

# Coventry Health Care

[www.chcde.com](http://www.chcde.com)



## 2005

**Serving:** *All of Delaware, Maryland and select counties in Southern New Jersey*

**Enrollment in this Plan is limited. You must live or work in our geographic service area to enroll. See page 11 for requirements.**

### Enrollment codes for this Plan:

#### Delaware and New Jersey:

- 2J1 High Option – Self Only
- 2J2 High Option – Self and Family
- 2J4 HDHP Option – Self Only
- 2J5 HDHP Option – Self and Family

#### Maryland:

- IG1 High Option – Self Only
- IG2 High Option – Self and Family
- IG4 HDHP Option – Self Only
- IG5 HDHP Option – Self and Family

**Special notice:** This plan is offering for the first time under the Federal Employees Health Benefits Program for the 2004 Open Season an Open Access HMO Plan and a Consumer-driven High Deductible Health Plan (HDHP).



*This plan has been accredited by URAC for the 2005 plan year.*

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**



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

OFFICE OF THE DIRECTOR

Dear Federal Employees Health Benefits Program Participant:

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

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

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

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

Sincerely,

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

Kay Coles James

Director



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

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

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

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

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

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

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

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

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

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

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

- See and get a copy of your personal medical information held by OPM.
- Amend any of your personal medical information created by OPM if you believe that it is wrong or if information is missing, and OPM agrees. If OPM disagrees, you may have a statement of your disagreement added to your personal medical information.
- Get a listing of those getting your personal medical information from OPM in the past 6 years. The listing will not cover your personal medical information that was given to you or your personal representative, any information that you authorized OPM to release, or that was given out for law enforcement purposes or to pay for your health care or a disputed claim.
- Ask OPM to communicate with you in a different manner or at a different place (for example, by sending materials to a P.O. Box instead of your home address).
- Ask OPM to limit how your personal medical information is used or given out. However, OPM may not be able to agree to your request if the information is used to conduct operations in the manner described above.
- Get a separate paper copy of this notice.

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

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

Privacy Complaints

Unites States Office of Personnel Management

P.O. Box 707

Washington, DC 20004-0707

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

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

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## Introduction

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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 the Coventry's administrative offices is:

**Coventry Health Care**  
**2751 Centerville Road, Suite 400**  
**Wilmington, DE 19808**

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.

OPM negotiates benefits and rates with each plan annually. Rates are shown at the end of this brochure.

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## Plain Language

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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," "us," or "our" 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](http://www.opm.gov/insure) or e-mail OPM at [fehwebcomments@opm.gov](mailto:fehwebcomments@opm.gov). You may also write to OPM at the U.S. Office of Personnel Management, Insurance Services Programs, Program Planning & Evaluation Group, 1900 E Street, NW, Washington, DC 20415-3650.

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## Stop Health Care Fraud!

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

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

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

Be wary of giving your plan identification (ID) number over the telephone or to people you do not know, except to your doctor, other provider, or authorized plan or OPM representative.

Let only the appropriate medical professionals review your medical record or recommend services.

Avoid using health care providers who say that an item or service is not usually covered, but they know how to bill us to get it paid.

Carefully review explanations of benefits (EOBs) that you receive from us.

Do not ask your doctor to make false entries on certificates, bills or records in order to get us to pay for an item or service.

If you suspect that a provider has charged you for services you did not receive, billed you twice for the same service, or misrepresented any information, do the following:

- Call the provider and ask for an explanation. There may be an error.
- If the provider does not resolve the matter, call us at 800-733-7426 and explain the situation.
- If we do not resolve the issue:

**CALL — THE HEALTH CARE FRAUD HOTLINE  
202-418-3300**

**OR WRITE TO:  
United States Office of Personnel Management  
Office of the Inspector General Fraud Hotline  
1900 E Street NW Room 6400  
Washington, DC 20415-1100**

Do not maintain as a family member on your policy:

- Your former spouse after a divorce decree or annulment is final (even if a court order stipulates otherwise); or
- Your child over age 22 (unless he/she is disabled and incapable of self-support).

If you have any questions about the eligibility of a dependent, check with your personnel office if you are employed, with your retirement office (such as OPM) if you are retired, or with the National Finance Center if you are enrolled under Temporary Continuation of Coverage.

You can be prosecuted for fraud and your agency may take action against you if you falsify a claim to obtain FEHB benefits or try to obtain services for someone who is not an eligible family member or who is no longer enrolled in the Plan.

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## **Preventing medical mistakes**

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

### **1. Ask questions if you have doubts or concerns.**

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

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

- Give your doctor and pharmacist a list of all the medicines that you take, including non-prescription medicines.
- Tell them about any drug allergies you have.
- Ask about side effects and what to avoid while taking the medicine.
- Read the label when you get your medicine, including all warnings.
- Make sure your medicine is what the doctor ordered and know how to use it.
- Ask the pharmacist about your medicine if it looks different than you expected.

**3. Get the results of any test or procedure.**

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

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

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

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

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

Want more information on patient safety?

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

- [www.talkaboutrx.org/consumer.html](http://www.talkaboutrx.org/consumer.html). The National Council on Patient Information and Education is dedicated to improving communication about the safe, appropriate use of medicines.
- [www.leapfroggroup.org](http://www.leapfroggroup.org). The Leapfrog Group is active in promoting safe practices in hospital care.
- [www.ahqa.org](http://www.ahqa.org). The American Health Quality Association represents organizations and health care professionals working to improve patient safety.
- [www.quic.gov/report](http://www.quic.gov/report). Find out what federal agencies are doing to identify threats to patient safety and help prevent mistakes in the nation's health care delivery system.

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## Section 1. Facts about this plan

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### 1) High Option – Individual Practice HMO:

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.

**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.**

### 2) High Deductible Health Plan (HDHP):

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

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

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

#### General features of an HDHP:

HDHPs have higher annual deductibles and annual out-of-pocket maximum limits than other types of FEHB plans. Preventive care services are generally paid as first dollar coverage or after a small deductible or copayment. First dollar coverage may be limited to a maximum dollar amount each year. The annual deductible must be met before Plan benefits are paid for care other than preventive care services.

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

- You may use the money in your HSA to pay all or a portion of the annual deductible, copayments, coinsurance, or other out-of-pocket costs that meet the IRS definition of a qualified medical expense. Distributions from

your HSA are tax-free for qualified medical expenses for you, your spouse, and your dependents, even if they are not covered by a HDHP. You may withdraw money from your HSA for items other than qualified medical expenses, but it will be subject to income tax and, if you are under 65 years old, an additional 10% penalty tax on the amount withdrawn.

- For each month that you are enrolled in an HDHP and eligible for an HSA, the HDHP will pass through (contribute) a portion of the health plan premium to your HSA. In addition, you (the account holder) may contribute your own money to your HSA up to an allowable amount determined by IRS rules. In addition, your HSA dollars earn tax-free interest.
- You may allow the contributions in your HSA to grow over time, like a savings account. The HSA is portable – you may take the HSA with you if you leave the Federal government or switch to another plan.
- If you are not eligible for an HSA, or become ineligible to continue an HSA, you are eligible for a Health Reimbursement Arrangement (HRA). Although an HRA is similar to an HSA, there are major differences.
  - An HRA does not earn interest.
  - An HRA is not portable if you leave the Federal government or switch to another plan.
- We protect you against catastrophic out-of-pocket expenses for covered services. Your annual out-of-pocket expenses for covered services, including deductibles and copayments, are limited to \$5,000 for Self-Only enrollment, or \$10,000 for family coverage.

## **We have network providers**

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

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

## **How we pay providers**

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.

## **Your rights**

OPM requires that all FEHB Plans provide certain information to their FEHB members. You may get information about us, our networks, providers, and facilities. OPM's FEHB Web site ([www.opm.gov/insure](http://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.

### **As a Member of Coventry Health Care, you have the right to:**

- Receive information about Coventry Health Care, including your rights and responsibilities, products, directory of participating providers and the plan's policies and procedures.
- Receive information on the amount, duration, and scope of all benefits and services included and excluded as a condition of your enrollment in the plan.
- Offer suggestions for changes in policies and procedures.

- Prompt notification of termination or changes in benefits, services or provider network. To the extent practical, you will be informed of such termination or changes before your effective date.
- Obtain information that is readable and easily understood.
- Choose a primary care provider within the limits of the covered benefits and plan network including the right to refuse care from specific providers.
- Be treated with respect, courtesy, and recognition of your dignity with consideration of your privacy, personal values and beliefs.
- Confidentiality, privacy and security of your medical records and other information as well as the right to access your medical records in accordance with Federal and State laws. Coventry will act to ensure that the confidentiality of your specified information and records is protected.
- Not be discriminated against because of age, sex, race, creed, color, marital status, national origin, and physical or mental handicap, health status, or need for health care services.
- Participate with providers in decision making about your health care and treatment decisions. The information will be provided in a language you understand.
- Receive from your doctor, an explanation of your complete medical condition, recommended treatment, risk of treatment, expected results, and reasonable medical alternatives.
- Designate a surrogate decision-maker when you can't understand or communicate your wishes regarding care.
- Voice complaints, grievances, or appeals about Coventry or its providers and to receive an answer in a timely manner. Coventry must provide you with written instructions on this process. To file a complaint with your local department of health or with the insurance commissioner's office.
- Have available and accessible services including urgent or emergency services, 24 hours a day 7 days a week. Based on the federal government's definition, emergency care can be sought when individuals who, possessing average knowledge of health and medicine, could reasonably assume their symptoms are of sufficient severity to cause serious impairment to health and bodily functions, or organ dysfunction. Emergency care does not require prior primary care physician approval.
- Have access to both clinical and non-clinical services including individuals with limited English proficiency or reading skills, and diverse cultural and ethnic backgrounds as well as the homeless and individuals with physical and mental disabilities and hearing or speech impairments.
- Formulate advance directives in accordance with federal and state law.
- Refuse medication and treatment as a patient in a licensed health care facility afforded by law or regulation after possible consequences of this decision have been explained in a language the Member understands.
- To have on-line access to the health plan.

**As a Member of Coventry Health Care you have the responsibility to:**

- Review all membership and benefit materials carefully and to follow the guidelines pertaining to your specific plan.
- Treat others with respect and consideration.
- Provide information needed by professional staff to care for you.
- Follow instructions and guidelines given by those providing health care services.
- Keep scheduled appointments and to contact the appropriate person when you're late or in need of canceling an appointment.

Coventry Health Care is a for profit health maintenance organization (HMO) domiciled in Delaware and licensed by the Maryland Insurance Administration and the Delaware Department of Insurance. 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 2751 Centerville Road, Suite 400, Wilmington, DE 19808-1627. You may also contact us by fax at 302-998-7085 or visit our Web site at [www.CHCDE.com](http://www.CHCDE.com).

### **Service Area(s)**

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

Delaware – All of Delaware

Maryland – All of Maryland.

Southern New Jersey - Camden, Cumberland, Gloucester, & Salem Counties.

Ordinarily, you must get your care from providers who contract with us. If you receive care outside our service area, we will pay only for emergency or urgent 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 moves outside of our service area, you can enroll in another plan. If a dependent lives out of the area (for example, if your child goes to college in another state), you should consider enrolling in a fee-for-service plan or another plan that has agreements with affiliates in other areas. If you or a family member moves, you do not have to wait until Open Season to change plans - contact your employing or retirement office.

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## **Section 2. We are a new plan**

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This Plan is new to the FEHB Program. We are being offered for the first time during the 2004 open season to enroll in 2005 benefits.

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## Section 3. How you get care

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### Identification cards

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

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

**COVENTRY HEALTH CARE**  
**Pencader Corporate Center**  
**211 Lake Drive**  
**Newark, DE 19702-3320**

You may also request replacement cards through our Web site at [www.chcde.com](http://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 and coinsurance and you will not have to file claims. 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.

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 find a provider in our network, you can go to our website at [www.chcde.com](http://www.chcde.com), or call 800-833-7423. In an emergency situation, please go to the nearest emergency facility or urgent care center and notify us within 48 hours.

