbeing is a free service available only to Coventry Health Care members. This on-line tool is available through our website, www.chcde.com/wellbeing. This program allows Coventry members to utilize the MyEPHIT tool to develop a customized exercise, nutrition or personal improvement program with the assistance of on-line fitness experts. This online Personal Health Improvement Training program is designed to enhance your overall Wellbeing. Through Wellbeing, you can: • Customize a daily fitness routine, including on-line demonstrations of specific exercises. • Personalize a nutrition plan, including receiving a meal planner with menus and shopping lists. • Download materials on life skills management, and family activity planning. • Communicate on-line with a Certified personal trainer, registered dieticians, and psychologists. • Download recipes for healthy menus. • Discover online family programs through KidPHIT and TeenPHIT, which allows your children to become motiviated for a healthier lifestyle. • Earn REWARDS! Through the Wellbeing program, just by signing on every month, you will be entered into a monthly drawing for prizes such as mountain bikes, DVD players, and other fitness related prizes! • Earn points towards the purchase of discounted fitness items. Through the online My EPHIT Mall, members can use the points they earn on the website to purchase items such as Yoga Mats, vitamins, or workout videos.

Feature	Description
Travel benefit/services overseas	
Travel benefit/services overseas	Your Benefit Plan does not include out-of-network benefits, however; if you are out of our service area and in need of Urgent or Emergent Care, please call 800-639-9154 for a First Health network provider in your area.

High Deductible Health Plan Benefits

See page 8 for how our benefits changed this year and page 117 for a benefits summary.

Section 5. High Deductible Health Plan Benefits Overview

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

HDHP Section 5, which describes the HDHP benefits, is divided into subsections. Please read *Important things you should keep in mind about these benefits* at the beginning of each subsection. Also read the General Exclusions in Section 6; they apply to benefits in the following subsections. To obtain claim forms, claims filing advice, or more information about HDHP benefits, contact us at 800-833-7423 or at our Web site at www.chcde.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 65. You can choose to use funds available in your HSA to make payments toward the deductible or you can pay toward your deductible entirely out-of-pocket, allowing your savings to continue to grow.

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

- **Preventive care** — The Plan covers preventive care services, such as periodic health evaluations (e.g., annual physicals), screening services (e.g., mammograms), routine prenatal and well-child care, child and adult immunizations, tobacco cessation programs, obesity weight loss programs, disease management and wellness programs. Preventive services are covered at 100% if you use a network provider and the services are described in Section 5 *Preventive care*. *You do not have to meet the deductible before using these services.*

- **Traditional medical coverage** — After you have paid the Plan's deductible, we pay benefits under traditional medical coverage described in Section 5. The Plan typically pays 100% of allowable charges for in-network and 70% for out-of-network care.

  Covered services include:

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

- **Savings** — Health Savings Accounts or Health Reimbursement Arrangements provide a means to help you pay out-of-pocket expenses (see page 57 for more details).

- **Health Savings Accounts (HSA)**

By law, HSAs are available to members who are not enrolled in Medicare, cannot be claimed as a dependent on someone else's tax return, have not received VA 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 $41.67 per month for a Self Only enrollment or $83.34 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 plan and $6,150 for a family. See maximum contribution information on page 60. 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
- Your contributions to the HSA are tax deductible
- You may establish pre-tax HSA deductions from your paycheck to fund your HSA up to IRS limits using the same method that you use to establish other deductions (i.e., Employee Express, MyPay, etc.)
- Your HSA earns tax-free interest
- You can make tax-free withdrawals for qualified medical expenses for you, your spouse and dependents (see IRS publication 502 for a complete list of eligible expenses)
- Your unused HSA funds and interest accumulate from year to year
- It's portable - the HSA is owned by you and is yours to keep, even when you leave Federal employment or retire
- When you need it, funds up to the actual HSA balance are available.

Important consideration if you want to participate in a Health Care Flexible Spending Account (HCFSA): If you are enrolled in this HDHP with a Health Savings Account (HSA), and start or become covered by a HCFSA health care flexible spending account (such as FSAFEDS offers – see Section 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 that you are ineligible for an HSA.

In 2011, we will give you an HRA credit of $500 per year for a Self Only enrollment and $1,000 per year for a Self and Family enrollment. You can use funds in your HRA to help pay your health plan deductible and/or for certain expenses that don't count toward the deductible.

HRA features include:

- For our HDHP option, we administer the HRA through Coventry Consumer Choice.

- Entire HRA credit (prorated from your effective date to the end of the plan year) is available from your effective date of enrollment
- Tax-free credit can be used to pay for qualified medical expenses for you and any individuals covered by this HDHP
- Unused credits carryover from year to year
- HRA credit does not earn interest
- HRA credit is forfeited if you leave Federal employment or switch health insurance plans.
- An HRA does not affect your ability to participate in an FSAFEDS Health Care Flexible Spending Account (HCFSA). However, you must meet FSAFEDS eligibility requirements.

• **Catastrophic protection for out-of-pocket expenses**	When you use network providers, your annual maximum for out-of-pocket expenses (deductibles, coinsurance and copayments) for covered services is limited to $ 4,000 per person or $ 8,000 per family enrollment. However, certain expenses do not count toward your out-of-pocket maximum and you must continue to pay these expenses once you reach your out-of-pocket maximum (such as expenses in excess of the Plan's allowable amount or benefit maximum). Refer to Section 4 Your catastrophic protection out-of-pocket maximum and HDHP Section 5 *Traditional medical coverage subject to the deductible* for more details.
• **Health education resources and account management tools**	HDHP Section 5(i) describes the health education resources and account management tools available to you to help you manage your health care and your health care dollars.

Section 5. Savings – HSAs and HRAs

Feature Comparison	Health Savings Account (HSA)	Health Reimbursement Arrangement (HRA) Provided when you are ineligible for an HSA
Administrator	The Plan will establish an HSA for you with Coventry Consumer Advantage, this HDHP's fiduciary (an administrator, trustee or custodian as defined by Federal tax code and approved by IRS.) ***Name: Coventry Consumer Advantage*** ***Street Address: P.O. Box 7758*** ***City, State ZIP Code: London, KY 40742*** ***Phone: 800-722-1758*** ***OR*** ***www.chcde.com***	The Plan will establish and HRA for you with Coventry Consumer Advantage. ***HRA Administrator: Coventry Consumer Advantage*** ***Fiduciary: There is no fiduciary for HRA's.*** ***Street Address: P.O. Box 7758*** ***City, State ZIP Code: London, KY 40742***
Fees	Order New Debit Card: $5.00 Debit Card Reissue: $10.00 Close Account: $30.00 Overdraft/Insufficient Funds: $50.00 Stop payment requests per item: $30.00 Request copy of debit card transaction merchant receipt: $30.00	None.
Eligibility	You must: • Enroll in this HDHP • Have no other health insurance coverage (does not apply to specific injury, accident, disability, dental, vision or long-term care coverage) • Not be enrolled in Medicare • Not be claimed as a dependent on someone else's tax return • Not have received VA benefits in the last three months • Complete and return all banking paperwork	You must enroll in this HDHP. Eligibility is determined on the first day of the month following your effective day of enrollment and will be prorated for lenth of enrollment.
Funding	If you are eligible for HSA contributions, a portion of your monthly health plan premium is deposited to your HSA each month. Premium pass through contributions are based on the effective date of your enrollment in the HDHP.	Eligibility for the annual credit will be determined on the first day of the month and will be prorated for length of enrollment. The entire amount of your HRA will be available to you upon your enrollment.

• **Self Only enrollment**	For 2011, a monthly premium pass through of $41.67 will be made by the HDHP directly into your HSA each month.	For 2011, your HRA annual credit is $500 (prorated for mid year enrollment).
• **Self and Family enrollment**	For 2011, a monthly premium pass through of $83.34 will be made by the HDHP directly into your HSA each month.	For 2011, your HRA annual credit is $1,000 (prorated for mid year enrollment).
Contributions/ credits	The maximum that can be contributed to your HSA is an annual combination of HDHP premium pass through and enrollee contribution funds, which when combined, do not exceed the maximum contribution amount set by the IRS of $3,050 for an individual and $6,150 for a family. If you enroll during Open Season, you are eligible to fund your account up to the maximum contribution limit set by the IRS. To determine the amount you may contribute, subtract the amount the Plan will contribute to your account for the year from the maximum allowable contribution. You are eligible to contribute up to the IRS limit for partial year coverage as long as you maintain your HDHP enrollment for 12 months, following the last month of the year of your first year of eligibility. To determine the amount you may contibute, take the IRS limit and subtract the amount the Plan will contribute to your account for the year. If you do not maintain your HDHP enrollment for 12 months, 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 you tax reduction is lost and a 10% pendalty is imposed. There is an exception for death or disability. You may rollover funds you have in other HSAs to this HDHP HSA (rollover funds do not affect your annual maximum contribution under this HDHP). HSAs earn tax-free interest (does not affect your annual maximum contribution). Catch-up contribution discussed on page 58.	The full HRA credit will be available, subject to proration, on the effective date of enrollment. The HRA does not earn interest.
• **Self Only enrollment**	You may make an annual maximum contribution of $2,550.	You cannot contribute to the HRA.
• **Self and Family enrollment**	You may make an annual maximum contribution of $6,150.	You cannot contribute to the HRA
Access funds	You can access your HSA by the following methods:	

	• Debit card • Withdrawal form • Checks	For qualified medical expenses under your HDHP, you will be automatically reimbursed when claims are submitted through the HDHP. For expenses not covered by the HDHP, such as orthodontia, a reimbursement form will be sent to you upon your request.
Distributions/ withdrawals • **Medical**	You can pay the out-of-pocket expenses for yourself, your spouse or your dependents (even if they are not covered by the HDHP) from the funds available in your HSA. See IRS Publication 502 for a list of eligible medical expenses.	You can pay the out-of-pocket expenses for qualified medical expenses for individuals covered under the HDHP. Non-reimbursed qualified medical expenses are allowable if they occur after the effective date of your enrollment in this Plan. See *Availability of funds* below for information on when funds are also available in the HRA. See IRS Publication 502 for a list of eligible medical expenses. Physicians prescribed over-the-counter drugs and Medicare premiums are also reimbursable. Most other types of medical insurance premiums are not reimbursable.
• **Non-medical**	If you are under age 65, withdrawal of funds for non-medical expenses will create a 20% income tax penalty in addition to any other income taxes you may owe on the withdrawn funds. When you turn age 65, distributions can be used for any reason without being subject to the 20% penalty, however they will be subject to ordinary income tax.	Not applicable – distributions will not be made for anything other than non-reimbursed qualified medical expenses.
Availability of funds	Funds are not available for withdrawal until all the following steps are completed: • Your enrollment in this HDHP is effective (effective date is determined by your agency in accord with the event permitting the enrollment change). • The HDHP receives record of your enrollment and initially establishes your HSA account with the fiduciary by providing information it must furnish and by contributing the minimum amount required to establish an HSA. • The fiduciary sends you HSA paperwork for you to complete and the fiduciary receives the completed paperwork back from you.	The entire amount of your HRA will be available to you upon your enrollment in the HDHP.
Account owner	FEHB enrollee	HDHP
Portable	You can take this account with you when you change plans, separate or retire.	