- **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 302-283-5400 within our service area or 800-833-7423; or logging on to our website at [www.chcde.com](http://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 provider network as is appropriate or necessary.

- **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.

- **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 prior to admission.**

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 92<sup>nd</sup> 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.

## **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 for Minor Children
- 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

### Authorization Process

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 Decisions for 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.

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## Section 4. Your costs for covered services

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

### Copayments

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

**High Option:** Example: when you see your primary care physician you pay a copayment of \$10 per office visit – and when you visit a specialist the copayment is \$20 per visit.

**High Deductible Health Plan:** Example: when you see your primary care physician you pay a copayment of \$15 per visit after your deductible has been met. When you visit a specialist the copayment is \$25 per visit.

### Deductible

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

**High Option:** There is no plan deductible.

**High Deductible Health Plan:** The deductible amount for this plan is \$1,050 for individual coverage (subscribers covering no spouse or dependents) and \$2,100 for family coverage (subscribers covering spouse and/or family).

No benefit is payable for Covered Services subject to a Deductible, until the Deductible is met. You are responsible for paying Your Deductible. The Schedule of Benefits specifies the time period for accumulating amounts applied to the Deductible (i.e., Calendar or Contract Year). The entire family deductible must be met before individual family members are eligible for benefits. The individual and family Deductibles, if any, are also shown in the Schedule of Benefits.

When the Member incurs expenses in the last three (3) months of a Calendar 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.

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

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

### Coinsurance

Coinsurance is the percentage of our allowance that you must pay for your care. Coinsurance doesn't begin until you meet your deductible.

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

**High Deductible Health Plan:** Example: you pay 15% of our allowance for durable medical equipment after you have met the deductible.

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).

**Your catastrophic protection out-of-pocket maximum**

**High Option:** After your 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.

**High Deductible Health Plan:** Your out-of-pocket maximum for this plan is \$5,000 per individual and \$10,000 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.

**Differences between our 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.

**When Government facilities bill us**

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

**If we overpay you**

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

**When you have the  
Original Medicare Plan  
(Part A, Part B, or both)**

We limit our payment to an amount that supplements the benefits that Medicare would pay under Medicare Part A (Hospital insurance) and Medicare Part B (Medical insurance), regardless of whether Medicare pays. Note: We pay our regular benefits for emergency services to an institutional provider, such as a hospital, that does not participate with Medicare and is not reimbursed by Medicare.

If you are covered by Medicare Part B and it is primary, your out-of-pocket costs for services that both Medicare Part B and we cover depend on whether your physician accepts Medicare assignment for the claim.

**High Option:** If your physician **accepts** Medicare assignment, then you pay nothing for covered charges.

**High Deductible Health Plan:** If your physician **does not accept** Medicare assignment, then you pay the difference between the “limiting charge” or the physician’s charge (whichever is less) and our payment combined with Medicare’s payment.

It is important to know that a physician who does not accept Medicare assignment may not bill you for more than 115% of the amount Medicare bases its payment on, called the “limiting charge.” The Medicare Summary Notice (MSN) that Medicare will send you will have more information about the limiting charge. If your physician tries to collect more than allowed by law, ask the physician to reduce the charges. If the physician does not, report the physician to your Medicare carrier who sent you the MSN form. Call us if you need further assistance.

**Please see Section 10, *Coordinating benefits with other coverage*, for more information about how we coordinate benefits with Medicare.**

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## Section 5. High Option Benefits

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Note: This benefits section is divided into subsections. Please read the important things you should keep in mind at the beginning of each subsection. Also read the General exclusions in Section 7; they apply to the benefits in the following subsections. To obtain claim forms, claims filing advice, or more information about our benefits, contact us at 800-833-7423 or at our Web site at [www.chcde.com](http://www.chcde.com).

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

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

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- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan physicians must provide or arrange your care.
- There is no calendar year deductible.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works. Also read Section 10 about coordinating benefits with other coverage, including with Medicare.

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Benefit Description	You pay
<b>Diagnostic and treatment services</b>	
Professional services of physicians	\$10 copayment per visit to a primary care physician
<ul style="list-style-type: none"> <li>• In physician's office</li> </ul>	\$20 copayment per visit to a specialist
<ul style="list-style-type: none"> <li>• Professional services of physicians               <ul style="list-style-type: none"> <li>· During a hospital stay</li> <li>· In a skilled nursing facility</li> <li>· Office medical consultations</li> <li>· Second surgical opinion</li> </ul> </li> </ul>	<p>Nothing</p> <p>Nothing</p> <p>\$10 copayment per visit to primary care physicians; \$20 copayment per visit to specialists</p> <p>\$20 copayment per visit to specialists</p>
<ul style="list-style-type: none"> <li>• At home</li> </ul>	Nothing
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• <i>Immunizations for meningococcal meningitis.</i></li> <li>• <i>Immunizations needed for travel.</i></li> </ul>	<i>All charges.</i>

Lab, X-ray and other diagnostic tests	You pay
<p>Tests, such as:</p> <ul style="list-style-type: none"> <li>• Blood tests</li> <li>• Urinalysis</li> <li>• Non-routine pap tests</li> <li>• Pathology</li> <li>• X-rays</li> <li>• Non-routine Mammograms</li> <li>• CAT Scans/MRI</li> <li>• Ultrasound</li> <li>• Bone mass measurement to identify bone mass or detect bone loss for prevention, diagnosis and treatment of osteoporosis.</li> <li>• Electrocardiogram and EEG</li> </ul>	<p>\$10 per test</p>
Preventive care, adult	You pay
<p>Routine screenings, such as:</p> <ul style="list-style-type: none"> <li>• Total Blood Cholesterol</li> <li>• Colorectal Cancer Screening, including <ul style="list-style-type: none"> <li>– Fecal occult blood test</li> <li>– Sigmoidoscopy, screening – every five years starting at age 50</li> <li>– Double contrast barium enema – every five years starting at age 50</li> <li>– Colonoscopy screening – every ten years starting at age 50</li> </ul> </li> </ul> <p>NOTE: For services rendered in a facility, such as sigmoidoscopy or colonoscopy, you pay either a \$30 copayment to an ambulatory surgi-center or 20% coinsurance to the outpatient department of a hospital.</p>	<p>\$10 copayment per visit to a primary care physician, or \$20 copayment per visit to a specialist</p>
<p>Routine Prostate Specific Antigen (PSA) test – one annually for men age 40 and older.</p>	<p>\$10 copayment per visit to a primary care physician; \$20 copayment per visit to a specialist</p>

*Preventive care, adult – continued on next page*

Preventive care, adult ( <i>continued</i> )	You pay
Routine annual pap test  Note: The office visit is covered if pap test is received on the same day; see <i>Diagnosis and Treatment</i> , above.	\$10 copayment per visit to a primary care physician; \$20 copayment per visit to a specialist
Routine mammogram – covered for women age 35 and older, as follows: <ul style="list-style-type: none"> <li>• From age 35 through 39, one during this five year period</li> <li>• From age 40 through 64, one every calendar year</li> <li>• At age 65 and older, one every two consecutive calendar years</li> </ul>	\$10 copayment per procedure.
Routine immunizations, limited to: <ul style="list-style-type: none"> <li>• Tetanus-diphtheria (Td) booster – once every 10 years, ages 19 and over (except as provided for under Childhood immunizations)</li> <li>• Influenza vaccine, annually</li> <li>• Pneumococcal vaccine, age 65 and older</li> </ul>	\$10 copayment per visit to a primary care physician; \$20 copayment per visit to a specialist
<i>Not covered:</i>  <i>Physical exams required for obtaining or continuing employment or insurance, marriage, sports, licensing, adoption, attending schools or camp, or travel or those ordered by a third party.</i> <ul style="list-style-type: none"> <li>• Immunizations for meningococcal meningitis.</li> <li>• Immunizations, boosters and medications for travel.</li> </ul>	<i>All charges.</i>
Preventive care, children	You pay
<ul style="list-style-type: none"> <li>• Childhood immunizations recommended by the American Academy of Pediatrics</li> </ul>	\$10 copayment per visit to a primary care physician; \$20 copayment per visit to a specialist
<ul style="list-style-type: none"> <li>• Well-child care charges for routine examinations, immunizations and care (up to age 22)</li> <li>• Examinations, such as:               <ul style="list-style-type: none"> <li>– Eye exams through age 17 to determine the need for vision correction</li> <li>– Ear exams through age 17 to determine the need for hearing correction</li> <li>– Examinations done on the day of immunizations (up to age 22)</li> </ul> </li> </ul>	\$10 copayment per visit to your primary care physician;  \$20 copayment per visit to a specialist

Maternity care	You pay
<p>Complete maternity (obstetrical) care, such as:</p> <ul style="list-style-type: none"> <li>• Prenatal care</li> <li>• Delivery</li> <li>• Postnatal care</li> </ul> <p>Note: Here are some things to keep in mind:</p> <ul style="list-style-type: none"> <li>• You do not need to precertify your normal delivery; see below for other circumstances, such as extended stays for you or your baby.</li> <li>• 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.</li> <li>• 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.</li> <li>• 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.</li> <li>• 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.</li> <li>• 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.</li> <li>• We pay hospitalization and surgeon services (delivery) the same as for illness and injury. See Hospital benefits (Section 5c) and Surgery benefits (Section 5b).</li> </ul>	<p>\$10 copayment for the initial office visits; Nothing for all visits thereafter.</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• <i>Routine sonograms to determine fetal age, size or sex</i></li> <li>• <i>Newborn home delivery</i></li> <li>• <i>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.</i></li> </ul>	<p><i>All charges.</i></p>

Family planning	You pay
<p>A range of voluntary family planning services, limited to:</p> <ul style="list-style-type: none"> <li>• Voluntary sterilization (See Surgical procedures Section 5 (b))</li> <li>• Surgically implanted contraceptives</li> <li>• Intrauterine devices (IUDs)</li> </ul> <p>Note: We cover injectable contraceptive drugs, oral contraceptives, and diaphragms under the prescription drug benefit.</p>	50% of charges
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• <i>Reversal of voluntary surgical sterilization</i></li> <li>• <i>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.</i></li> </ul>	<i>All charges.</i>
Infertility services	You pay
<p>Diagnosis and treatment of infertility such as:</p> <p>Artificial Insemination:</p> <ul style="list-style-type: none"> <li>• intravaginal insemination (IVI)</li> <li>• intracervical insemination (ICI)</li> <li>• ntrauterine insemination (IUI)</li> <li>• invitrofertlization</li> </ul> <p>Note: We cover injectable fertility drugs under medical benefit and oral fertility drugs under the prescription drug benefit.</p>	50% of charges.
Infertility services (Continued)	You pay
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• <i>Assisted reproductive technology (ART) procedures, such as:</i> <ul style="list-style-type: none"> <li>• <i>Intracytoplasmic sperm injection (ICSI), unless authorized as part of an approved IVF procedure</i></li> <li>• <i>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.</i></li> </ul> </li> <li>• <i>Cost of donor sperm</i></li> <li>• <i>Cost of donor egg</i></li> </ul>	<i>All charges.</i>

Allergy care	You pay
<ul style="list-style-type: none"> <li>• Testing and treatment</li> <li>• Allergy injections</li> </ul>	\$10 copayment per office visit to a primary care physicians; \$20 copayment per office visit to a specialists
Allergy serum	Nothing
<i>Not covered: Provocative food testing and sublingual allergy desensitization</i>	<i>All charges.</i>
Treatment therapies	You pay
<ul style="list-style-type: none"> <li>• Chemotherapy and radiation therapy  <p>Note: High dose chemotherapy in association with autologous bone marrow transplants is limited to those transplants listed under Organ/Tissue Transplants on page xx.</p> </li> <li>• Respiratory and inhalation therapy</li> <li>• Dialysis – hemodialysis and peritoneal dialysis</li> <li>• Cardiac Therapy – outpatient visits limited to 60 consecutive days beginning with the onset of therapy.</li> <li>• Intravenous (IV)/Infusion Therapy – Home IV and antibiotic therapy</li> <li>• Growth hormone therapy (GHT)</li> </ul> <p>Note:</p> <ul style="list-style-type: none"> <li>• 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.</li> <li>• 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 <i>Services requiring our prior approval</i> in Section 3.</li> </ul>	\$20 copayment per outpatient visit; Nothing per visit during covered inpatient admission.
Physical and occupational therapies	You pay
<p>60 visits per condition per calendar year for the following services:</p> <ul style="list-style-type: none"> <li>• qualified physical therapists, and</li> <li>• qualified occupational therapists.</li> </ul> <p>Note: We only cover therapy to restore bodily function when there has been a total or partial loss of bodily function due to illness or injury.</p>	\$20 copayment per outpatient visit; Nothing per visit during covered inpatient admission.
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• <i>Long-term rehabilitative therapy</i></li> <li>• <i>Exercise programs</i></li> </ul>	<i>All charges.</i>

Speech therapy	You pay
60 visits per condition	\$20 copayment per outpatient visit; Nothing per visit during covered inpatient admission.
Habilitative services	You pay
<p>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</p> <ul style="list-style-type: none"> <li>• occupational,</li> <li>• physical, and</li> <li>• speech therapy.</li> </ul>	\$20 copayment per office visit
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• <i>Habilitative services delivered through early intervention or school services</i></li> </ul>	<i>All charges.</i>
Hearing services (testing, treatment, and supplies)	You pay
<ul style="list-style-type: none"> <li>• First hearing aid &amp; testing only when necessitated by accidental injury.</li> <li>• Hearing testing for children through age 17 (see <i>Preventive care, children</i>)</li> <li>• 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.</li> </ul>	<p>\$10 copayment per office visit for primary care physicians; \$20 copayment per office specialists</p> <p>20% of charges.</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• <i>All other hearing testing</i></li> <li>• <i>Hearing aids (except for minor children as described above), testing and examinations for them</i></li> </ul>	<i>All charges.</i>
Vision services (testing, treatment, and supplies)	You pay
<p>Eye exam to determine the need for vision correction for children through age 17 (see <i>Preventive care, children</i>).</p> <p>First pair of eyeglasses or corrective lenses required following cataract surgery.</p>	<p>\$10 copayment per office visit for primary care physicians; \$20 copayment per office specialists</p> <p>20% of charges</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• <i>Eyeglasses or contact lenses and after age 17, examinations for them, except as specified above</i></li> <li>• <i>Eye exercises and orthoptics</i></li> <li>• <i>Radial keratotomy and other refractive surgery</i></li> </ul>	<i>All charges.</i>

Foot care	You pay
<p>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.</p> <p>Note: See Orthopedic and prosthetic devices for information on podiatric shoe inserts.</p>	<p>\$20 copayment per office visit to a specialist</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• <i>Cutting, trimming or removal of corns, calluses, or the free edge of toenails, and similar routine treatment of conditions of the foot, except as stated above</i></li> <li>• <i>Treatment of weak, strained or flat feet or bunions or spurs; and of any instability, imbalance or subluxation of the foot (unless the treatment is by open cutting surgery)</i></li> </ul>	<p><i>All charges.</i></p>
Orthopedic and prosthetic devices	You pay
<ul style="list-style-type: none"> <li>• Artificial limbs and eyes; stump hose</li> <li>• Externally worn breast prostheses and surgical bras, including necessary replacements following a mastectomy</li> <li>• Corrective orthopedic appliances for non-dental treatment of temporomandibular joint (TMJ) pain dysfunction syndrome.</li> </ul> <p>Note: Internal prosthetic devices, such as artificial joints, pacemakers, cochlear implants, and surgically implanted breast implant following mastectomy, 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 information.</p> <p>Prosthetic replacements are provided when preauthorized.</p>	<p>20% of covered charges</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• <i>Orthopedic and corrective shoes</i></li> <li>• <i>Arch supports</i></li> <li>• <i>Foot orthotics</i></li> <li>• <i>Heel pads and heel cups</i></li> <li>• <i>Lumbosacral supports</i></li> <li>• <i>Corsets, trusses, elastic stockings, support hose, and other supportive devices</i></li> <li>• <i>Braces and supports needed for athletic participation or employment.</i></li> <li>• <i>Prosthetic replacements are provided when preauthorized.</i></li> </ul>	<p><i>All charges.</i></p>

Durable medical equipment (DME)	You pay
<p>Rental or purchase, at our option, including repair and adjustment, of durable medical equipment prescribed by your Plan physician, such as oxygen and dialysis equipment. Under this benefit, we also cover:</p> <ul style="list-style-type: none"> <li>• Hospital beds;</li> <li>• Wheelchairs (see note below regarding motorized wheelchairs)</li> <li>• Crutches;</li> <li>• Walkers;</li> <li>• Blood glucose monitors;</li> <li>• Ostomy and disposable diabetic supplies;</li> <li>• Hair prosthesis as prescribed by the attending oncologist for a Member whose 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); and</li> <li>• Insulin pumps.</li> </ul>	20% of covered charges
<p><i>Not covered: Motorized wheelchair, wigs (except as noted above), and upgrades to equipment.</i></p>	All charges.
Home health services	You pay
<ul style="list-style-type: none"> <li>• 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.</li> <li>• Home visits following a mastectomy or removal of a testicle if the hospital stay is less than 48 hours</li> </ul> <p>Services include oxygen therapy, intravenous therapy and medications.</p>	Nothing
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• <i>Nursing care requested by, or for the convenience of, the patient or the patient's family;</i></li> <li>• <i>Home care primarily for personal assistance that does not include a medical component and is not diagnostic, therapeutic, or rehabilitative.</i></li> </ul>	All charges
Chiropractic	You pay
<p>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.</p>	\$20 copayment per visit to chiropractor.
Alternative treatments	You pay
No benefit	All charges

Educational classes and programs	You pay
<ul style="list-style-type: none"> <li>• Diabetic outpatient self-management training and education</li> <li>• Health Education such as instructions on achieving and maintaining physical and mental health, and preventing illness and injury.</li> <li>• Nutritional counseling provided by a Registered Dietician or Participating Physician in connection with diabetes, coronary artery disease and hyperlipidemia.</li> </ul>	Nothing.
Medical Clinical Trial	You pay
<p>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.</p> <p>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.</p> <p>Treatment in a Medical Clinical Trial must be authorized in advance by us.</p>	See coverage limitations based on setting (Inpatient, Outpatient, Home and Office, 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

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

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- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan physicians must provide or arrange your care.
- We have no calendar year deductible.
- Be sure to read Section 4, Your costs for covered services, for valuable information about how cost sharing works. Also read Section 10 about coordinating benefits with other coverage, including with Medicare.
- The amounts listed below are for the charges billed by a physician or other health care professional for your surgical care. Look in Section 5(c) for charges associated with the facility (i.e. hospital, surgical center, etc.).
- **YOUR PHYSICIAN MUST GET PRECERTIFICATION OF SOME SURGICAL PROCEDURES.** Please refer to the precertification information shown in Section 3 to be sure which services require precertification and identify which surgeries require precertification.

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Benefit Description	You pay
<b>Surgical procedures</b>	
<p>A comprehensive range of services, such as:</p> <ul style="list-style-type: none"> <li>• Operative procedures</li> <li>• Treatment of fractures, including casting</li> <li>• Normal pre- and post-operative care by the surgeon</li> <li>• Correction of amblyopia and strabismus</li> <li>• Endoscopy procedures</li> <li>• Biopsy procedures</li> <li>• Removal of tumors and cysts</li> <li>• Correction of congenital anomalies (see Reconstructive surgery)</li> <li>• Treatment of burns</li> <li>• Surgical treatment of morbid obesity – a condition in which an individual weighs 100 pounds or 100% over his or her normal weight according to current underwriting standards; eligible members must be age 18 or over. 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.</li> </ul>	<p>\$10 copayment for surgeries in a primary care physician office;</p> <p>\$20 copayment for surgeries in a specialist office;</p> <p>Nothing for facility visits.</p>

*Surgical procedures - continued on next page*

Surgical procedures <i>(continued)</i>	You pay
<ul style="list-style-type: none"> <li>• Voluntary sterilization (e.g., Tubal ligation, Vasectomy)</li> </ul> <p>Insertion of internal prosthetic devices. See 5(a) – <i>Orthopedic and prosthetic devices</i> for device coverage information.</p> <p>Note: Generally, we pay for internal prostheses (devices) according to where the procedure is done. For example, we pay Hospital benefits for a pacemaker and Surgery benefits for insertion of the pacemaker.</p>	50% of charges.
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• <i>Reversal of voluntary sterilization</i></li> <li>• <i>Routine treatment of conditions of the foot; see Foot care</i></li> </ul>	<i>All charges</i>
Reconstructive surgery	You pay
<ul style="list-style-type: none"> <li>• Surgery to correct a functional defect</li> <li>• Surgery to correct a condition caused by injury or illness if: <ul style="list-style-type: none"> <li>– the condition produced a major effect on the member’s appearance and</li> <li>– the condition can reasonably be expected to be corrected by such surgery</li> </ul> </li> <li>• Surgery to correct a condition that existed at or from birth and is a significant deviation from the common form or norm. Examples of congenital anomalies are: protruding ear deformities; cleft lip; cleft palate; birth marks; webbed fingers; and webbed toes.</li> <li>• All stages of breast reconstruction surgery following a mastectomy, such as: <ul style="list-style-type: none"> <li>– Surgery to produce a symmetrical appearance of breasts;</li> <li>– Treatment of any physical complications, such as lymphedemas;</li> <li>– Breast prostheses and surgical bras and replacements (see Prosthetic devices)</li> </ul> </li> </ul> <p>Note: If you need a mastectomy, you may choose to have the procedure performed on an inpatient basis and remain in the hospital up to 48 hours after the procedure.</p>	<p>\$10 copayment for surgeries in a primary care physician office;</p> <p>\$20 copayment for surgeries in a specialist office</p> <p>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.</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• <i>Cosmetic surgery – any surgical procedure (or any portion of a procedure) performed primarily to improve physical appearance through change in bodily form, except repair of accidental injury</i></li> <li>• <i>Surgeries related to sex transformation</i></li> </ul>	<i>All charges</i>

Oral and maxillofacial surgery	You pay
<p>Oral surgical procedures, limited to:</p> <ul style="list-style-type: none"> <li>• Reduction of fractures of the jaws or facial bones;</li> <li>• Surgical correction of cleft lip, cleft palate or severe functional malocclusion;</li> <li>• Removal of stones from salivary ducts;</li> <li>• Excision of leukoplakia or malignancies;</li> <li>• Excision of cysts and incision of abscesses when done as independent procedures;</li> <li>• Other surgical procedures that do not involve the teeth or their supporting structures, and</li> <li>• TMJ related services (non-dental)</li> </ul>	<p>\$10 copayment for surgeries in a primary care physician office;</p> <p>\$20 copayment for surgeries in a specialist office</p> <p>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.</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• <i>Oral implants and transplants</i></li> <li>• <i>Procedures that involve the teeth or their supporting structures (such as the periodontal membrane, gingiva, and alveolar bone)</i></li> </ul>	<p><i>All charges.</i></p>