	If you do not enroll in another HDHP, you can no longer contribute to your HSA. See page 55 for HSA eligibility.	If you retire and remain in this HDHP, you may continue to use and accumulate credits in your HRA. If you terminate employment or change health plans, only eligible expenses incurred while covered under the HDHP will be eligible for reimbursement subject to timely filing requirements. Unused funds are forfeited.
Annual rollover	Yes, accumulates without a maximum cap.	Yes, accumulates without a maximum cap.

If you have an HSA

- **Contributions**

  All contributions are aggregated and cannot exceed the maximum contribution amount set by the IRS. You may contribute your own money to your account through payroll deductions, or you may make lump sum contributions at any time, in any amount not to exceed an annual maximum limit. If you contribute, you can claim the total amount you contributed for the year as a tax deduction when you file your income taxes. Your own HSA contributions are either tax-deductible or pre-tax (if made by payroll deduction). You receive tax advantages in any case. To determine the amount you may contribute, subtract the amount the plan will contribute to your account for the year from the maximum contribution 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 in 2010 and beyond. 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 precribed over-the-counter drugs are not listed in the publication, they are reimbursable from your HSA. Also, insurance premiums are reimbursable under limited circumstances.

- **Non-qualified expenses**

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

- **Tracking your HSA balance**

  You will receive a periodic statement that shows the "premium pass through", withdrawals, and interest earned on your account. In addition, you will receive an Explanation of Payment statement when you withdraw money from your HSA.

- **Minimum reimbursements from your HSA**

  You can request reimbursement in any amount.

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 60 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 if you use network providers.
- You must use providers that are part of our network.
- For all other covered expenses, please see Section 5 – *Traditional medical coverage subject to the deductible*.

Benefit Description	You pay
Preventive care, adult	
Routine screenings, such as: • Blood tests • Urinalysis • Total Blood Cholesterol • Routine Prostate Specific Antigen (PSA) test — one annually for men age 50 and older • Colorectal Cancer Screening, including - Fecal occult blood test yearly starting at age 50, - Sigmoidoscopy screening — every five years starting at age 50, - Double contrast barium enema — 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, one visit every 12 months from last date of service • Routine mammogram — covered for women age 35 and older, as follows: - From age 35 through 39, one during this five year period - From age 40 through 64, one every calendar year - At age 65 and older, one every two consecutive calendar years • Annual Chlamydia Screening Test for women who are younger than 20 years old who are sexually active, and at least 20 years old who have multiple risk factors; and men who have multiple risk factors.	In Network: You pay nothing and do not have to meet the deductible before using these services. They are covered with no member cost share. Out of Network: Services are subject to the deductible and then you must pay 30% of our allowance.
• Adult routine immunizations endorsed by the Centers for Disease Control and Prevention (CDC). • Routine physicals which include: - One exam every 24 months up to age 65 - One exam every 12 months age 65 and older • Routine exams limited to: - 1 routine eye exam every 12 months - 1 routine OB/GYN exam every 12 months including 1 Pap smear and related services - 1 routine hearing exam every 24 months	In Network: You pay nothing and do not have to meet the deductible before using these services. They are covered with no member cost share. Out of Network: Services are subject to the deductible and then you must pay 30% of our allowance.
Not covered:	*All charges*

Preventive care, adult - continued on next page

Benefit Description	You pay
Preventive care, adult (cont.)	
• *Physical exams and immunizations required for obtaining or continuing employment or insurance, attending schools or camp, athletic exams or travel.* • *Immunizations, boosters, and medications for travel or work-related exposure.*	*All charges*
Preventive care, children	
• Professional services, such as: • Well-child care charges for routine examinations, immunizations and care (up to age 22) • Childhood immunizations recommended by the American Academy of Pediatrics • Examinations, such as: • Eye exam through age 17 to determine the need for vision correction • Hearing exams through age 17 to determine the need for hearing correction • Examinations done on the day of immunizations (up to age 22)	In Network: You pay nothing and do not have to meet the deductible before using these services. They are covered with no member cost share. Out of Network: Services are subject to the deductible and then you must pay 30% of our allowance.
Not covered: • *Physical exams and immunizations required for obtaining or continuing employment or insurance, attending schools or camp, or travel.* • *Immunizations, boosters, and medications for travel.*	*All charges*

Section 5. Traditional medical coverage subject to the deductible

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- In-network preventive care is covered at 100% of allowable charges (see page 60) up to the annual limit and is not subject to the calendar year deductible.
- The deductible is $2,000, per person or $4,000, per family enrollment. The family deductible can be satisfied by one or more family members. The deductible applies to almost all benefits under Traditional medical coverage. You must pay your deductible before your Traditional medical coverage may begin.
- Under Traditional medical coverage, you are responsible for your coinsurance and copayments for covered expenses.
- When you use network providers, you are protected by an annual catastrophic maximum on out-of-pocket expenses for covered services. After your coinsurance, copayments and deductibles total $4,000 per person or $8,000 per family enrollment in any calendar year, you do not have to pay any more for covered services from network providers. However, certain expenses do not count toward your out-of-pocket maximum and you must continue to pay these expenses once you reach your out-of-pocket maximum (such as expenses in excess of the Plan's benefit maximum, or if you use out-of-network providers, amounts in excess of the Plan allowance).
- In-network benefits apply only when you use a network provider. When a network provider is not available, out-of-network benefits apply and are covered at 30% after the deductible has been met.
- 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
Deductible before Traditional medical coverage begins	
The deductible applies to almost all benefits in this Section. In the **You pay** column, we say "No deductible" when it does not apply. When you receive covered services from network providers, you are responsible for paying the allowable charges until you meet the deductible.	100% of allowable charges until you meet the deductible of $2,000 per person or $4,000 per family enrollment
After you meet the deductible, we pay the allowable charge (less your coinsurance or copayment) until you meet the annual catastrophic out-of-pocket maximum.	In-network: After you meet the deductible, you pay the indicated coinsurance or copayments for covered services. You may choose to pay the coinsurance and copayments from your HSA or HRA, or you can pay for them out-of-pocket. Out-of-network: After you meet the deductible, you pay the 30% coinsurance based on our Plan allowance and any difference between our allowance and the billed amount.

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

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan physicians must provide or arrange your care.
- The deductible is $2,000 for Self Only enrollment and $4,000 for Self and Family enrollment each calendar year. The Self and Family deductible can be satisfied by one or more family members. The deductible applies to all benefits in this Section unless we indicate differently.
- After you have satisfied your deductible, coverage begins for traditional medical services.
- Under your Traditional medical coverage, you will be responsible for your coinsurance amounts or 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
Diagnostic and treatment services	
Professional services of physicians • In physician's office • In an urgent care center • During a hospital stay • In a skilled nursing facility • Office medical consultations • Second surgical opinion	In-Network: All of our allowable amounts up to the deductible amount and nothing thereafter Out of Network: 30% of our allowance after the calendar year deductible
Lab, X-ray and other diagnostic tests	
Tests, such as: • Blood tests • Urinalysis • Non-routine Pap tests • Pathology • X-rays • Non-routine mammograms • CAT Scans/MRI • Ultrasound • Electrocardiogram and EEG	In-Network: All of our allowable amounts up to the deductible amount and nothing thereafter Out of Network: 30% of our allowance after the calendar year deductible

Benefit Description	You pay
Maternity care	
Complete maternity (obstetrical) care, such as: • Prenatal care • Delivery • Postnatal care Note: Here are some things to keep in mind: • You do not need to pre-certify 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 extend your inpatient stay if medically necessary, however you will need to get preauthorization for extended days. • For a mother and newborn child who have a Hospital stay of less than 48 hours for vaginal delivery or 96 hours for cesarean section, benefits are provided for one home visit to occur within 24 hours after discharge and an additional home visit if prescribed by the attending provider. • For a mother and newborn child who remain in the Hospital for at least 48 or 96 hours of inpatient hospitalization, we shall provide coverage for a home visit if prescribed by the attending provider. • 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 for the first 31 days after birth. An enrollment form must be completed to cover the infant under a Self and Family enrollment after the 31 days if you do not already have Self and Family coverage. Surgical benefits, not maternity benefits, apply to circumcision. • If a mother is required to remain hospitalized after childbirth for medical reasons and the mother requests that the newborn remain in the Hospital, we shall provide as part of the hospitalization services, payment for the cost of additional hospitalization for the newborn for up to 4 days. • We pay hospitalization and surgeon services for non-maternity care the same as for illness and injury.	In-Network: All of our allowable amounts up to the deductible amount and nothing thereafter Out of Network: 30% of our allowance after the calendar year deductible
Family planning	
A range of voluntary family planning services, limited to: • Voluntary sterilization (See Surgical procedures Section 5 (b)) • Surgically implanted contraceptive s • Injectable contraceptive drugs (such as Depo provera) • Intrauterine devices (IUDs) • Diaphragms Note: We cover oral contraceptives under the prescription drug benefit.	In-Network: All of our allowable amounts up to the deductible amount and nothing thereafter Out of Network: 30% of our allowance after the calendar year deductible
Not covered: • *Reversal of voluntary surgical sterilization*	*All charges*