Organ/tissue transplants	You pay
<p>Limited to:</p> <ul style="list-style-type: none"> <li>• Cornea</li> <li>• Heart</li> <li>• Heart/lung</li> <li>• Kidney</li> <li>• Kidney/Pancreas</li> <li>• Liver</li> <li>• Lung: Single – Double</li> <li>• Pancreas</li> <li>• Allogeneic (donor) bone marrow transplants</li> </ul> <ul style="list-style-type: none"> <li>• Autologous bone marrow transplants (autologous stem cell and peripheral stem cell support) for the following conditions: acute lymphocytic or non-lymphocytic leukemia; advanced Hodgkin’s lymphoma; advanced non-Hodgkin’s lymphoma; advanced neuroblastoma; breast cancer; multiple myeloma; epithelial ovarian cancer; and testicular, mediastinal, retroperitoneal and ovarian germ cell tumors</li> <li>• Intestinal transplants (small intestine) and the small intestine with the liver or small intestine with multiple organs such as the liver, stomach, and pancreas</li> <li>• Only covered when rendered at a Coventry Transplant Network participating facility approved by Us.</li> <li>• Donor screening tests are covered and are subject to a lifetime benefit maximum of \$10,000 when performed at a Coventry Transplant Network participating facility approved by Us.</li> <li>• If not covered by any other source, the cost of any care, including complications, arising from an organ donation by a non-covered individual when the recipient is a covered individual will be covered for the duration of the contract of the covered individual when approved by Us.</li> <li>• Travel expenses for members and living donors are covered according to Our transplant travel benefit. Details of the transplant travel benefit will be provided upon request and at any time Transplant Services are authorized. Members are covered when CHCDE is the primary insurer and a Coventry Transplant Network participating facility approved by Us is used.</li> <li>• Limited Benefits – Treatment for breast cancer, multiple myeloma, and epithelial ovarian cancer may be provided in a National Cancer Institute – or National Institutes of Health-approved clinical trial at a Plan-designated center of excellence and if approved by the Plan’s medical director in accordance with the Plan’s protocols.</li> </ul> <p>We cover related medical and hospital expenses of the donor when we cover the recipient.</p>	<p>Nothing</p>

*Organ/tissue transplants – continued on next page*

Organ/tissue transplants <i>(continued)</i>	You pay
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• <i>Donor screening tests and donor search expenses, except those performed for the actual donor</i></li> <li>• <i>Implants of artificial organs</i></li> <li>• <i>Transplants not listed as covered</i></li> </ul>	<p><i>All charges</i></p>
<b>Anesthesia</b>	
<ul style="list-style-type: none"> <li>• Professional services provided in a Hospital (inpatient)</li> </ul>	<p>Nothing</p>
<p>Professional services provided in –</p> <ul style="list-style-type: none"> <li>• Hospital outpatient department</li> <li>• Skilled nursing facility</li> <li>• Ambulatory surgical center</li> <li>• Office</li> </ul>	<p>Nothing for a hospital visit, ambulatory surgical center, or skilled nursing facility.</p> <p>\$10 copayment for surgeries in a primary care physician office; \$20 copayment for surgeries in a specialist office.</p>

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

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

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- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan physicians must provide or arrange your care and you must be hospitalized in a Plan facility.
- We have no calendar year deductible.
- Be sure to read Section 4, *Your costs for covered services* for valuable information about how cost sharing works. Also read Section 10 about coordinating benefits with other coverage, including with Medicare.
- The amounts listed below are for the charges billed by the facility (i.e., hospital or surgical center) or ambulance service for your surgery or care. Any costs associated with the professional charge (i.e., physicians, etc.) are in Sections 5(a) or (b).
- **YOUR PHYSICIAN MUST GET PRECERTIFICATION OF HOSPITAL STAYS.** Please refer to Section 3 to be sure which services require precertification.

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

<b>Inpatient hospital (continued)</b>	<b>You pay</b>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• Custodial care</li> <li>• Non-covered facilities, such as nursing homes, schools</li> <li>• Personal comfort items, such as telephone, television, barber services, guest meals and beds</li> <li>• Private nursing care</li> </ul>	<p><i>All charges</i></p>
<b>Outpatient hospital or ambulatory surgical center</b>	<b>You pay</b>
<ul style="list-style-type: none"> <li>• Operating, recovery, and other treatment rooms</li> <li>• Prescribed drugs and medicines</li> <li>• Diagnostic laboratory tests, X-rays, and pathology services</li> <li>• Administration of blood, blood plasma, and other biologicals</li> <li>• Blood and blood plasma, if not donated or replaced</li> <li>• Pre-surgical testing</li> <li>• Dressings, casts, and sterile tray services</li> <li>• Medical supplies, including oxygen</li> <li>• Anesthetics and anesthesia service</li> </ul> <p>Note: We cover hospital services and supplies related to dental procedures when necessitated by a non-dental physical impairment. We do not cover the dental procedures.</p>	<p>\$30 per visit to an ambulatory surgical center</p> <p>10% of charges for surgery in an outpatient department of a hospital</p>
<p><i>Not covered:</i></p> <p><i>Blood and blood derivatives not replaced by the member</i></p>	<p><i>All charges</i></p>
<b>Extended care benefits/Skilled nursing care facility benefits</b>	<b>You pay</b>
<p>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.</p>	<p>Nothing</p>
<p><i>Not covered:</i></p> <p><i>Custodial care</i></p>	<p><i>All charges</i></p>

Hospice care	You pay
<p>Authorized within the service area for 30 days of inpatient care per member. Includes the following:</p> <ul style="list-style-type: none"> <li>• Part-time nursing care by or supervised by a registered graduate nurse;</li> <li>• Counseling, including dietary counseling, for the terminally ill Member,</li> <li>• Family counseling for the Immediate Family and the Family Caregiver before the death of the terminally ill Member;</li> <li>• 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;</li> <li>• Respite Care subject to the following: <ul style="list-style-type: none"> <li>• The annual benefit shall be at least 14 days; and</li> <li>• The carrier may limit any one inpatient stay for Respite Care to 5 consecutive days; and</li> </ul> </li> <li>• Medical supplies, equipment, and medication required to maintain the comfort and manage the pain of the terminally ill Member.</li> </ul>	Nothing
<p><i>Not covered:</i> <i>Independent nursing, homemaker services</i></p>	<i>All charges</i>
Ambulance	You pay
Local professional ambulance service when medically appropriate.	Nothing

## Section 5(d) Emergency services/accidents

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

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- We have no calendar year deductible.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works. Also read Section 10 about coordinating benefits with other coverage, including with Medicare.

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### What is a medical emergency?

A medical emergency is the sudden and unexpected onset of a physical, mental, or dental 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. Other situations are deemed an emergency because of the risk of serious impairment to bodily functions, serious dysfunction of any bodily organ, or the development or continuance of severe pain. 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
<b>Emergency within our service area</b>	
Emergency care at a doctor’s office	\$10 copayment at primary care physician office; \$20 copayment at specialist office
Emergency care at an urgent care center	\$30 copayment per visit
Emergency care at a hospital emergency room (waived if admitted)	\$50 copayment per visit
<i>Not covered:</i>	
<i>Elective care or non-emergency care</i>	<i>All charges</i>

Emergency outside our service area	You pay
<p>Emergency care at a doctor's office</p> <p>Emergency care at an urgent care center</p> <p>Emergency care at a hospital emergency room (waived if admitted)</p>	<p>\$10 copayment at primary care physician office; \$20 copayment at specialist office</p> <p>\$30 copayment per visit</p> <p>\$50 copayment per visit</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• <i>Elective care or non-emergency care</i></li> <li>• <i>Emergency care provided outside the service area if the need for care could have been foreseen before leaving the service area</i></li> <li>• <i>Medical and hospital costs resulting from a normal full-term delivery of a baby outside the service area within 3 weeks of the estimated delivery date.</i></li> </ul>	<p><i>All charges</i></p>
Ambulance	You pay
<p>Professional ground or air ambulance service for emergency services is covered.</p> <p>Note: See 5(c) for non-emergency service.</p>	<p>Nothing</p>

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

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

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

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- We have no calendar year deductible,
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works. Also read Section 10 about coordinating benefits with other coverage, including with Medicare.
- **YOU MUST GET PREAUTHORIZATION OF THESE SERVICES.** See the instructions after the benefits description below.

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Benefit Description	You pay
<b>Mental health and substance abuse benefits</b>	
<p>All diagnostic and treatment services recommended by a Plan provider and contained in a treatment plan that we approve. The treatment plan may include services, drugs, and supplies described elsewhere in this brochure.</p> <p>Note: Plan benefits are payable only when we determine the care is clinically appropriate to treat your condition and only when you receive the care as part of a treatment plan that we approve.</p>	<p>Your cost sharing responsibilities are no greater than for other illnesses or conditions.</p>
<ul style="list-style-type: none"> <li>• Professional services, including individual or group therapy by providers such as psychiatrists, psychologists, or clinical social workers.</li> </ul>	<p>\$20 copayment per visit</p>
<ul style="list-style-type: none"> <li>• Diagnostic tests</li> </ul>	<p>\$10 per test.</p>
<ul style="list-style-type: none"> <li>• Services provided by a hospital or other facility</li> <li>• Services provided in approved alternative care settings such as partial hospitalization, halfway house, residential treatment, full-day hospitalization, facility based intensive outpatient treatment.</li> </ul>	<p>Nothing</p> <p>Nothing</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• <i>Services we have not approved.</i></li> <li>• <i>OPM will base its review of disputes about treatment plan on the treatment plan's clinical appropriateness. OPM will generally not order us to pay or provide one clinically appropriate treatment plan in favor of another.</i></li> </ul>	<p><i>All charges.</i></p>

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**Preauthorization**

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

APS HealthCare, Inc. 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 APS HealthCare, at 800-572-7242.

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**Limitation**

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

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## Section 5(f) Prescription drug benefits

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

- We cover prescribed drugs and medications, as described in the chart beginning on the next page.
- All benefits are subject to the definitions, limitations and exclusions in this brochure and are payable only when we determine they are medically necessary.
- We have no calendar year deductible.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works. Also read Section 10 about coordinating benefits with other coverage, including with Medicare.

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

- **Who can write your prescription?** 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 Caremark, our mail order prescription program. Caremark’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.

### 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 (\$10 for generic prescriptions; \$20 for preferred brand name prescriptions, \$45 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 (\$20 copayment for generic prescriptions; \$40 for preferred brand name prescriptions). Non-preferred brand name prescriptions are not available by mail order. **To order prescription drugs or refills please contact Caremark's Customer Service at 800-378-7040 or visit the website [www.rxrequest.com](http://www.rxrequest.com). 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 to 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.**
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**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 Caremark at 800-378-7040.

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Benefit Description	You pay
<p><b>Covered medications and supplies</b></p> <p>We cover the following when prescribed by a Plan physician and obtained from a Plan pharmacy or through our mail order program:</p> <ul style="list-style-type: none"> <li>• Drugs and medicines that by Federal law of the United States require a physician’s prescription for purchase except those listed as Not covered.</li> <li>• Insulin</li> <li>• Disposable needles and syringes for the administration of covered medications</li> <li>• Drugs for sexual dysfunction (see Prior authorization below)</li> <li>• Contraceptive drugs and devices</li> <li>• 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. Self-Administered injectable drugs are only available through a Specialty Pharmacy.</li> </ul>	<p><b>Retail and Specialty Pharmacy:</b></p> <p>\$10 per prescription or refill for generic formulary drugs;</p> <p>\$20 per prescription or refill for formulary drugs (brand name drugs)</p> <p>\$45 per prescription or refill for non-formulary drugs (brand name drugs)</p> <p><b>Mail Order (Maintenance Drugs only):</b></p> <p>\$20 per prescription or refill for a 90 consecutive day supply for maintenance generic drugs;</p> <p>\$40 per prescription or refill for a 90 consecutive day supply for maintenance preferred drugs (brand name drugs);</p> <p>\$90 per prescription or refill for non-preferred drugs (brand name drugs).</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• <i>Compounded prescriptions whose only ingredients do not require prescription</i></li> <li>• <i>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</i></li> <li>• <i>Prescription Drugs and supplies for cosmetic purposes</i></li> <li>• <i>Drugs to enhance athletic performance</i></li> <li>• <i>Smoking cessation products</i></li> <li>• <i>Dietary supplements, appetite suppressants, and other drugs used to treatment obesity or assist in weight reduction</i></li> <li>• <i>Drugs obtained at a non-Plan pharmacy; except for out-of-area emergencies</i></li> <li>• <i>Vitamins, nutrients and food supplements even if a physician prescribes or administers them, except as specified herein</i></li> <li>• <i>Nonprescription medicines</i></li> <li>• <i>Charges for special re-packaging of medications prepared by the pharmacy such as “unit dose” or “bubble pack”</i></li> <li>• <i>Oral dental preparations, fluoride rinses, except fluoride tablets or drops</i></li> <li>• <i>Refill prescriptions resulting from loss or theft</i></li> </ul>	<p><i>All charges.</i></p>

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## Section 5(g) Special features

Feature	Description
<b>Travel benefit/services overseas</b>	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 1-866-676-7427 for a PHCS network provider in your area.