Family planning - continued on next page

Benefit Description	You pay
Family planning (cont.)	
• *Genetic counseling.* • *Surrogate motherhood services and supplies, including, but not limited to, all services and supplies relating to the conception and pregnancy of a Member acting as a surrogate mother*	*All charges*
Infertility services	
Diagnosis and treatment of infertility such as: • Artificial insemination: - intravaginal insemination (IVI) - intracervical insemination (ICI) - intrauterine insemination (IUI) • Fertility drugs Note: We cover injectible fertility drugs under medical benefits and oral fertility drugs under the prescription drug benefit.	In-Network: All of our allowable amounts up to the deductible amount and nothing thereafter Out of Network: 30% of our allowance after the calendar year deductible.
Not covered: • *Assisted reproductive technology (ART) procedures, such as:* - *in vitro fertilization* - *embryo transfer, gamete intra-fallopian transfer (GIFT) and zygote intra-fallopian transfer (ZIFT)* • *Services and supplies related to ART procedures* • *Cost of donor sperm* • *Cost of donor egg.*	*All charges*
Allergy care	
• Testing and treatment • Allergy injections	In-Network: All of our allowable amounts up to the deductible amount and nothing thereafter Out of Network: 30% of our allowance after the calendar year deductible.
Allergy serum	In-Network: All of our allowable amounts up to the deductible amount and nothing thereafter Out of Network: 30% of our allowance after the calendar year deductible.
Treatment therapies	
• Chemotherapy and radiation therapy Note: High dose chemotherapy in association with autologous bone marrow transplants is limited to those transplants listed under Organ/ Tissue Transplants on page xx. • Respiratory and inhalation therapy • Dialysis – hemodialysis and peritoneal dialysis • Intravenous (IV)/Infusion Therapy – Home IV and antibiotic therapy • Growth hormone therapy (GHT)	In-Network: All of our allowable amounts up to the deductible amount and nothing thereafter Out of Network: 30% of our allowance after the calendar year deductible.

Treatment therapies - continued on next page

Benefit Description	You pay
Treatment therapies (cont.)	
Note: Growth hormone is covered under the prescription drug benefit. Note: – We only cover GHT when we preauthorize the treatment. We will ask you to submit information that establishes that the GHT is medically necessary. Ask us to authorize GHT before you begin treatment; 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 *Services requiring our prior approval* in Section 3.	In-Network: All of our allowable amounts up to the deductible amount and nothing thereafter Out of Network: 30% of our allowance after the calendar year deductible.
Physical and occupational therapies	
60 visits for the services of each of the following: • qualified physical therapists and • occupational therapists 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. • Cardiac rehabilitation following a heart transplant, bypass surgery or a myocardial infarction is provided for up to 60 sessions.	In-Network: All of our allowable amounts up to the deductible amount and nothing thereafter Out of Network: 30% of our allowance after the calendar year deductible.
Not covered: • *Long-term rehabilitative therapy* • *Exercise programs*	*All charges*
Speech therapy	
60 visits per condition per calendar year	In-Network: All of our allowable amounts up to the deductible amount and nothing thereafter Out of Network: 30% of our allowance after the calendar year deductible.
Habilitative services	
Habilitative services for the treatment of a child with congenital or genetic birth defects to enhance the child's ability to function are covered for children under the age of 19 if preauthorized by us. Services include • occupational, • physical • speech therapy	In-Network: All of our allowable amounts up to the deductible amount and nothing thereafter Out of Network: 30% of our allowance after the calendar year deductible.
Not covered: *Habilitative services delivered through early intervention or school services*	*All charges*

Benefit Description	You pay
Hearing services (testing, treatment, and supplies)	
• First hearing aid and testing only when necessitated by accidental injury. • Hearing exams for children through age 17, as shown in *Preventive care, children;* • Hearing aids for minor children up to a maximum Plan benefit of $1,400 per hearing aid per ear every 36 months when prescribed by a licensed audiologist. • Hearing aids for adults up to a maximum Plan benefit of $500 per hearing aid per ear every 5 years when prescribed by a licensed audiologist.	In-Network: All of our allowable amounts up to the deductible amount and nothing thereafter Out of Network: 30% of our allowance after the calendar year deductible.
Not covered: • *All other hearing testing* • *Hearing aids (except for minor children as described above), testing and examinations for them*	*All charges*
Vision services (testing, treatment, and supplies)	
• One pair of eyeglasses or contact lenses to correct an impairment directly caused by accidental ocular injury or intraocular surgery (such as for cataracts) • Eye exam to determine the need for vision correction for children through age 17 (see Preventive care, children)	In-Network: All of our allowable amounts up to the deductible amount and nothing thereafter Out of Network: 30% of our allowance after the calendar year deductible.
Not covered: • *Eyeglasses or contact lenses, except as shown above* • *Eye exercises and orthoptics* • *Radial keratotomy and other refractive surgery* • *Annual Refraction*	*All charges*
Foot care	
Routine foot care when you are under active treatment for a metabolic or peripheral vascular disease, such as diabetes.	In-Network: All of our allowable amounts up to the deductible amount and nothing thereafter Out of Network: 30% of our allowance after the calendar year deductible.
Not covered: • *Cutting, trimming or removal of corns, calluses, or the free edge of toenails, and similar routine treatment of conditions of the foot, except as stated above* • *Treatment of weak, strained or flat feet or bunions or spurs; and of any instability, imbalance or subluxation of the foot (unless the treatment is by open cutting surgery)*	*All charges*

Benefit Description	You pay
Orthopedic and prosthetic devices	
• Artificial limbs and eyes; stump hose • Externally worn breast prostheses and surgical bras, including necessary replacements following a mastectomy • Hearing aids and testing to fit them (for details refer to Hearing Services page 72) • 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. Prosthetic replacements are provided when preauthorized.	In-Network: All of our allowable amounts up to the deductible amount and nothing thereafter Out of Network: 30% of our allowance after the calendar year deductible.
Not covered: • *Orthopedic and corrective shoes* • *Arch supports* • *Foot orthotics* • *Heel pads and heel cups* • *Lumbosacral supports* • *Corsets, trusses, elastic stockings, support hose, and other supportive devices* • *Braces and supports needed for athletic participation or employment*	*All charges*
Durable medical equipment (DME)	
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; • Blood glucose monitors; and • Insulin pumps. Note: Call us at 800-833-7423 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.	In-Network: All of our allowable amounts up to the deductible amount and nothing thereafter Out of Network: 30% of our allowance after the calendar year deductible.
Not covered: *Motorized wheelchair, wigs (except as noted above), and upgrades to equipment.*	*All charges*

Benefit Description	You pay
Home health services	
• Home health care ordered by a Plan physician and provided by a registered nurse (R.N.), licensed practical nurse (L.P.N.), licensed vocational nurse (L.V.N.), or home health aide. • Services include oxygen therapy, intravenous therapy and medications.	In-Network: All of our allowable amounts up to the deductible amount and nothing thereafter Out of Network: 30% of our allowance after the calendar year deductible.
Not covered: • *Nursing care requested by, or for the convenience of, the patient or the patient's family;* • *Home care primarily for personal assistance that does not include a medical component and is not diagnostic, therapeutic, or rehabilitative.*	*All charges*
Chiropractic	
• Limited to 20 visits per calendar year • Manipulation of the spine and extremities • Adjunctive procedures such as ultrasound, electrical muscle stimulation, vibratory therapy, and cold pack application	In-Network: All of our allowable amounts up to the deductible amount and nothing thereafter Out of Network: 30% of our allowance after the calendar year deductible.
Alternative treatments	
No benefit	*All charges*
Not covered: • *Naturopathic services* • *Hypnotherapy* • *Biofeedback*	*All charges*
Educational classes and programs	
Coverage is provided for: • Diabetic outpatient self-management training and education • Health Education such as instructions on achieving and maintaining physical and mental health, and preventing illness and injury and childhood obesity education. • Nutritional counseling provided by a Registered Dietician or Participating Physician in connection with diabetes, coronary artery disease and hyperlipidemia.	In-Network: Nothing Out of Network: Not covered
Smoking cessation programs, including individual/group/telephone counseling, and for over the counter (OTC) and prescription drugs approved by the FDA to treat tobacco dependence.	Benefits are limited to two quit attempts per year. You pay nothing for OTC and prescription drugs approved by the FDA to treat tobacco dependence.

Benefit Description	You pay
Medical Clinical Trial	
If you are a participant in a clinical trial, we will provide related care if it is not provided by the clinical trial as follows: We provide coverage for Routine Patient Care Cost to a Member in a Medical Clinical Trial for randomized and controlled Phase III treatment of a life threatening disease, if such expenses are covered under this agreement, and we authorize them in advance. We provide coverage for Phase I and Phase II clinical trials and any randomized and controlled clinical trial for treatment of cancer that are sanctioned by the National Cancer Institute (NCI), or for the cost of any investigational drug. Treatment in a Medical Clinical Trial must be authorized in advance by us.	See coverage limitations based on setting (Inpatient, page 83; Outpatient, page 84; Home, page 68 and Office, page 68, etc.), and type of provider (Specialist care in office, hospital, etc.)

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

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan physicians must provide or arrange your care.
- The deductible is $2,000 for Self Only enrollment and $4,000 for Self and Family enrollment each calendar year. The Self and Family deductible can be satisfied by one or more family members. The deductible applies to almost all benefits in this Section.
- After you have satisfied your deductible, your Traditional medical coverage begins.
- Under your Traditional medical coverage, you will be responsible for your coinsurance amounts or copayments for eligible medical expenses and prescriptions.
- The amounts listed below are for the charges billed by a physician or other health care professional for your surgical care. Look in Section 5(c) for charges associated with the facility (i.e. hospital, surgical center, etc.).
- **YOUR PHYSICIAN MUST GET PRECERTIFICATION FOR SOME SURGICAL PROCEDURES.** Please refer to the precertification information shown in Section 3 to be sure which services require precertification and identify which surgeries require precertification.