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## Section 5(h) Dental benefits

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

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary
- 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.

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<b>Accidental injury benefit</b>	<b>You pay</b>
We cover restorative services and supplies necessary to promptly repair (but not replace) sound natural teeth. The need for these services must result from an accidental injury.	\$10 copayment per office visit to a primary care physician; \$20 per office visit to a specialist. Nothing per visit during covered inpatient admissions.
<b>Dental Benefits</b>	<b>You pay</b>
We have no other dental benefits.	All harges.

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## Section 6: High Deductible Health Plan

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Note: This benefits section is divided into subsections. Please read the important things you should keep in mind at the beginning of each subsection. Also read the General exclusions in Section 7; they apply to the benefits in the following subsections. To obtain claim forms, claims filing advice, or more information about our benefits, contact us at 800-833-7423 or at our Web site at [www.chcde.com](http://www.chcde.com).

### Summary

Our High-Deductible Health Plan (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 option, we establish either a Health Savings Account (HSA) or a Health Reimbursement Arrangement (HRA) for you. Each month, we automatically pass through a portion of the total health Plan premium to your HSA based upon your eligibility as of the first day of the month.

With this Plan, preventive care is covered in full. As you receive other non-preventive medical care, you must meet the Plan's deductible before we pay benefits according to the benefit chart beginning in Section 6(a). You can choose to use funds available in your HSA to make payments toward the deductible or you can pay toward your deductible entirely out-of-pocket, allowing your savings to continue to grow.

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

- **In-network preventive care**

The Plan covers preventive care services, such as periodic health evaluations (e.g., annual physicals), screening services (e.g., mammograms), routine prenatal and well-child care, child and adult immunizations, obesity weight loss programs, disease management and wellness programs. You pay \$15 copayments for PCP office visits and \$25 copayments for specialist office visits with the exception of immunizations and procedures that are covered at 100%. *You do not have to meet the deductible before you are covered for these services.*
- **Traditional in-network medical care**

After you have paid the Plan's deductible, we pay benefits under traditional in-network coverage described in Section 6(b). The Plan typically pays 85% for in-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 Section 6(c) for more details).

- **HSA**

By law, HSAs are available to members who are not eligible for Medicare or do not have other health insurance coverage. In 2005, for each month you are eligible for an HSA premium pass through, we will contribute to your HSA \$41.67 per month for a Self-Only enrollment or \$83.33 per month for a Self and Family enrollment. In addition to our monthly contribution, you have the option to make additional tax-free contributions to your HSA, so long as total contributions do not exceed the limit established by law. See maximum contribution information in Section 6(c). You can use funds in your HSA to help pay your health plan deductible.

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

HSA features include:

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

- **HRA**

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

In 2005, we will give you an HRA credit of \$500 per year for a Self-Only enrollment and \$1,000 for a Self and Family enrollment. You can use funds in your HRA to help pay your health plan deductible and/or for certain expenses that don't count toward the deductible.

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

- **Catastrophic protection for out-of-pocket expenses** When you use network providers, your annual maximum for out-of-pocket expenses (deductibles, coinsurance and copayments) for covered services is limited to \$5,000 per person or \$10,000 per family enrollment. However, certain expenses do not count toward your out-of-pocket maximum and you must continue to pay these expenses once you reach your out-of-pocket maximum (such as expenses in excess of the Plan's allowance or benefit maximum). Refer to Section 4 *Your catastrophic protection out-of-pocket maximum*, Section 6(b) *Traditional medical coverage subject to the deductible*, and Section 6(d) *Catastrophic protection for out-of-pocket expenses* for more details.
- **Health education resources and account management tools** Section 6(e) describes the health education resources and account management tools available to you to help you manage your health care and your health care dollars.

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## Section 6(a) Preventive care

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

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- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- The deductible is \$1,050 per person or \$2,100 per family enrollment. The family deductible can be satisfied by one or more family members. The deductible applies to almost all benefits in Section 6(b). You must pay your deductible before your Traditional Medical Coverage may begin. Most benefits after the deductible is met are covered at 85%; you are responsible for 15% of allowed charges up to the Out-of-Pocket maximum.
- For all other covered expenses, please see Section 6(b) –Traditional Medical Coverage, which are subject to the deductible.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works. Also read Section 10 about coordinating benefits with other coverage.

Benefits Description	You pay
<b>Preventive care, adult</b>	
Routine screenings, such as: <ul style="list-style-type: none"> <li>• Total Blood Cholesterol</li> <li>• Colorectal Cancer Screening, including                             <ul style="list-style-type: none"> <li>– Fecal occult blood test</li> <li>– Sigmoidoscopy, screening – every five years starting at age 50</li> <li>– Double contrast barium enema – every five years starting at age 50</li> <li>– Colonoscopy screening – every ten years starting at age 50</li> </ul> </li> <li>• 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.</li> <li>• Routine Prostate Specific Antigen (PSA) test – one annually for men age 40 and older.</li> </ul>	\$15 per primary care office visit; \$25 per specialist office visits.
Routine annual pap test  Note: The office visit is covered if pap test is received on the same day; see <i>Diagnosis and Treatment</i> , above.	\$15 per primary care office visit; \$25 per specialist office visits.
Routine mammogram – covered for women age 35 and older, as follows: <ul style="list-style-type: none"> <li>• From age 35 through 39, one during this five year period</li> <li>• From age 40 through 64, one every calendar year</li> <li>• At age 65 and older, one every two consecutive calendar years</li> </ul>	\$15 per primary care office visit; \$25 per specialist office visits.

Preventive care, adult, continued	After the deductible, you pay
<p>Routine immunizations, limited to:</p> <ul style="list-style-type: none"> <li>• Tetanus-diphtheria (Td) booster – once every 10 years, ages 19 and over (except as provided for under Childhood immunizations)</li> <li>• Influenza vaccine, annually</li> <li>• Pneumococcal vaccine, age 65 and older</li> </ul>	Nothing.
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• <i>Physical exams required for obtaining or continuing employment or insurance, marriage, sports, licensing, adoption, attending schools or camp, or travel or those ordered by a third party.</i></li> <li>• <i>Immunizations, boosters, and medications for travel.</i></li> <li>• <i>Immunizations for meningococcal meningitis.</i></li> </ul>	<i>All Charges</i>
Preventive care, child	After the deductible, you pay
<ul style="list-style-type: none"> <li>• Childhood immunizations recommended by the American Academy of Pediatrics</li> </ul>	Nothing.
<ul style="list-style-type: none"> <li>• Hearing loss screening for newborns provided by the Hospital before discharge</li> <li>• Well-child care charges for routine examinations, immunizations and care (up to age 22)</li> <li>• Examinations, such as: <ul style="list-style-type: none"> <li>– Eye exams through age 17 to determine the need for vision correction</li> <li>– Ear exams through age 17 to determine the need for hearing correction</li> </ul> </li> <li>• Examinations done on the day of immunizations (up to age 22)</li> </ul>	<p>\$15 copayment at primary care physician office</p> <p>\$25 copayment at specialist office</p>

## Section 6(b) Traditional Medical Coverage subject to the deductible

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

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- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- The deductible is \$1,050 per person or \$2,100 per family enrollment. The family deductible can be satisfied by one or more family members. The deductible applies to almost all benefits in Section 6(b). You must pay your deductible before your Traditional Medical Coverage may begin. Most benefits after the deductible is met are covered at 85%; you are responsible for 15% of allowed charges up to the Out-of-Pocket maximum.
- 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 expense for covered services. After your coinsurance, copayments and deductibles total \$5,000 per person or \$10,000 per family enrollment in any calendar year, you do not have to pay any more for covered services from network providers. However, certain expenses do not count toward your out-of-pocket maximum and you must continue to pay these expenses once you reach your out-of-pocket maximum (such as expenses in excess of the Plan's benefit maximum, or if you use out-of-network providers, amounts in excess of the Plan allowance).
- In-network benefits apply only when you use a network provider. This plan does not include out of network coverage. When a network provider is not available, you must obtain prior authorization from Us to use a non-network provider. In the case of Emergency, please use the nearest facility and your benefits will be covered at the same level without regard to the Network status of the provider.
- 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.

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Deductible before Traditional Medical Coverage begins	You pay
The deductible applies to almost all benefits in this Section. In the <i>You pay</i> column, we say "No deductible" when it does not apply. When you receive covered services from network providers, you are responsible for paying the allowable charges until you meet the deductible.	100% of allowable charges until you meet the deductible of \$1,050 per person or \$2,100 per family enrollment. You may choose to pay deductible expenses from your HSA or HRA, or you can pay for them out-of-pocket.
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.	After you meet the deductible, you pay the 15% coinsurance or listed copayments for covered services. You may choose to pay the coinsurance and copayments from your HSA or HRA, or you can pay for them out-of-pocket.

**Section 6(b)(1).Medical services and supplies provided by physicians and other health care professionals**

Benefit Description	After the deductible, you pay
<b>Diagnostic and treatment services</b>	
Professional services of physicians <ul style="list-style-type: none"> <li>• In physician’s office</li> <li>• In an urgent care center</li> <li>• During a hospital stay</li> <li>• In a skilled nursing facility</li> <li>• At home</li> </ul>	\$15 copayment per visit to a primary care physician; \$25 copayment per visit to a specialist. For covered services at all other locations, you pay 15% of the Plan allowance.
<b>Lab, X-ray and other diagnostic tests</b>	
Tests, such as: <ul style="list-style-type: none"> <li>• Blood tests</li> <li>• Urinalysis</li> <li>• Non-routine pap tests</li> <li>• Pathology</li> <li>• X-rays</li> <li>• Non-routine Mammograms</li> <li>• CAT Scans/MRI/PET</li> <li>• Ultrasound</li> <li>• Electrocardiogram and EEG</li> </ul>	15% of the Plan allowance
<i>Not covered: See Exclusions</i>	<i>All charges</i>

Maternity care	After the deductible, you pay
<p>Complete maternity (obstetrical) care, such as:</p> <ul style="list-style-type: none"> <li>• Prenatal care</li> <li>• Delivery</li> <li>• Postnatal care</li> </ul> <p>Note: Here are some things to keep in mind:</p> <ul style="list-style-type: none"> <li>• You do not need to precertify your normal delivery; see below for other circumstances, such as extended stays for you or your baby.</li> <li>• 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.</li> <li>• 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.</li> <li>• 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.</li> <li>• 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.</li> <li>• 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.</li> <li>• We pay hospitalization and surgeon services (delivery) the same as for illness and injury. See Hospital benefits (Section 5c) and Surgery benefits (Section 5b).</li> </ul>	<p>\$15 copayment for first visit;</p> <p>15% of Plan allowance after the first visit</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• <i>Routine sonograms to determine fetal age, size or sex</i></li> <li>• <i>Newborn home delivery</i></li> <li>• <i>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.</i></li> </ul>	<p><i>All charges.</i></p>

Family planning	After the deductible, you pay
<p>A range of voluntary family planning services limited to:</p> <ul style="list-style-type: none"> <li>• Voluntary sterilization (See Surgical procedures)</li> <li>• Surgically implanted contraceptives</li> <li>• Intrauterine devices (IUDs)</li> </ul> <p>Note: We cover injectable contraceptive drugs, oral contraceptive drugs, and diaphragms under the prescription drug benefit.</p>	<p>50% of the Plan allowance</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• <i>Reversal of voluntary surgical sterilization</i></li> <li>• <i>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.</i></li> </ul>	<p><i>All charges</i></p>
Infertility services	After the deductible, you pay
<p>Diagnosis and treatment of infertility such as:</p> <p>Artificial insemination:</p> <ul style="list-style-type: none"> <li>• intravaginal insemination (IVI)</li> <li>• intracervical insemination (ICI)</li> <li>• intrauterine insemination (IUI)</li> <li>• invitro fertilization</li> </ul> <p>Note: We cover injectable fertility drugs under medical benefit and oral fertility drugs under the prescription drug benefit.</p>	<p>50% of the Plan allowance</p>

<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• <i>Assisted reproductive technology (ART) procedures, such as:</i> <ul style="list-style-type: none"> <li>– <i>Intracytoplasmic sperm injection (ICSI), unless authorized as part of an approved IVF procedure</i></li> <li>– <i>in vivo fertilization including but not limited to all other 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.</i></li> </ul> </li> <li>• <i>Cost of donor sperm</i></li> <li>• <i>Cost of donor egg</i></li> </ul>	<p><i>All charges</i></p>
<p><b>Allergy care</b></p>	<p><b>After the deductible, you pay</b></p>
<ul style="list-style-type: none"> <li>• Testing and treatment</li> <li>• Allergy injections</li> <li>•</li> </ul>	<p>15% of the Plan allowance</p> <p>15% of the Plan allowance</p>
<ul style="list-style-type: none"> <li>• Not covered: Provocative food testing and sublingual allergy desensitization.</li> </ul>	<p>All charges.</p>
<ul style="list-style-type: none"> <li>• Allergy serum</li> </ul>	<p>Nothing</p>

Treatment therapies	After the deductible, you pay
<ul style="list-style-type: none"> <li>• Chemotherapy and radiation therapy</li> </ul> <p>Note: High dose chemotherapy in association with autologous bone marrow transplants is limited to those transplants listed under Organ/Tissue Transplants on page xx.</p> <ul style="list-style-type: none"> <li>• Respiratory and inhalation therapy</li> <li>• Dialysis – hemodialysis and peritoneal dialysis</li> <li>• Intravenous (IV)/Infusion Therapy – Home IV and antibiotic therapy</li> <li>• Cardiac Therapy – outpatient is limited to 60 consecutive days beginning with the onset of therapy</li> <li>• Growth hormone therapy (GHT)</li> </ul> <p>Note:</p> <p>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.</p> <p>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 <i>Services requiring our prior approval</i> in Section 3.</p>	<p>15% of the Plan allowance</p>
<p><i>Not covered: see exclusions</i></p>	<p><i>All charges</i></p>
Physical and occupational therapies	After the deductible, you pay
<ul style="list-style-type: none"> <li>• 60 visits per condition per calendar year for the services of the following: <ul style="list-style-type: none"> <li>– qualified physical therapists, and</li> <li>– qualified occupational therapists.</li> </ul> </li> </ul> <p>Note: We only cover therapy to restore bodily function when there has been a total or partial loss of bodily function due to illness or injury.</p>	<p>15% of the Plan allowance</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• <i>Long-term rehabilitative therapy</i></li> <li>• <i>Exercise programs</i></li> </ul>	<p><i>All charges</i></p>
Speech therapy	After the deductible, you pay
<p>60 visits per condition.</p>	<p>15% of the Plan allowance</p>

Habilitative services	After the deductible, you pay
<p>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</p> <ul style="list-style-type: none"> <li>• occupational,</li> <li>• physical, and</li> <li>• speech therapy.</li> </ul>	15% of the Plan allowance
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• <i>Habilitative services delivered through early intervention or school services</i></li> </ul>	<i>All charges.</i>
Hearing services (testing, treatment, and supplies)	After the deductible, you pay
<ul style="list-style-type: none"> <li>• First hearing aid &amp; testing only when necessitated by accidental injury.</li> <li>• Hearing testing for children through age 17 (see <i>Preventive care, children</i>).</li> <li>• 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.</li> </ul>	<p>15% of Plan allowance</p> <p>Nothing</p> <p>15% of Plan allowance</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• <i>All other hearing testing</i></li> <li>• <i>Hearing aids (except for minor children as described above), testing and examinations for them</i></li> </ul>	<i>All charges</i>
Vision services (testing, treatment, and supplies)	After the deductible, you pay
<ul style="list-style-type: none"> <li>• One pair of eyeglasses or contact lenses to correct an impairment directly caused by accidental ocular injury or intraocular surgery (such as for cataracts)</li> <li>• Eye exam to determine the need for vision correction for children through age 17 (see <i>Preventive care, children</i>)</li> </ul>	15% of plan allowance
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• <i>Eyeglasses or contact lenses and after age 17, examinations for them, except as specified above</i></li> <li>• <i>Eye exercises and orthoptics</i></li> <li>• <i>Radial keratotomy and other refractive surgery</i></li> </ul>	<i>All charges.</i>

<b>Foot Care</b>	<b>After the deductible, you pay</b>
<p>Routine foot care when you are under active treatment for a metabolic or peripheral vascular disease, such as diabetes, limited to 10 visits per calendar year to podiatrist</p> <p>Note: See Orthopedic and prosthetic devices for information on podiatric shoe inserts.</p>	15% of Plan allowance
<p><i>Not Covered:</i></p> <p><i>Cutting, trimming or removal of corns, calluses, or the free edge of toenails, and similar routine treatment of conditions of the foot, except as stated above</i></p> <p><i>Treatment of weak, strained or flat feet or bunions or spurs; and of any instability, imbalance or subluxation of the foot (unless the treatment is by open cutting surgery)</i></p>	<i>All charges</i>
<b>Orthopedic and prosthetic devices</b>	<b>After the deductible, you pay</b>
<ul style="list-style-type: none"> <li>• Artificial limbs and eyes; stump hose</li> <li>• Externally worn breast prostheses and surgical bras, including necessary replacements following a mastectomy</li> <li>• Corrective orthopedic appliances for non-dental treatment of temporomandibular joint (TMJ) pain dysfunction syndrome.</li> </ul> <p>Note: Internal prosthetic devices, such as artificial joints, pacemakers, cochlear implants, and surgically implanted breast implant following mastectomy. are paid as hospital benefits. Insertion of the device is paid as surgery.</p> <p>Prosthetic replacements are provided when preauthorized.</p>	15% of plan allowance
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• <i>Orthopedic and corrective shoes</i></li> <li>• <i>Arch supports</i></li> <li>• <i>Foot orthotics</i></li> <li>• <i>Heel pads and heel cups</i></li> <li>• <i>Lumbosacral supports</i></li> <li>• <i>Corsets, trusses, elastic stockings, support hose, and other supportive devices</i></li> <li>• Braces and supports needed for athletic participation or employment.</li> </ul>	<i>All charges</i>

<b>Durable medical equipment (DME)</b>	<b>After the deductible, you pay</b>
<p>Rental or purchase, at our option, including repair and adjustment, of durable medical equipment prescribed by your Plan physician, such as oxygen and dialysis equipment. Under this benefit, we also cover:</p> <ul style="list-style-type: none"> <li>• Hospital beds;</li> <li>• Wheelchairs; motorized wheelchairs are not covered.</li> <li>• Crutches;</li> <li>• Walkers;</li> <li>• Blood glucose monitors;</li> <li>• Ostomy and disposable diabetic supplies;</li> <li>• Hair prosthesis as prescribed by the attending oncologist for a Member whose 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); and</li> <li>• Insulin pumps.</li> </ul>	15% of Plan allowance
<p><i>Not covered:</i></p> <p><i>Motorized wheelchair, wigs (except as noted above), and upgrades to equipment.</i></p>	<i>All charges.</i>
<b>Home health services</b>	<b>After the deductible, you pay</b>
<ul style="list-style-type: none"> <li>• 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.</li> <li>• home visits following a mastectomy or removal of a testicle if the hospital stay is less than 48 hours</li> </ul> <p>Services include oxygen therapy, intravenous therapy and medications.</p>	15% of Plan allowance
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• <i>Nursing care requested by, or for the convenience of, the patient or the patient's family;</i></li> <li>• <i>Home care primarily for personal assistance that does not include a medical component and is not diagnostic, therapeutic, or rehabilitative.</i></li> </ul>	<i>All charges</i>

<b>Chiropractic</b>	<b>After the deductible, you pay</b>
Coverage is limited to 20 visits per calendar year. Services include consultation, diagnosis, and treatment of disease relating to subluxations of the articulations of the spine and adjacent tissues	15% of Plan allowance
<b>Alternative treatments</b>	<b>After the deductible, you pay</b>
No Benefit	All charges
<b>Educational classes and programs</b>	<b>After the deductible, you pay</b>
<p>Diabetic outpatient self-management training and education</p> <p>Health Education such as instructions on achieving and maintaining physical and mental health, and preventing illness and injury.</p> <p>Nutritional counseling provided by a Registered Dietician or Participating Physician in connection with diabetes, coronary artery disease and hyperlipidemia.</p>	Nothing
<b>Medical Clinical Trial</b>	<b>After the deductible, you pay</b>
<p>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.</p> <p>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.</p> <p>Treatment in a Medical Clinical Trial must be authorized in advance by us.</p>	See coverage limitations based on setting (Inpatient, Outpatient, Home and Office, etc.), and type of provider (Specialist care in office, hospital, etc.)

## Section 6(b)(2) Surgical and anesthesia services provided by physicians and other health care professionals

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

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- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan physicians must provide or arrange your care.
- 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.
- The amounts listed below are for the charges billed by a physician or other health care professional for your surgical care. Look in Section 6.b. (3) for charges associated with the facility (i.e. hospital, surgical center, etc.).
- **YOUR PHYSICIAN MUST GET PRECERTIFICATION OF SOME SURGICAL PROCEDURES.** Please refer to the precertification information shown in Section 3 to be sure which services require precertification and identify which surgeries require precertification.

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Benefit Description	After the deductible, you pay
<p><b>Surgical procedures</b></p> <p>A comprehensive range of services, such as:</p> <ul style="list-style-type: none"> <li>• Operative procedures</li> <li>• Treatment of fractures, including casting</li> <li>• Normal pre- and post-operative care by the surgeon</li> <li>• Correction of amblyopia and strabismus</li> <li>• Endoscopy procedures</li> <li>• Biopsy procedures</li> <li>• Removal of tumors and cysts</li> <li>• Correction of congenital anomalies (see Reconstructive surgery)</li> <li>• Surgical treatment of morbid obesity -- a condition in which an individual weighs 100 pounds or 100% over his or her normal weight according to current underwriting standards; eligible members must be age 18 or over. When approved by Us, coverage is provided 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. Benefits are provided 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.</li> </ul>	<p>\$15 copayment in a primary care physician office;</p> <p>\$25 copayment in a specialist office.</p> <p>15% of Plan allowance when performed in Hospital or Surgi-Center settings.</p>

*Surgical procedures – continued on next page*

Surgical procedures (continued)	After the deductible, you pay
<ul style="list-style-type: none"> <li>• Voluntary sterilization (e.g., Tubal ligation, Vasectomy – see <i>Family planning</i>)</li> <li>• Insertion of internal prosthetic devices. See 5(a) – <i>Orthopedic and prosthetic devices</i> for device coverage information</li> </ul>	
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• <i>Reversal of voluntary sterilization</i></li> <li>• <i>Routine treatment of conditions of the foot; see Foot care</i></li> </ul>	<p><i>All charges</i></p>
Reconstructive surgery	After the deductible, you pay
<ul style="list-style-type: none"> <li>• Surgery to correct a functional defect</li> <li>• Surgery to correct a condition caused by injury or illness if: <ul style="list-style-type: none"> <li>– the condition produced a major effect on the member’s appearance and</li> <li>– the condition can reasonably be expected to be corrected by such surgery</li> </ul> </li> <li>• Surgery to correct a condition that existed at or from birth and is a significant deviation from the common form or norm. Examples of congenital anomalies are: protruding ear deformities; cleft lip; cleft palate; birth marks; webbed fingers; and webbed toes.</li> <li>• All stages of breast reconstruction surgery following a mastectomy, such as: <ul style="list-style-type: none"> <li>– surgery to produce a symmetrical appearance of breasts;</li> <li>– treatment of any physical complications, such as lymphedemas;</li> <li>– breast prostheses and surgical bras and replacements (see <i>Prosthetic devices</i>)</li> </ul> </li> </ul> <p>Note: If you need a mastectomy, you may choose to have the procedure performed on an inpatient basis and remain in the hospital up to 48 hours after the procedure.</p>	<p>\$15 copayment in a primary care physician office; \$25 copayment in a specialist office.</p> <p>15% of Plan allowance when performed in Hospital or Surgi-Center settings.</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• <i>Cosmetic surgery – any surgical procedure (or any portion of a procedure) performed primarily to improve physical appearance through change in bodily form, except repair of accidental injury</i></li> <li>• <i>Surgeries related to sex transformation</i></li> </ul>	<p><i>All charges.</i></p>