Benefit Description	You pay
Surgical procedures	
A comprehensive range of services, such as: • Operative procedures • Treatment of fractures, including casting • Normal pre-and-post-operative care by the surgeon • Correction of amblyopia and strabismus • Endoscopy procedures • Biopsy procedures • Removal of tumors and cysts • Correction of congenital anomalies (see *Reconstructive surgery)* • Surgical treatment of morbid obesity (bariatric surgery) - 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. - When we approve, we provide coverage for treatment of morbid obesity through gastric bypass surgery or another surgical method that is recognized by the National Institutes of Health as effective for the long-term reversal of morbid obesity and consistent with criteria approved by the National Institutes of Health. - We provide benefits like any other medically necessary surgical procedure for Members whose body mass index is greater than 40 kilograms per meter squared, or equal to or greater than 35 kilograms per meter squared with a comorbid medical condition including hypertension, cardiopulmonary condition, sleep apnea or diabetes. - Body mass index is calculated by dividing the Member's weight in kilograms by the Member's height in meters squared.	In-Network: All of our allowable amounts up to the deductible amount and nothing thereafter Out of Network: 30% of our allowance after the calendar year deductible.

Surgical procedures - continued on next page

Benefit Description	You pay
Surgical procedures (cont.)	
• Insertion of internal prosthetic devices . See 5(a) *Orthopedic and prosthetic devices* for device coverage information • Voluntary sterilization (e.g., tubal ligation, vasectomy) • Treatment of burns Note: Generally, we pay for internal prostheses (devices) according to where the procedure is done. For example, we pay Hospital benefits for a pacemaker and Surgery benefits for insertion of the pacemaker.	In-Network: All of our allowable amounts up to the deductible amount and nothing thereafter Out of Network: 30% of our allowance after the calendar year deductible.
Not covered: • *Reversal of voluntary sterilization* • *Routine treatment of conditions of the foot; see Foot care*	*All charges*
Reconstructive surgery	
• Surgery to correct a functional defect • Surgery to correct a condition caused by injury or illness if: - the condition produced a major effect on the member's appearance and - the condition can reasonably be expected to be corrected by such surgery • Surgery to correct a condition that existed at or from birth and is a significant deviation from the common form or norm. Examples of congenital anomalies are: protruding ear deformities; cleft lip; cleft palate; birth marks; and webbed fingers and toes. • All stages of breast reconstruction surgery following a mastectomy, such as: - surgery to produce a symmetrical appearance of breasts; - treatment of any physical complications, such as lymphedemas; - breast prostheses and surgical bras and replacements (see Prosthetic devices) Note: If you need a mastectomy, you may choose to have the procedure performed on an inpatient basis and remain in the hospital up to 48 hours after the procedure.	In-Network: All of our allowable amounts up to the deductible amount and nothing thereafter Out of Network: 30% of our allowance after the calendar year deductible.
Not covered: • *Cosmetic surgery – any surgical procedure (or any portion of a procedure) performed primarily to improve physical appearance through change in bodily form, except repair of accidental injury* • *Surgeries related to sex transformation*	*All charges*

Benefit Description	You pay
Oral and maxillofacial surgery	
Oral surgical procedures, limited to: • Reduction of fractures of the jaws or facial bones; • Surgical correction of cleft lip, cleft palate or severe functional malocclusion; • Removal of stones from salivary ducts; • Excision of leukoplakia or malignancies; • Excision of cysts and incision of abscesses when done as independent procedures; and • Other surgical procedures that do not involve the teeth or their supporting structures. • TMJ related services (non-dental)	In-Network: All of our allowable amounts up to the deductible amount and nothing thereafter Out of Network: 30% of our allowance after the calendar year deductible.
Not covered: • *Oral implants and transplants* • *Procedures that involve the teeth or their supporting structures (such as the periodontal membrane, gingiva, and alveolar bone)*	*All charges*
Organ/tissue transplants	
These solid organ transplants are subject to medical neccessity and experimental/investigational review by the Plan. Refer to *Other services* in Section 3 for prior authorization procedures. Transplant services must be performed at a participating Center of Excellence. We approve and designate where all transplants must be performed including hospitals for specific transplant procedures. If you would like to know about a specific facility, please contact Customer Service. Solid organ transplants imited to: • Cornea • Heart • Heart/lung • Single, double or lobar lung • Kidney • Kidney/Pancreas • Liver • Pancreas • Autologous pancreas islet cell transplant (as an adjunct to total or near total pancreatectomy) only for patients with chronic pancreatitis • Intestinal transplants - Small intestine - Small intestine with the liver - Small intestine with multiple organs, such as the liver, stomach, and pancreas	In-Network: All of our allowable amounts up to the deductible amount and nothing thereafter Out of Network: 30% of our allowance after the calendar year deductible.

Organ/tissue transplants - continued on next page

Benefit Description	You pay
Organ/tissue transplants (cont.)	
Blood or marrow stem cell transplants limited to the stages of the following diagnoses: (the medical necessity limitation is considered satisfied if the patient meets the staging description) • Allogeneic transplants for - Acute lymphocytic or non-lymphocytic (i.e., myelogeneous) leukemia - Chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL) - Advanced Hodgkin's lymphoma with reoccurence - Advanced non-Hodgkin's lymphoma with reoccurence - Marrow failure and related disorders (i.e. Fanconi's PNH, pure red cell aplaisia) - Chronic myleogenous leukemia - Hemoglobinopathies - Myelodysplasia/Myelodysplastic syndromes - Severe combined immunodeficiency - Severe or very severe aplastic anemia - Amyloidosis - Paroxysmal Nocturnal Hemoglobinuria • Autologous transplant for - Acute lymphocytic or nonlymphocytic (i.e., myelogenous) leukemia - Advanced Hodgkin's lymphoma with reoccurence - Advanced non-Hodgkin's lymphoma with reoccurence - Neuroblastoma - Amyloidosis • Autologous tandem transplants for - Recurrent germ cell tumors (including testicular cancer) - Multiple myeloma - Denovo myeloma Blood or marrow stem cell transplants for • Allogeneic transplants for - Phagocytic/Hemophagocytic deficiency diseases (e.g., Wiskott-Aldrich syndrome) - Advanced neuroblastoma - Infantile malignant osteoporosis - Kostmann's syndrome - Leukocyte adhesion deficiencies - Mucolipidosis (e.g., Gaucher's disease, metachromatic leukodystrophy, adrenoleukodystrophy)	In-Network: All of our allowable amounts up to the deductible amount and nothing thereafter Out of Network: 30% of our allowance after the calendar year deductible.

Organ/tissue transplants - continued on next page

Benefit Description	You pay
Organ/tissue transplants (cont.)	
- Mucopolysaccharidosis (e.g., Hunter's syndrome, Hurler's syndrome, Sanfilippo's syndrome, Maroteaux-Lamy syndrome variants) - Myeloproliferative disorders - Sickle cell anemia - X-linked lymphoproliferative syndrome	In-Network: All of our allowable amounts up to the deductible amount and nothing thereafter Out of Network: 30% of our allowance after the calendar year deductible.
Autologous transplants for - Multiple myeloma - Testicular, mediastinal, retroperitoneal, and ovarian germ cell tumors - Breast cancer - Epithelial ovarian cancer - Ependymoblastoma - Ewing 's sarcoma - Medulloblastoma - Pineoblastoma - Waldenstrom's macroglobulinemia	In-Network: All of our allowable amounts up to the deductible amount and nothing thereafter Out of Network: 30% of our allowance after the calendar year deductible.
Mini-transplants (nonmyeloblative, reduced intensity conditioning) for covered tranplants: Subject to medical necessity. Refer to *Other services* in Section 3 for prior authorization procedures.	In-Network: All of our allowable amounts up to the deductible amount and nothing thereafter Out of Network: 30% of our allowance after the calendar year deductible.
Tandem transplants for covered transplants: Subject to medical necessity. Refer to *Other services* in Section 3 for prior authorization procedures.	In-Network: All of our allowable amounts up to the deductible amount and nothing thereafter Out of Network: 30% of our allowance after the calendar year deductible.
These blood or marrow stem cell transplants covered only in a National Cancer Institute or National Institutes of Health approved clinical trial at a Plan-designated center of excellence and if approved by the Plan's medical director in accordance with the Plan's protocols. If you are a participant in a clinical trial, the Plan will provide benefits for related routine care that is medically neccessary (such as doctor visits, lab tests, x-rays and scans, and hospitalization related to treating the patient's condition) if it is not provided by the clinical trial. Section 9 has additional information on costs related to clinical trials. We encourage you to contact the Plan to discuss specific services if you participate in a clinical trial. • Allogeneic transplants for - Chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL) - Hemoglobinopathies - Early stage (indolent or non-advanced) small cell lymphocytic lymphoma	In-Network: All of our allowable amounts up to the deductible amount and nothing thereafter Out of Network: 30% of our allowance after the calendar year deductible.

Organ/tissue transplants - continued on next page

Benefit Description	You pay
Organ/tissue transplants (cont.)	
- Myelodysplasia/Myelodysplastic syndromes - Multiple myeloma - Multiple sclerosis • Nonmyeloablative allogeneic transplants or Reduced intensity conditioning (RIC) for - Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia - Myelodysplasia/Myelodysplastic syndromes - Advanced Hodgkin's lymphoma with reoccurrence - Advanced non-Hodgkin's lymphoma with reoccurrence - Breast cancer - Chronic lymphocytic leukemia - Chronic myelogenous leukemia - Colon cancer - Early stage (indolent or non-advanced) small cell lymphocytic lymphoma - Chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL) - Multiple myeloma - Multiple sclerosis - Myeloproliferative disorders - Non-small cell lung cancer - Ovarian cancer - Prostate cancer - Renal cell carcinoma - Sarcomas - Sickle Cell disease	In-Network: All of our allowable amounts up to the deductible amount and nothing thereafter Out of Network: 30% of our allowance after the calendar year deductible.
• Autologous transplants for - Chronic lymphocytic leukemia - Chronic myelogenous leukemia - Early state (indolent or non-advanced) small cell lymphonic lymphoma - Chronic lymphocytic lymphoma/small lymphocytic lymphoma (CLL/SLL) - Small cell lung cancer - Multiple sclerosis - Systemic lupus erythematosus - Systemic sclerosis • National Transplant Program (NTP) -	In-Network: All of our allowable amounts up to the deductible amount and nothing thereafter Out of Network: 30% of our allowance after the calendar year deductible.