Oral and maxillofacial surgery	After the deductible, you pay
<p>Oral surgical procedures, limited to:</p> <ul style="list-style-type: none"> <li>• Reduction of fractures of the jaws or facial bones;</li> <li>• Surgical correction of cleft lip, cleft palate or severe functional malocclusion;</li> <li>• Removal of stones from salivary ducts;</li> <li>• Excision of leukoplakia or malignancies;</li> <li>• Excision of cysts and incision of abscesses when done as independent procedures; and</li> <li>• Other surgical procedures that do not involve the teeth or their supporting structures.</li> <li>• TMJ related services (non-dental)</li> </ul>	<p>\$15 copayment in a primary care physician office;</p> <p>\$25 copayment in a specialist office.</p> <p>15% of Plan allowance when performed in Hospital or Surgi-Center settings.</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• <i>Oral implants and transplants</i></li> <li>• <i>Procedures that involve the teeth or their supporting structures (such as the periodontal membrane, gingiva, and alveolar bone)</i></li> </ul>	<p><i>All charges</i></p>
Organ/tissue transplants	After the deductible, you pay
<p>Limited to:</p> <ul style="list-style-type: none"> <li>• Cornea</li> <li>• Heart</li> <li>• Heart/lung</li> <li>• Kidney</li> <li>• Kidney/Pancreas</li> <li>• Liver</li> <li>• Lung: Single – Double</li> <li>• Pancreas</li> <li>• Allogeneic (donor) bone marrow transplants</li> <li>• Autologous bone marrow transplants (autologous stem cell and peripheral stem cell support) for the following conditions: acute lymphocytic or non-lymphocytic leukemia; advanced Hodgkin’s lymphoma; advanced non-Hodgkin’s lymphoma; advanced neuroblastoma; breast cancer; multiple myeloma; epithelial ovarian cancer; and testicular, mediastinal, retroperitoneal and ovarian germ cell tumors</li> <li>• Intestinal transplants (small intestine) and the small intestine with the liver or small intestine with multiple organs such as the liver, stomach, and pancreas</li> </ul>	<p>15% of Plan allowance</p>

*Organ/tissue transplants – continued on next page*

Organ/tissue transplants (continued)	After the deductible, you pay
<ul style="list-style-type: none"> <li>• Only covered when rendered at a Coventry Transplant Network participating facility approved by Us. Donor screening tests are covered and are subject to a lifetime benefit maximum of \$10,000 when performed at a Coventry Transplant Network participating facility approved by Us.</li> <li>• If not covered by any other source, the cost of any care, including complications, arising from an organ donation by a non-covered individual when the recipient is a covered individual will be covered for the duration of the contract of the covered individual when approved by Us.</li> <li>• Travel expenses for members and living donors are covered according to Our transplant travel benefit. Details of the transplant travel benefit will be provided upon request and at any time Transplant Services are authorized. Members are covered when CHCDE is the primary insurer and a Coventry Transplant Network participating facility approved by Us is used.</li> <li>• Limited Benefits – Treatment for breast cancer, multiple myeloma, and epithelial ovarian cancer may be provided in a National Cancer Institute – or National Institutes of Health-approved clinical trial at a Plan-designated center of excellence and if approved by the Plan’s medical director in accordance with the Plan’s protocols.</li> </ul> <p>We cover related medical and hospital expenses of the donor when we cover the recipient.</p>	
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• Donor screening tests and donor search expenses, except those performed for the actual donor</li> <li>• Implants of artificial organs</li> <li>• Transplants not listed as covered</li> </ul>	<p><i>All charges.</i></p>
Anesthesia	After the deductible, you pay
<p>Professional services provided in –</p> <ul style="list-style-type: none"> <li>• Hospital (inpatient)</li> </ul>	<p>15% of Plan allowance</p>
<p>Professional services provided in –</p> <ul style="list-style-type: none"> <li>• Hospital outpatient department</li> <li>• Skilled nursing facility</li> <li>• Ambulatory surgical center</li> </ul>	<p>15% of Plan allowance</p>
<p>Professional services provided in the office</p>	<p>\$15 copayment in a primary care physician office; \$25 copayment in a specialist office.</p>

## Section 6(b)(3) Services provided by a hospital or other facility, and ambulance services

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

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- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan physicians must provide or arrange your care and you must be hospitalized in a Plan facility.
- 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.
- 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 Section 6 (b) (2)
- **YOUR PHYSICIAN MUST GET PRECERTIFICATION OF HOSPITAL STAYS.** Please refer to Section 3 to be sure which services require precertification.

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Benefit Description	After the deductible, you pay
<b>Inpatient hospital</b>	
Room and board, such as <ul style="list-style-type: none"> <li>• Ward, semiprivate, or intensive care accommodations;</li> <li>• General nursing care; and</li> <li>• Meals and special diets.</li> </ul> Note: If you want a private room when it is not medically necessary, you pay the additional charge above the semiprivate room rate.	15% of Plan allowance
Other hospital services and supplies, such as: <ul style="list-style-type: none"> <li>• Operating, recovery, maternity, and other treatment rooms</li> <li>• Prescribed drugs and medicines</li> <li>• Diagnostic laboratory tests and X-rays</li> <li>• Blood or blood plasma, if not donated or replaced</li> <li>• Dressings, splints, casts, and sterile tray services</li> <li>• Medical supplies and equipment, including oxygen</li> <li>• Anesthetics, including nurse anesthetist services</li> <li>• Take-home items</li> <li>• Medical supplies, appliances, medical equipment, and any covered items billed by a hospital for use at home</li> </ul>	15% of Plan allowance

*Inpatient hospital – continued on the next page*

<b>Inpatient Hospital (continued)</b>	<b>After the deductible, you pay</b>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• <i>Custodial care</i></li> <li>• <i>Non-covered facilities, such as nursing homes, schools</i></li> <li>• <i>Personal comfort items, such as telephone, television, barber services, guest meals and beds</i></li> <li>• <i>Private nursing care</i></li> </ul>	<p><i>All charges.</i></p>
<b>Outpatient hospital or ambulatory surgical center</b>	<b>After the deductible, you pay</b>
<ul style="list-style-type: none"> <li>• Operating, recovery, and other treatment rooms</li> <li>• Prescribed drugs and medicines</li> <li>• Diagnostic laboratory tests, X-rays, and pathology services</li> <li>• Administration of blood, blood plasma, and other biologicals</li> <li>• Blood and blood plasma, if not donated or replaced</li> <li>• Pre-surgical testing</li> <li>• Dressings, casts, and sterile tray services</li> <li>• Medical supplies, including oxygen</li> <li>• Anesthetics and anesthesia service</li> </ul> <p>Note: We cover hospital services and supplies related to dental procedures when necessitated by a non-dental physical impairment. We do not cover the dental procedures.</p>	<p>15% of Plan allowance</p>
<p><i>Not covered:</i></p> <p><i>Blood and blood derivatives not replaced by the member</i></p>	<p><i>All charges</i></p>
<b>Extended care benefits/Skilled nursing care facility benefits</b>	<b>After the deductible, you pay</b>
<p>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.</p>	<p>15% of Plan allowance</p>
<p><i>Not covered:</i></p> <p><i>Custodial Care</i></p>	<p><i>All charges</i></p>

<b>Hospice care</b>	<b>After the deductible, you pay</b>
<p>Authorized within the service area for 30 days of inpatient care per member. Includes the following:</p> <ul style="list-style-type: none"> <li>• Part-time nursing care by or supervised by a registered graduate nurse;</li> <li>• Counseling, including dietary counseling, for the terminally ill Member,</li> <li>• Family counseling for the Immediate Family and the Family Caregiver before the death of the terminally ill Member;</li> <li>• 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;</li> <li>• Respite Care subject to the following: <ul style="list-style-type: none"> <li>• The annual benefit shall be at least 14 days; and</li> <li>• The carrier may limit any one inpatient stay for Respite Care to 5 consecutive days; and</li> </ul> </li> <li>• Medical supplies, equipment, and medication required to maintain the comfort and manage the pain of the terminally ill Member.</li> </ul>	<p>15% of Plan allowance</p>
<p><i>Not covered:</i></p> <p><i>Independent nursing, homemaker services</i></p>	<p><i>All charges.</i></p>
<b>Ambulance</b>	<b>After the deductible, you pay</b>
<p>Local professional ambulance service when medically appropriate.</p>	<p>15% of Plan allowance</p>

## Section 6(b)(4) Emergency services/accidents

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

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- 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.

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### What is a medical emergency?

A medical emergency is the sudden and unexpected onset of a condition or an injury that 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	After deductible, you pay
<b>Emergency within our service area</b>	
Emergency care at a doctor’s office	\$15 copayment at primary care physician office \$25 copayment at specialist office
Emergency care at an urgent care center	15% of Plan allowance
Emergency care as an outpatient at a hospital, including doctor’s services	15% of Plan allowance
<i>Not covered:</i>	<i>All charges</i>
<i>Elective care or non-emergency care</i>	

Emergency outside our service area	After deductible, you pay
<p>Emergency care at a doctor's office</p> <p>Emergency care at an urgent care center</p> <p>Emergency care as an outpatient at a hospital, including doctor's services</p>	<p>\$15 copayment at primary care physician office \$25 copayment at specialist office</p> <p>15% of Plan allowance</p> <p>15% of Plan allowance</p>
<p><i>Not covered:</i></p> <p><i>Elective care or non-emergency care</i></p> <p><i>Emergency care provided outside the service area if the need for care could have been foreseen before leaving the service area</i></p> <p><i>Medical and hospital costs resulting from a normal full-term delivery of a baby outside the service area within 3 weeks of the estimated delivery date.</i></p>	<p><i>All charges</i></p>
Ambulance	After deductible, you pay
<p>Professional ground or air ambulance service for emergency services is covered.</p> <p>Note: See 6(b)(3) for non-emergency service.</p>	<p>15% of Plan allowance</p>

## Section 6(b)(5) Mental health and substance abuse benefits

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

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

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- 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.
- **YOU MUST GET PREAUTHORIZATION OF THESE SERVICES.** See the instructions after the benefits description below.

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Benefit Description	After the deductible, you pay
<b>Mental health and substance abuse benefits</b>	
<p>All diagnostic and treatment services recommended by a Plan provider and contained in a treatment plan that we approve. The treatment plan may include services, drugs, and supplies described elsewhere in this brochure.</p> <p>Note: Plan benefits are payable only when we determine the care is clinically appropriate to treat your condition and only when you receive the care as part of a treatment plan that we approve.</p>	<p>Your cost sharing responsibilities are no greater than for other illnesses or conditions.</p>
<ul style="list-style-type: none"> <li>• Professional services, including individual or group therapy by providers such as psychiatrists, psychologists, or clinical social workers.</li> <li>• Medication Management</li> </ul>	<p>\$25 copayment per visit to a specialist</p> <p>15% of Plan allowance for outpatient facility</p>
<ul style="list-style-type: none"> <li>• Diagnostic tests</li> </ul>	<p>15% of Plan allowance</p>
<ul style="list-style-type: none"> <li>• Services provided by a hospital or other facility</li> <li>• Services provided in approved alternative care settings such as partial hospitalization, half-way house, residential treatment, full-day hospitalization, facility based intensive outpatient treatment.</li> </ul>	<p>15% of Plan allowance</p> <p>15% of Plan allowance</p>
<p><i>Not Covered:</i></p> <ul style="list-style-type: none"> <li>• <i>Services we have not approved</i></li> <li>• <i>OPM will base its review about treatment plans on the treatment plan's clinical appropriateness. OPM will generally not order us to pay or provide one clinically appropriate treatment plan in favor of another.</i></li> </ul>	<p><i>All charges.</i></p>

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**Preauthorization**

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

APS HealthCare, Inc. 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 APS HealthCare, at 800-572-7242.