Organ/tissue transplants - continued on next page

Benefit Description	You pay
Organ/tissue transplants (cont.)	
Note: We cover related medical and hospital expenses of the donor when we cover the recipient. We cover donor testing for the acutal solid organ donor or up to four bone marrow/stem cell transplant donors in addition to the testing of family members.	In-Network: All of our allowable amounts up to the deductible amount and nothing thereafter Out of Network: 30% of our allowance after the calendar year deductible.
Not covered: • *Implants of artificial organs* • *Transplants not listed as covered*	*All charges*
Anesthesia	
Professional services provided in – • Hospital (inpatient)	In-Network: All of our allowable amounts up to the deductible amount and nothing thereafter Out of Network: 30% of our allowance after the calendar year deductible.
Professional services provided in – • Hospital outpatient department • Skilled nursing facility • Ambulatory surgical center • Office	In-Network: All of our allowable amounts up to the deductible amount and nothing thereafter Out of Network: 30% of our allowance after the calendar year deductible.

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

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions , limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary .
- Plan physicians must provide or arrange your care and you must be hospitalized in a Plan facility.
- The deductible is $2,000 for Self Only enrollment and $4,000 for Self and Family enrollment each calendar year. The Self and Family deductible can be satisfied by one or more family members. The deductible applies to all benefits in this Section.
- After you have satisfied your deductible, your Traditional medical coverage begins.
- Under your Traditional medical coverage, you will be responsible for your coinsurance amounts or copayments for eligible medical expenses and prescriptions.
- Be sure to read Section 4, *Your costs for covered services* for valuable information about how cost-sharing works. Also, read Section 9 about coordinating benefits with other coverage, including with Medicare.
- The amounts listed below are for the charges billed by the facility (i.e., hospital or surgical center) or ambulance service for your surgery or care. Any costs associated with the professional charge (i. e., physicians, etc.) are in Sections 5(a) or (b).
- **YOUR PHYSICIAN MUST GET PRECERTIFICATION FOR HOSPITAL STAYS.** Please refer to Section 3 to be sure which services require precertification.

Benefit Description	You pay
Inpatient hospital	
Room and board, such as • Ward, semiprivate, or intensive care accommodations; • General nursing care; and • Meals and special diets. Note: If you want a private room when it is not medically necessary, you pay the additional charge above the semiprivate room rate.	In-Network: All of our allowable amounts up to the deductible amount and nothing thereafter Out of Network: 30% of our allowance after the calendar year deductible.
Other hospital services and supplies, such as: • Operating, recovery, maternity, and other treatment rooms • Prescribed drugs and medicines • Diagnostic laboratory tests and X-rays • Blood or blood plasma, if not donated or replaced • Dressings , splints , casts , and sterile tray services • Medical supplies and equipment, including oxygen • Anesthetics, including nurse anesthetist services • Take-home items • Medical supplies, appliances, medical equipment, and any covered items billed by a hospital for use at home (Note: calendar year deductible applies.)	In-Network: All of our allowable amounts up to the deductible amount and nothing thereafter Out of Network: 30% of our allowance after the calendar year deductible.
Not covered: • *Custodial care*	*All charges*

Inpatient hospital - continued on next page

Benefit Description	You pay
Inpatient hospital (cont.)	
• *Non-covered facilities, such as nursing homes, schools* • *Personal comfort items, such as telephone, television, barber services, guest meals and beds* • *Private nursing care*	*All charges*
Outpatient hospital or ambulatory surgical center	
• Operating, recovery, and other treatment rooms • Prescribed drugs and medicines • Diagnostic laboratory tests, X-rays , and pathology services • Administration of blood, blood plasma, and other biologicals • Pre-surgical testing • Dressings, casts , and sterile tray services • Medical supplies, including oxygen • Anesthetics and anesthesia service Note: We cover hospital services and supplies related to dental procedures when necessitated by a non-dental physical impairment. We do not cover the dental procedures.	In-Network: All of our allowable amounts up to the deductible amount and nothing thereafter Out of Network: 30% of our allowance after the calendar year deductible.
Not covered: Blood and blood derivatives not replaced by the member	*All charges*
Extended care benefits/Skilled nursing care facility benefits	
Covered up to 100 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.	In-Network: All of our allowable amounts up to the deductible amount and nothing thereafter Out of Network: 30% of our allowance after the calendar year deductible.
Not covered: Custodial care	*All charges*
Hospice care	
Authorized within the service area for 30 days of inpatient care per member. Includes the following: • Part-time nursing care by or supervised by a registered graduate nurse; • Counseling, including dietary counseling, for the terminally ill Member, • Family counseling for the Immediate Family and the Family Caregiver before the death of the terminally ill Member; • Bereavement counseling for the Immediate Family or Family Caregiver of the Member for at least the 6-month period following the Member's death or 15 visits, whichever occurs first; • Respite Care subject to the following: - The annual benefit shall be at least 14 days; and - The carrier may limit any one inpatient stay for Respite Care to 5 consecutive days; and Medical supplies, equipment, and medication required to maintain the comfort and manage the pain of the terminally ill Member.	In-Network: All of our allowable amounts up to the deductible amount and nothing thereafter Out of Network: 30% of our allowance after the calendar year deductible.

Hospice care - continued on next page

Benefit Description	You pay
Hospice care (cont.)	
Not covered: Independent nursing, homemaker services	*All charges*
Ambulance	
Local professional ambulance service when medically appropriate	$100 copayment after the deductible

Section 5(d). Emergency services/accidents

Important things you should keep in mind about these benefits:

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

What is a medical emergency?

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

What to do in case of emergency:

In a life-threatening emergency, call the local emergency system (e.g. the local 911 telephone system), or go to the nearest emergency facility. If an ambulance comes, tell the paramedics that the person who needs help is a Coventry Health Care member.

Emergencies within our service area:

When a need for Emergency Services occurs in the Service Area, a member should seek medical attention immediately from a hospital, physician's office or other emergency facility. The determination of covered benefits for services rendered in an emergency facility is based on our review of the member's emergency room medical records, along with those relevant symptoms and circumstances that preceded the provision of care. Services provided by an emergency facility for non-Emergency Services are not covered except if you are directed to an emergency room by us or a physician and the care is deemed not to be an emergency. Coverage will also be provided for Emergency Services in cases where you do not have 24-hour access to a physician, even if those services are deemed not to be an emergency.

Emergencies outside our service area:

The member may be transported from outside the service area to the service area for continued medical management of an emergency services condition at the option of the Medical Director or Medical Director's Designee. We will only exercise this option when the Medical Director or Medical Director's Designee decides that such action will not have a detrimental effect on the Member's medical condition. Ground ambulance transportation to return a member to a participating provider is covered when authorized by us. Refusal to be transferred may result in loss of benefits.

Benefit Description	You pay
Emergency within our service area	
• Emergency care at a doctor's office • Emergency care at an urgent care center • Emergency care as an outpatient in a hospital, including doctors' services Note: We waive the ER copay if you are admitted to the hospital.	$100 copayment
Not covered: Elective care or non-emergency care	*All charges*
Emergency outside our service area	
• Emergency care at a doctor's office • Emergency care at an urgent care center • Emergency care as an outpatient in a hospital, including doctors' services Note: We waive the ER copay if you are admitted to the hospital.	$100 copayment
Not covered: • *Elective care or non-emergency care and follow-up care recommended by non-Plan providers that has not been approved by the Plan or provided by Plan providers* • *Emergency care provided outside the service area if the need for care could have been foreseen before leaving the service area* • *Medical and hospital costs resulting from a normal full-term delivery of a baby outside the service area*	*All charges*
Ambulance	
Professional ambulance service when medically appropriate. Note: See 5(c) for non-emergency service.	$100 copayment
Not covered: Air ambulance	*All charges*

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

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

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- The calendar year deductible or, for facility care, the inpatient deductible, applies to almost all benefits in this Section. We added "(No deductible)" to show when a deductible does not apply.
- Be sure to read Section 4, *Your costs for covered services,* for valuable information about how cost-sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- **YOU MUST GET PREAUTHORIZATION FOR THESE SERVICES.** Benefits are payable only when we determine that care is clinically appropriate to treat your condition and only when you receive the care as part of a treatment plan that we approve. The treatment plan may include services, drugs, and supplies described elsewhere in this brochure. To be eligible to receive full benefits, you must follow the preauthorization process and get Plan approval of your treatment plan. We will provide medical review criteria or reasons for treatment plan denials to enrollees, members or providers upon request or as otherwise required.
- OPM will base its review of disputes about treatment plans on the treatment plan's clinical appropriateness. OPM will generally not order us to pay or provide one clinically appropriate treatment plan in favor of another.

Benefit Description	You pay
Professional services	
When part of a treatment plan we approve, we cover professional services by licensed professional mental health and substance abuse practioners when acting within the scope of their license, such as psychiatrists, psychologists, clinical social workers, licensed professional counselors, or marriage and family therapists. Diagnosis and treatment of psychiatric conditions, mental illness, or mental discorders. Services include: • Diagnostic evaluation • Crisis intervention and stabilization for acute episodes • Medication evaluation and management (pharmacotherapy) • Pyschological and neuropsychological testing necessary to determine the appropriate psychiatric treatment • Treatment and counseling (including individual or group therapy visits) • Diagnostic and treatment of alcoholism and drug abuse, including detoxification, treatment and counseling • Professional charges for intensive outpatient treatment in a provider's office or other professional setting • Electroconvulsive therapy	Your cost-sharing responsibilities are no greater than for other illnesses or conditions

Benefit Description	You pay
Diagnostics	
Outpatient diagnostic tests provided and billed by a licensed mental health and substance abuse practitioner Outpatient diagnostic tests provided and billed by a laboratory, hospital or other covered facility Inpatatient diagnostic tests provided and billed by a hospital or other covered facility	In-Network: All of our allowable amounts up to the deductible amount and nothing thereafter Out of Network: 30% of our allowable after the calendar year deductible Nothing for inpatient tests
Inpatient hospital or other covered facility	
Inpatient services provided and billed by a hospital or other covered facility • Room and board, such as semiprivate or intensive accommodations, general nursing care, meals and special diets, and other hospital services	In-Network: All of our allowable amounts up to the deductible amount and nothing thereafter Out of Network: 30% of our allowable after the calendar year deductible
Outpatient hospital or other covered facility	
Outpatient services provided and billed by a hospital or other covered facility • Services in approved treatment programs, such as partial hospitalization, half-way house, residential treatment, full-day hospitalization, or facility-based intensive outpatient treatment *Not covered: Services we have not approved*	In-Network: Nothing for services provided in an out-patient setting Out of Network: 30% of our allowable after the calendar year deductible

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 CHCDE 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 by MHNet at 866-808-2808 or 800-862-2244 (for the deaf and hard of hearing).
Limitation	We may limit your benefits if you do not obtain a treatment plan.

Section 5(f). Prescription drug benefits

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

- We cover prescribed drugs and medications, as described in the chart beginning on the next page.
- Please remember that all benefits are subject to the definitions, limitations and exclusions in this brochure and are payable only when we determine they are medically necessary.
- The deductible is $2,000 for Self Only enrollment and $4,000 for Self and Family enrollment each calendar year. The Self and Family deductible can be satisfied by one or more family members. The deductible applies to all benefits in this Section.
- After you have satisfied your deductible, your Traditional medical coverage begins.
- Under your Traditional medical coverage, you will be responsible for your coinsurance amounts for eligible medical expenses or copayments for eligible prescriptions.
- Be sure to read Section 4, *Your costs for covered services,* for valuable information about how cost-sharing works. Also, read Section 9 about coordinating benefits with other coverage, including with Medicare.

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

- **Who can write your prescription.** You may obtain a prescription from a prescribing physician or other health care professional who is licensed and who, in the usual course of business, may legally prescribe prescription drugs.
- **Where you can obtain them.** You may fill the prescription at a participating pharmacy, including a participating mail order or specialty pharmacy, except for Emergency or Urgent Care Services, out of the service area. A “specialty pharmacy” is a pharmacy from which you may obtain self-administered injectable drugs. You may obtain maintenance medication through Medco Health Solutions, our mail order prescription program. Medco's Customer Service number is 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 may be included in the formulary. If you would like information on whether a specific drug is included in our drug formulary, please call our Customer Service Department at 302-283-6500 within our service area or 800-833-7423.
- **We have an open formulary.** If your physician believes a name brand product is necessary or there is no generic available, your physician may prescribe a name brand drug from a formulary list. This list of name brand drugs is a preferred list of drugs that we selected to meet patient needs at a lower cost. To order a prescription drug brochure, call 800-833-7423.
- **There are dispensing limitations.** These are the dispensing and quantity limitations. **Prescription drugs will be dispensed in the quantity determined by Us.** In order for Prescription Drugs to be covered in excess of the specific quantity limit, your physician must call Us before you fill the Prescription Order or Refill for a drug that exceeds the specific quantity limit.

Dispensing limits are described below:

Retail Drugs

In general, the quantity of a Prescription Drug dispensed by a Retail Pharmacy for each Prescription Order or Refill is limited to the lesser of:

- The amount determined by Us to be a 30-day supply
- The amount prescribed in the Prescription Order or Refill; or

- Depending on the form and packaging of the product, the following:
  - 100 tablets/capsules, or
  - 480 cc of oral liquids; or
  - A single commercially prepackaged item (including but not limited to inhalers, topicals, and vials).

Mail Order Drugs

The quantity of a Prescription Drug dispensed by the Mail Order Pharmacy for one Prescription Order or Refill for a Maintenance Drug is limited to the lesser of:

- The amount prescribed in the Prescription Order or Refill; or
- The amount determined by Us to be Medically Necessary; or
- The amount determined by Us to be a 90-day supply; or
- Depending on the form and packaging of the product, the following:
  - 300 tablets/capsules, or
  - 1,440 cc of oral liquids; or
  - three (3) single commercially prepackaged items (including but not limited to inhalers, topicals, and vials).

The following Member payments shall apply:

1. One (1) copayment (i.e. $5 for generic prescriptions; $30 for preferred brand name prescriptions, $60 for non-preferred brand name prescriptions) or the cost of the prescription drug, whichever is less, is due each time a prescription is filled or refilled at a retail or specialty pharmacy.
2. Formulary maintenance drugs obtained through a mail order pharmacy designated by the Health Plan may be dispensed with two (2) copayments for a ninety- (90) day's supply (i.e. $10 copayment for generic prescriptions; $60 for preferred brand name prescriptions). Non-preferred brand name prescriptions are not available by mail order. **To order prescription drugs or refills please contact Medco's Customer Service at 800-378-7040. This service is available 24 hours a day – 7 days a week.**
3. Total member payments shall not exceed the price of the prescription drug. Copayments and Ancillary Charges do not apply do the member's Out-of-Pocket Maximum.

A generic equivalent will be dispensed if it is available. If the brand name prescription drug is dispensed and an equivalent generic prescription drug is available, the member shall pay an "ancillary charge" in addition to the brand name copayment. The ancillary charge will be due regardless of whether or not the prescribing physician indicates that the pharmacy is to "Dispense as Written." **The Ancillary Charge is the difference between the price of the brand name and generic.**

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.

- You can save money by using generic drugs. However, you and your physician have the option to request a name brand if a generic option is available. Using the most cost-effective medication saves money.

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. To file a pharmacy claim, call Medco at 800-378-7040.

Benefit Description	You pay
Covered medications and supplies	
We cover the following medications and supplies prescribed by a Plan physician and obtained from a Plan pharmacy or through our mail order program: • Drugs and medicines that by Federal law of the United States require a physician's prescription for their purchase, except those listed as *Not covered.* • Insulin • Disposable needles and syringes for the administration of covered medications • Drugs for sexual dysfunction (see prior authorization below) • Contraceptive drugs and devices Self-Administered injectable Prescription that include but are not limited to the following: multiple sclerosis agents, growth hormones, colony stimulating factors given more than once monthly, chronic medications for hepatitis C, certain rheumatoid arthritis medications, certain injectable HIV drugs, certain osteoporosis agents, and heparin products. Self Administered Injectable drugs are only available through Specialty Pharmacies. The following are not considered Self-Administered Injectable Drugs because they are not obtained from a Specialty Pharmacy: insulin, glucagon, and bee sting kits, Imitrex and injectable contraceptives.	Note: If there is no generic equivalent available, you will still have to pay the name brand copay. **In-Network: you pay all charges up to the calendar year deductible and then the below copays thereafter.** **Retail and Specialty Pharmacy:** $15 per prescription or refill for generic formulary drugs; $30 per prescription or refill for formulary drugs (brand name) $60 per prescription or refill for non-formulary drugs (brand or generic non-formulary name) **Mail Order (Maintenance drugs only):** $30 per prescription or refill for a 90 consecutive day supply for maintenance generic drugs; $60 per prescription or refill for a 90 consecutive day supply for maintenance preferred drugs (brand name drugs) $120 per prescription or refill for non-formulary drugs (brand or generic non-formulary name) **Out-of-Network: Not Covered**
Not covered: • *Compounded prescriptions whose only ingredients do not require prescription* • *Legend drugs for which there is a non-prescription equivalent such as vitamins, except legend prenatal vitamins for pregnant/ nursing females, liquid or chewable legend pediatric vitamins for children under age 13, and potassium supplements to prevent/treat low potassium* • *Prescription Drugs and supplies for cosmetic purposes* • *Drugs to enhance athletic performance* • *Dietary supplements, appetite suppressants, and other drugs used to treatment obesity or assist in weight reduction* • *Drugs obtained at a non-Plan pharmacy; except for out-of-area emergencies* • *Vitamins, nutrients and food supplements even if a physician prescribes or administers them, except as specified herein* • *Nonprescription medicines* • *Charges for special re-packaging of medications prepared by the pharmacy such as "unit dose" or "bubble pack"* • *Oral dental preparations, fluoride rinses, except fluoride tablets or drops*	*All charges*

Covered medications and supplies - continued on next page

Benefit Description	You pay
Covered medications and supplies (cont.)	
• *Refill prescriptions resulting from loss or theft* Note: Over-the-counter and prescription drugs approved by the FDA to treat tobacco dependence are covered under the Smoking cessation benefit. (see Educational classes and Programs, page 74).	*All charges*

Section 5(g). Dental benefits

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- If you are enrolled in a Federal Employees Dental /Vision Insurance Program (FEDVIP) Dental plan, your FEHB Plan will be First/Primary payor of any Benefit payments and your FEDVIP Plan is secondary to your FEHB Plan. See Section 9 Coordinating benefits with other coverage.
- Plan dentists must provide or arrange your care.
- The deductible is $2,000 for Self Only enrollment and $4,000 for Self and Family enrollment each calendar year. The Self and Family deductible can be satisfied by one or more family members. The deductible applies to all benefits in this Section.
- After you have satisfied your deductible, your Traditional medical coverage begins.
- Under your Traditional medical coverage, you will be responsible for your coinsurance amounts and copayments for eligible medical expenses and prescriptions.
- We cover hospitalization for dental procedures only when a non-dental physical impairment exists which makes hospitalization necessary to safeguard the health of the patient. See Section 5(c) for inpatient hospital benefits. We do not cover the dental procedure unless it is described below.
- Be sure to read Section 4, *Your costs for covered services,* for valuable information about how cost-sharing works. Also, read Section 9 about coordinating benefits with other coverage, including with Medicare.

Accidental injury benefit	You Pay
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.	Nothing after the deductible

Dental benefits	
We have no other dental benefits	*All charges*

Section 5(h). Special features

Feature	Description
Feature	
Flexible benefits option	Under the flexible benefits option, we determine the most effective way to provide services. • 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 and extension of the time period, but regular benefits will resume if we do not approve your request. • Our decision to offer or withdraw alternative benefits is not suject to OPM review under the disputed claims process.
Wellness Programs	Coventry Health Care, Inc. offers an on-line wellness program called *Wellbeing*. Wellbeing is a free service available only to Coventry Health Care members. This on-line tool available through our website, www.chcde.com/wellbeing. This program allows Coventry members to utilize the MyEPHIT tool to develop a customized exercise, nutrition or personal improvement program with the assistance of on-line fitness experts. This online Personal Health Improvement Training program is designed to enhance your overall Wellbeing. Through Wellbeing, you can: • Customize a daily fitness routine, including on-line demonstrations of specific exercises. • Personalize a nutrition plan, including receiving a meal planner with menus and shopping lists. • Download materials on life skills management, and family activity planning. • Communicate on-line with a Certified personal trainer, registered dieticians, and psychologists. • Download recipes for healthy menus. • Discover online family programs through KidPHIT and TeenPHIT, which allows your children to become motivated for a healthier lifestyle. • Earn REWARDS! Through the Wellbeing program, just by signing on every month, you will be entered into a monthly drawing for prizes such as mountain bikes, DVD players, and other fitness related prizes! • Earn points towards the purchase of discounted fitness items. Through the online My EPHIT Mall, members can use the points they earn on the website to purchase items such as Yoga Mats, vitamins, or workout videos.

Feature - continued on next page

Feature	Description
Feature (cont.)	
Travel benefit/services overseas	Your Benefit Plan does not include out-of-network benefits, however; if you are out of our service area and in need of Urgent or Emergent Care; please call 1-800-639-9154 for a First Health network provider in your area.

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

Special features	Description
Health education resources	Visit the Health Information section of our website at www.chcde.com for information to help you take command of your health. The site is organized in simple, user-friendly, sections: ***Assess Your Health*** **-** where you will find a simple, free, online health risk assessment tool to benchmark your wellness, and better understand your overall health status and risks. ***About Your Health*** **-** for information about a specific condition or general preventive guidelines. ***WebMD*** **-** our link to this health site also provides wellness and disease information to help improve health. ***Prescription Drug*** - educational materials are also accessible through our website, through a link to our pharmacy benefit manager, Caremark. There, you will find: • Detailed information about a wide range of prescription drugs; • A drug interaction tool to help easily determine if a specific drug can have any adverse interactions with each other, with over-the-counter drugs, or with herbals and vitamins; • Facts about why FDA-approved generic drugs should be a first choice for effective, economical treatment. Another key health information tool that we make available to you is our online quality tool, powered by HealthShareÒ. 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, postoperative complications, and even death rates. We also publish an e-newsletter to keep you informed on a variety of issues related to your good health. Visit our Web site at www.chcde.com for back editions of this publication, *Living Well*. In addition, we augment our health education tools with access to our ***Nurse Advisor Services***. Experienced RNs are available through an inbound call center 24x7x365 to assist you and help you to maximize your benefits, by providing clinical and economic information to make an informed decision on how to proceed with care.
Account management tools	For each HSA and HRA account holder, we maintain a complete claims payment history online through Coventry Health Care's password-protected, self-service functionality, My Online Services, at www.chcde.com. You will receive an *Explanation of Benefits* (EOB) after every claim. **If you have an HSA,** • You may also access your account on-line at www.chcde.com. **If you have an HRA,** • Your HRA balance will be available online through www.chcde.com • Your balance will also be shown on your EOB form
	• As a member of this HDHP, you may choose any provider. However, you will receive discounts when you see a network provider. Directories are available online at www.chcde.com.

Consumer choice information	• As a member of this HDHP, you may choose any provider. However, you will receive discounts when you see a network provider. Our provider search function on our website www.chcde.com is updated every week. It lets you easily search for a participating physician based on the criteria *you* choose, such as provider specialty, gender, secondary languages spoken, or hospital affiliation. You can even specify the maximum distance you are 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.chcde.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.chcde.com). Through a password-protected account, you will have the ability to estimate prescription costs before ordering. Educational materials on the topics of HSAs, HRAs and HDHPs are available at www.chcde.com. Pricing information for medical care is available at www.chcde.com. Pricing information for prescription drugs is available at www.chcde.com. Link to online pharmacy through www.chcde.com. Educational materials on the topics of HSAs, HRAs and HDHPs are available at www.chcde.com
Care support	• Our complex case management programs offer special assistance to members with intricate, long-term medical needs. Our disease management program fosters a proactive approach to managing care from prevention through treatment and management. Your physician can help arrange for participation in these programs, or you can simply contact our member service department. • Patient safety information is available online at www.chcde.com. Care support is also available to you, in the form of a relationship that we have established with the *College of American Pathologists* for e-mail reminder notifications. We will send a message to the e-mail address you provide on a scheduled basis, reminding you to arrange for screening tests.

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

The exclusions in this section apply to all benefits. There may be other exclustions 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.**

We do not cover the following:

- Care by non-plan providers except for authorized referrals or emergencies (see *Emergencyservices/accidents*);
- Services, drugs, or supplies you receive while you are not enrolled in this Plan;
- Services, drugs, or supplies not medically necessary;
- Services, drugs, or supplies not required according to accepted standards of medical, dental, or psychiatric practice;
- Experimental or investigational procedures, treatments, drugs or devices (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; or
- Services, drugs, or supplies you receive without charge while in active military service.
- Extra care costs related to taking part in a clinical trial such as additional tests that a patient may need as part of the trial, but not as part of the patient's routine care.
- Research costs related to conducting the clinical trial such as research, physician and nurse time, analysis of results and clinical tests performed only for research purposes.

Section 7. Filing a claim for covered services

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 thses claims/requests and Section 10 for the definitions of these 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

To obtain claim forms or other claims filing advice or answers about our benefits, call our Customer Service Department at 302-283-6500 within the service area or 800-833-7423 or log on our Web site at www.chcde.com.

In most cases, providers and facilities file claims for you. Your physician must file on the form CMS-1500, Health Insurance Claim Form. Your facility must file on the UB-04 form. For claims questions and assistance, call us at 302-283-6500.

When you must file a claim – such as for services you receive outside of 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;
- A copy of the explanation of benefits, payment, or denial from any primary payor such as the Medicare Summary Notice (MSN); and
- The charge for each service or supply;
- Receipts, if you paid for your services. Note: Canceled checks, cash register receipts, or balance due statements are not acceptable substitutes for itemized bills.

Mail the claim to:

Medical & Hospital Benefits:

Coventry Health Care
PO Box 7712
London, KY 40742

Prescription Drugs:

Medco Health Solutions
P.O. Box 14711
Lexington, KY 40512
800-378-7040

Mental Health and Substance Abuse:

MHNet Behavioral Health
PO Box 209010
Austin, TX 78720

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, cleary mark it as "Urgent". Please contact our Customer Service Department at (800)-833-7423. 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 no 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 no 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 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 procedures

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 neccessary 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 procedures

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.
Overseas claims	For covered services, you receive in hospitals outside the United States and Puerto Rico and performed by physicians outside the United States, send a completed Overseas Claim Form and the itemized bills to: Coventry Health Care; PO Box 7712, London, KY 40742. Send any written inquiries concerning the processing of overseas claims to this address. Obtain Overseas Claim Forms from us by calling our Customer Service Department at 302-283-6500 within the service area or 800-833-7423.

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. Disagreements between you and the CDHP or 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 material and Plan documents under our control relating to your claim, including those that involve any expert review(s) of your claim.

Step	Description
1	Ask us in writing to reconsider our initial decision. You must: a) Write to us within 6 months from the date of our decision; and b) Send your request to us at: Coventry Health Care, 750 Prides Crossing, Suite 200, Newark, DE 19713 ; and c) Include a statement about why you believe our initial decision was wrong, based on specific benefit provisions in this brochure; and d) Include copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms. e) Include your email address (optional), if you would like to receive our decision via email. Please note that by providing your email address, you may be able to provide our decision quicker.
2	We have 30 days from the date we receive your request to: a) Pay the claim (or, if applicable, arrange for the health care provider to give you the care or precertify your hospital stay or grant your request for prior approval for a service, drug or supply); or b) Write to you and maintain our denial - go to step 4; or c) Ask you or your provider for more information. If we ask your provider, we will send you a copy of our request—go to step 3.
3	You or your provider must send the information so that we receive it within 60 days of our request. We will then decide within 30 more days. If we do not receive the information within 60 days, we will decide within 30 days of the date the information was due. We will base our decision on the information we already have. We will write to you with our decision. In the case of an appeal of an urgent care claim, we will notify you of our decision no later than 72 hours after receipt of your reconsideration request. We will hasten the review process, which allows oral or written request for appeals and the exchange of information by telephone, electronic mail, facisimile, or other expeditious methods.
4	If you do not agree with our decision, you may ask OPM to review it. You must write to OPM within • 90 days after the date of our letter upholding our initial decision; or • 120 days after you first wrote to us - if we did not answer that request in some way within 30 days; or • 120 days after we asked for additional information. Write to OPM at: United States Office of Personnel Management, Insurance Operations, Health Insurance 3 (HI3), 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 providing your email address, you may receive OPM's decision quicker.

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.

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

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

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

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

Note: **If you have a serious or life threatening condition** (one that may cause permanent loss of bodily functions or death if not treated as soon as possible), and you did not indicate that your claim was a claim for urgent care, then call us at 800-833-7423. We will hasten our review (if we have not yet responded to your claim); or we will inform OPM so they can quickly review your claim on appeal. You may call OPM's Health Insurance 3 (HI3) at 202-606-0737 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 do not sign up for Medicare Part B when you are first eligible, you may be charged a Medicare Part B late enrollment penalty of a 10% increase in premium for every 12 months you are not enrolled. If you didn't take Part B at age 65 because you were covered under FEHB as an active empleoyee (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.

- **Medicare prescription drug coverage (Part D)**

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

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

You must tell us if you or a covered family member has Medicare coverge, 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.

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 800-833-7423 or see our Web site at www.chcde.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.

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

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 do not have a 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 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 the program.

Workers' Compensation

We do not cover services that:

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

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

Medicaid

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

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

When other Government agencies are responsible for your care

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

When others are responsible for injuries

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

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

When you have Federal Employees Dental and Vision Insurance 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 you 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 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, 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, 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

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

- Routine care costs - costs for routine services such as doctor visits, lab tests, x-rays, 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.

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.

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.

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

Experimental or investigational services includes medical, surgical, diagnostic, psychiatric, substance abuse or other health care services, technologies, supplies, treatments, procedures, drug therapies or devices that, at the time the Health Plan makes a determination regarding coverage in a particular phase, is determined to be:

- Not approved by the U.S. Food and Drug Administration ("FDA") to be lawfully marketed for the proposed use and not identified in the *American Hospital Formulary Service*, the *United States Pharmacopoeia Dispensing Information*, or in the medical literature as appropriate for the proposed use; or
- Subject to review and approval by the institutional review board of the treating facility for the proposed use; or
- The subject of a written protocol used by the treating facility for research, clinical trials or other tests or studies to evaluate its safety, effectiveness, toxicity or efficacy, as evidenced in the protocol itself or in the written content form used by the treating facility; or
- Not demonstrated through prevailing peer-reviewed medical literature to be safe and effective for treating or diagnosing the condition or illness for which its use is proposed.

The Health Plan, in its judgment, may deem an Experimental Investigational or Unproven Service a Covered Health Service for treating a life threatening Sickness or condition if it is determined by the Plan that the Experimental, Investigational or Unproven Service at the time of the determination:

- Is safe with promising efficacy; and
- Is provided in a clinically controlled research setting; and

- Uses a specific research protocol that meets standards equivalent to those defined by the National Institute of Health.

(For the purpose of this definition, the term "life threatening" is used to describe Sickness or conditions that are more likely than not to cause death within one year of the date of the request for treatment.)

This definition does not include Covered Health Services in a Medical Clinical Trial.

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 Any service or supply for the prevention, diagnosis or treatment which is:

- consistent with Illness, Injury or condition of the Member; and
- according to the approved and generally accepted medical or surgical practice prevailing in the geographical locality where, and at the time when, the service or supply is ordered, and for a condition which is treatable and subject to clinical improvement with active medical intervention. Determination of "generally accepted practice" and "treatable" is at the discretion of the Medical Director or Designee. Upon disagreement between a Member and a Participating Physician as to the Medical Necessity of a particular service, the Medical Director or Designee shall make the final determination.

Plan allowance Our Plan allowance is the amount we use to determine our payment and your coinsurance for covered services. Fee-for-service plans determine their allowances in different ways.

Participating Provider

When services are rendered by a Participating Provider, payment will be made to the Provider for services rendered, based on the contract we have with the provider.

Non-Participating Provider

When services are rendered by a Non-Participating Provider, we will pay our Out-of-Network Plan Allowance for covered services. The Out-of-Network Plan Allowance is the maximum amount covered by Us for approved out-of-network services.

For more information, see *Differences between our allowance and the bill* in Section 4.

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 the regular time limit for non-urgent care claims could have one of the following impacts:

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

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

	If you believe your claim qualifies as an urgent care claim, please contact our Customer Service Department at (800) 833-7423. You may also prove that your claims 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.
You	You refers to the enrollee and each covered family member.

High Deductible Health Plan (HDHP) Definitions

Calendar year deductible	A deductible is a fixed amount of covered expenses you must incur covered services and supplies before we start paying benefits for those services, See Section 4.
Catastrophic limit	The maximum you will pay out of pocket before ALL services are covered at 100%. For the HDHP, the individual catastrophic limit is $4,000 for in-network services. For a family, the catastrophic limit is $8,000 for in-network services.

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 stepchildren 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 your marriage, divorce, annulment, or when your child under age 26 turns 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 responsiblity 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 extensio is entitled to continuation of the benefits of the Plan during the continuance of the confinement but not beyond the 60th day after the end of the 31 day temporary extension.

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

Upon divorce

If you are divorced from a Federal employee 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 compliment 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.

If you are a new or newly eligible employee you have 60 days from your hire date to enroll in an HCFSA or LEXHCFSA 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.

- **Health Care FSA (HCFSA)** – Reimburses you for eligible health care expenses (such as copayments, deductibles, insulin, products, physician prescribed over-the-counter medications, vision and dental expenses, and much more) for you and your tax dependents, including adult children (through the end of the calendar year in which they turn 26) which are not covered or reimbursed by FEHBP or FEDVIP coverage or any other insurance.
- **Limited Expense Health Care FSA (LEX HCFSA**) – Designed for employees enrolled in or covered by a High Deductible Health Plan with a Health Savings Account. Eligible expenses are limited to dental and vision care expenses for you and your tax dependents including adult children (through the end of the calendar year in which they turn 26)which are not covered or reimbursed by FEHBP or FEDVIP coverage or any other insurance.
- **Dependent Care FSA (DCFSA)** – Reimburses you for 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 an HCFSA or LEX HCFSA and/or DCFSA, but you must enroll before October 1. If you are hired or become eligible on or after October 1 you must wait and enroll during the Federal Benefits Open Season held each fall.

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

The Federal 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/vision and at www.opm.gov/insure/dental. 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 eligibe 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.

Summary of benefits for the High Option of Coventry Health Care - 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.

Benefits	You pay	Page
Medical services provided by physicians:		
Diagnostic and treatment services provided in the office	Office visit copay: $20 primary care; $40 specialist; preventive care services are covered at 100%	22
Services provided by a hospital:		
• **Inpatient**	$200 copayment per day up to a maximum of $600 per admission	40
• **Outpatient**	$150 per visit to an ambulatory surgical center; Charges for surgery in an outpatient department of a hospital covered at 100%	41
Emergency benefits:		
• **In-area**	$30 per urgent care visit; $150 per hospital emergency room visit	44
• **Out-of-area**	$30 per urgent care visit; $150 per hospital emergency room visit	44
Mental health and substance abuse treatment:	Your cost-sharing responsiblities are no greater than for other illnesses or conditions	45
Prescription drugs:		49
• Retail pharmacy	$5 for generic formulary $30 for formulary $60 for non-formulary	
• Mail order	$10 for generic formulary 90 day supply $60 for formulary 90 day supply $120 for non-formulary 90 day supply	
Dental care:	$20 PCP copayment or $40 Specialist co-payment; Nothing during a covered inpatient admission.	51
Protection against catastrophic costs (out-of-pocket maximum)**:**	Nothing after $1,000/Self Only or $3,000/ Family enrollment per year Some costs do not count toward this protection	18

Summary of benefits for the Standard Option of Coventry Health Care - 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.
- Below, an asterisk (*) means the item is subject to the $300 per individual, $600 per family calendar year deductible.

Standard Option Benefits	You Pay	Page
Medical services provided by physicians:		
Diagnostic and treatment services provided in the office	$20 PCP copayment or $40 Specialist copayment; preventive care services are covered at 100%	22
Services provided by a hospital:		
• Inpatient	$200 per day copay up to a maximum of $600 per admission copay	40
• Outpatient	20% coinsurance*	41
Emergency benefits:		
• In-area	20% coinsurance*	44
• Out-of-area	20% coinsurance*	44
Mental health and substance abuse treatment:	Your cost-sharing responsibilities are no greater than for other illnesses or conditions	45
Prescription drugs:		49
• Retail pharmacy	$15 for generic formulary $30 for formulary $60 for non-formulary	
• Mail order	$30 for generic 90 day supply $60 for formulary 90 day supply $120 for non-formulary 90 day supply	
Dental care:	$20 PCP copayment or $40 Specialist copayment; Nothing during a covered inpatient admission.	51
Protection against catastrophic costs (out-of-pocket maximum)**:**	Nothing after $3,000/Self Only or $9,000/ Family enrollment per year Some costs do not count toward this protection	18

Summary of benefits for the HDHP of Coventry Health Care - 2011

Do not rely on this chart alone. All benefits are subject to the definitions, limitations, and exclusions in this prochure. 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 $41.67 per month for Self Only enrollment or $83.34 per month for Self and Family enrollment to your HSA. For the Health Savings Account (HSA), you must satisfy your calendar year deductible of $2,000 for Self only and $4,000 for Self and Family before using your HSA. Once you satisfy your calendar year deductible, Traditional medical coverage begins.

For the Health Reimbursement Arrangement (HRA), your health charges are applied to you annual HRA Fund of $500 for Self Only and $1,000 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.

Benefits	You pay	Page
In-network medical preventive care	In-Network: $0 copayment (no deductible) Out-of-Network: 30% of our allowance after the calendar year deductible	65
Medical services provided by physicians:		68
Treatment for illness or injury provided in the office	In-Network: All of our allowable amounts up to the deductible amount and nothing thereafter Out-of-Network: 30% of our allowance after the calendar year deductible	68
Services provided by a hospital:		83
• Inpatient	In-Network: All of our allowabel amounts up to the deductible amount and nothing thereafter Out-of-Network: 30% of our allowance after the calendar year deductible	83
• Outpatient	In-Network: All of our allowable amounts up to the deductible amount and nothing thereafter Out-of-Network: 30% of our allowance after the calendar year deductible	84
Emergency benefits:		86
• In-area	$100 copayment after the calendar year deductible	87
• Out-of-area	$100 copayment after the calendar year deductible	87
Mental health and substance abuse treatment:	Your cost-sharing responsiblities are no greater than for other illnesses or conditions	88
Prescription drugs:		90
• Retail pharmacy	$15 for generic formulary $30 for formulary	92

	$60 for non formulary	
• Mail order	$30 for generic formulary $60 for formulary $120 for non formulary	96
Dental care:	In-network: nothing after the calendar year deductible Out-of-network: 30% of our allowance after the calendar deductible	94
Protection against catastrophic costs (out-of-network maximum):	$4,000 for self only $8,000 for family	58

2011 Rate Information for Coventry Health Care-Maryland

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* UnitedStates Postal Service Employees, RI 70-2, and to the rates shown below.

The rates shown below do not apply to *Post*al 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 States 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
High Option Self Only	IG1	$147.11	$49.03	$318.73	$106.24	$165.74	$30.40
High Option Self and Family	IG2	$369.18	$123.06	$799.89	$266.63	$415.94	$76.30
Standard Option Self Only	IG4	$129.95	$43.32	$281.57	$93.85	$146.41	$26.86
Standard Option Self and Family	IG5	$324.88	$108.29	$703.91	$234.63	$366.03	$67.14
HDHP Option Self Only	GZ1	$127.98	$42.66	$277.29	$92.43	$144.19	$26.45
HDHP Option Self and Family	GZ2	$297.34	$99.11	$644.24	$214.74	$335.00	$61.45