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**Limits:** We may deny your benefits if you do not obtain a treatment plan

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## Section 6(b)(6) Prescription drug benefits

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

- We cover prescribed drugs and medications, as described in the chart beginning on the next page.
- All benefits are subject to the definitions, limitations and exclusions in this brochure and are payable only when we determine they are medically necessary.
- We have no calendar year deductible.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works. Also read Section 10 about coordinating benefits with other coverage, including with Medicare.

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

- **Who can write your prescription?** 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 Caremark, our mail order prescription program. Caremark’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).

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*Prescription Drug Benefits – continued on next page*

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## 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 (\$10 for generic prescriptions; \$20 for preferred brand name prescriptions, \$45 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 (\$20 copayment for generic prescriptions; \$40 for preferred brand name prescriptions). Non-preferred brand name prescriptions are not available by mail order. **To order prescription drugs or refills please contact Caremark's Customer Service at 800-378-7040 or visit the website [www.rxrequest.com](http://www.rxrequest.com). 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 to 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.**

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**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 Caremark at 800-378-7040.

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*Prescription drug benefits – continued on next page*

Benefit Description	After the deductible, you pay
<p><b>Covered medications and supplies</b></p> <p>We cover the following when prescribed by a Plan physician and obtained from a Plan pharmacy or through our mail order program:</p> <ul style="list-style-type: none"> <li>• Drugs and medicines that by Federal law of the United States require a physician’s prescription for purchase, except those listed as not covered.</li> <li>• Insulin</li> <li>• Disposable needles and syringes for the administration of covered medications</li> <li>• Drugs for sexual dysfunction (see Prior authorization below)</li> <li>• Contraceptive drugs and devices</li> <li>• 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.</li> </ul>	<p><b>Retail and Specialty Pharmacy:</b></p> <p>\$10 per prescription or refill for generic formulary drugs;</p> <p>\$20 per prescription or refill for formulary drugs (brand name)</p> <p>\$45 per prescription or refill for non-formulary drugs (brand name)</p> <p><b>Mail Order (Maintenance drugs only):</b></p> <p>\$20 per prescription or refill for a 90 consecutive day supply for maintenance generic drugs;</p> <p>\$40 per prescription or refill for a 90 consecutive day supply for maintenance preferred drugs (brand name drugs)</p> <p>\$90 per prescription or refill for a 90 consecutive day supply for maintenance non-preferred drugs (brand name drugs)</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• <i>Compounded prescriptions whose only ingredients do not require prescription</i></li> <li>• <i>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</i></li> <li>• <i>Prescription Drugs and supplies for cosmetic purposes</i></li> <li>• <i>Drugs to enhance athletic performance</i></li> <li>• <i>Smoking cessation products</i></li> <li>• <i>Dietary supplements, appetite suppressants, and other drugs used to treatment obesity or assist in weight reduction</i></li> <li>• <i>Drugs obtained at a non-Plan pharmacy; except for out-of-area emergencies</i></li> <li>• <i>Vitamins, nutrients and food supplements even if a physician prescribes or administers them, except as specified herein</i></li> <li>• <i>Nonprescription medicines</i></li> <li>• <i>Charges for special re-packaging of medications prepared by the pharmacy such as “unit dose” or “bubble pack”</i></li> <li>• <i>Oral dental preparations, fluoride rinses, except fluoride tablets or drops</i></li> <li>• <i>Refill prescriptions resulting from loss or theft</i></li> </ul>	<p><i>All charges.</i></p>

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### Section 6(b)(7) Special features

Special feature	Description
<b>Travel benefit/services overseas</b>	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 1-866-676-7427 for a PHCS network provider in your area.

## Section 6(b)(8) Dental benefits

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

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- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary
- Plan 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.

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<b>Accidental injury benefit</b>	<b>After the deductible, you pay</b>
Coverage is limited to the functional restoration of structures and treatment as a result of trauma resulting in fracture of jaw or laceration of mouth, tongue, or gums when services are provided within 48 hours of injury.	15% of the Plan allowance
<b>Dental Benefits</b>	<b>After the deductible, you pay</b>
We have no other dental benefits.	All charges.

**Section 6(c) Savings – HSAs and HRAs**

<b>Feature Comparison</b>	<b>Health Savings Account (HSA)</b>	<b>Health Reimbursement Arrangement (HRA)</b>  <b>Provided when you are ineligible for an HSA</b>
<b>Administrator</b>	<p>The Plan will establish an HSA for you with Corporate Benefit Services of America (CBSA), this HDHP’s fiduciary (an administrator, trustee or custodian as defined by Federal tax code and approved by IRS.)</p> <p><i>Name: Corporate Benefit Services of America (CBSA)</i></p> <p><i>Street Address: P.O. Box 270520</i></p> <p><i>City, State ZIP Code: Golden Valley, MN 55427</i></p> <p><i>Phone: 800-566-9311</i></p> <p><b>OR</b></p> <p><i><a href="https://services.cbsainc.com/eehome.asp">https://services.cbsainc.com/eehome.asp</a></i></p>	<p>Corporate Benefit Services of America (CBSA) is the HRA fiduciary for this Plan.</p> <p><i>Name: Corporate Benefit Services of America (CBSA)</i></p> <p><i>Street Address: P.O. Box 270520</i></p> <p><i>City, State ZIP Code: Golden Valley, MN 55427</i></p> <p><i>Phone: 800-566-9311</i></p> <p><b>OR</b></p> <p><i><a href="https://services.cbsainc.com/eehome.asp">https://services.cbsainc.com/eehome.asp</a></i></p>
<b>Fees</b>	None.	None.
<b>Eligibility</b>	<p>You must be enrolled in Coventry Health Care’s High Deductible Health Plan.</p> <p>You must have no other health insurance coverage (does not apply to specific injury, accident, disability, dental, vision or long-term care coverage)</p> <p>You must not eligible for Medicare Part A or Part B</p> <p>You must not be claimed as a dependent on someone else’s tax return</p> <p>You must complete and return all banking paperwork</p> <p>Eligibility is determined on the first day of the month</p>	<p>You must be enrolled in Coventry Health Care’s High Deductible Health Plan.</p> <p>You must be eligible for Medicare Part A or Part B</p> <p>You must complete and return all banking paperwork</p> <p>Eligibility is determined on the first day of the month</p>

Feature Comparison	Health Savings Account (HSA)	Health Reimbursement Arrangement (HRA)  Provided when you are ineligible for an HSA
<p><b>Funding</b></p> <ul style="list-style-type: none"> <li>• <b>Self Only coverage</b></li> <li>• <b>Self and Family coverage</b></li> </ul>	<p><i>\$500 annual</i> premium pass through by HDHP directly into account, prorated on a monthly basis.</p> <p><i>\$1,000 annual</i> premium pass through by HDHP directly into account, prorated on a monthly basis.</p> <p>Eligibility for contributions will be determined on the first day of the month and will be prorated for length of enrollment.</p>	<p><i>\$500</i> annual credit (prorated monthly and credited to the account) provided by the HDHP upon effective date</p> <p><i>\$1,000</i> annual credit (prorated monthly and credited to the account) provided by the HDHP upon effective date</p> <p>Eligibility for annual credit will be determined on the first day of the month and will be prorated for length of enrollment.</p>

Feature Comparison	Health Savings Account (HSA)	Health Reimbursement Arrangement (HRA)  Provided when you are ineligible for an HSA
<p><b>Contributions/credits</b></p> <ul style="list-style-type: none"> <li>• <b>Self Only coverage</b></li> <li>• <b>Self and Family coverage</b></li> </ul>	<p>The maximum that can be contributed to your HRA is an annual combination of HDHP premium pass through and enrollee contribution funds, which when combined, do not exceed the amount of the deductible, which is \$1,050 self/\$2,100 family for each month you are eligible for HSA contributions,</p> <p>The HDHP will make a premium pass through of <b>\$41.67 per</b> month. You may make a maximum annual contribution of <b>\$550.</b></p> <p>The HDHP will make a premium pass through of <b>\$83.33</b> per month. Your annual maximum contribution cannot exceed <b>\$1,100</b></p> <p>If you choose to contribute to your HSA,</p> <ul style="list-style-type: none"> <li>-You must deduct 1/12 of total annual maximum contribution for every month you are not eligible for the HDHP the whole month. For instance, if your enrollment in this Plan was not effective on January 1, 2005, you cannot receive a credit for January and you would need to deduct 1/12 of the annual maximum contribution.</li> <li>-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).</li> <li>- HSAs earn tax-free interest (does not affect your annual maximum contribution).</li> </ul>	<p>The full HRA credit will be available, subject to proration, on the effective date of enrollment. The HRA does not earn interest. You cannot contribute to the HRA.</p> <p>The HDHP will make a premium pass through of <b>\$41.67 per</b> month. You may make a maximum annual contribution of <b>\$550.</b></p> <p>The HDHP will make a premium pass through of <b>\$83.33</b> per month. Your annual maximum contribution cannot exceed <b>\$1,100</b></p>
<p><b>Access funds</b></p>	<p>You can access your HSA by the following methods:</p> <ul style="list-style-type: none"> <li>• Debit card</li> <li>• Withdrawal form</li> </ul>	<p>For qualified medical expenses under your HDHP, you will be automatically reimbursed when claims are submitted through your Coventry Health Care Flex Choice HDHP.</p> <p>For expenses not covered by the HDHP, such as orthodontia, a reimbursement form will be sent to you.</p>

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

<b>Feature Comparison</b>	<b>Health Savings Account (HSA)</b>	<b>Health Reimbursement Arrangement (HRA)</b>  <b>Provided when you are ineligible for an HSA</b>
<b>Portable</b>	Yes, you can take this account with you when you separate or retire.	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.
<b>Annual rollover</b>	Yes, accumulates without a maximum cap.	Yes, accumulates without a maximum cap.

## HSAs

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

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

**Can I contribute to my HSA?**

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

IRS contribution rules reduce the total annual maximum contribution if you are not eligible for the HDHP during the whole month. For instance, if your enrollment in this Plan was not effective on January 1, 2005, you cannot receive a credit for January and you would need to deduct 1/12 of the annual maximum contribution. Contact CBSA for more details.

**Catch-up contributions**

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

**Rate of interest earned**

Depending on how you choose to invest your HSA savings, the interest rate and payment of interest will vary. Contact CBSA for more details on the investment options available to you.

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

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

**What happens to my HSA if I die?**

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

**What expenses can I pay for with my HSA?**

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

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

For the complete list of IRS-allowable expenses, request a copy of IRS Publication 502 by calling 1-800-829-3676, or visit the IRS Web site at [www.irs.gov](http://www.irs.gov) and click on “Forms and Publications.”

**Non-qualified health expenses**

You may withdraw money from your HSA for items other than qualified health expenses, but it will be subject to income tax and if you are under 65 years old, an additional 10% penalty tax on the amount withdrawn.

**Tracking your HSA balance**

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

**Minimum reimbursements from your HSA**

You can request reimbursement in any amount.

**How do I know if I qualify for an HRA?**

If you don't qualify for an HSA when you enroll, or later become ineligible for an HSA, the HDHP will establish an HRA for you. If you are Medicare eligible, even if you have not elected to enroll in Medicare, you are ineligible for an HSA and your HDHP will establish an HRA for you.

**HRA and HSA differences**

Please review the chart at the beginning of this Section, which details the differences. 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.

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## **Section 6(d) Catastrophic protection for out-of-pocket expenses**

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Our system will monitor (auto calculate) out-of-pocket expenses for HDHP, just as with any product we administer. Once the out of pocket threshold is met, claims will pay at 100%. Pursuant to IRS regulations for qualified HDHPs, out of pocket expenses are calculated the same way as the deductible for both Family and Single coverages.

## Section 6(e) Health education resources and account management tools

Special features	Description
<p><b>Health education resources</b></p>	<p>Visit the Health Information section of our website at <a href="http://www.chcde.com">www.chcde.com</a> for information to help you take command of your health. The site is organized in simple, user-friendly, sections:</p> <ul style="list-style-type: none"> <li>- <b>Assess Your Health</b> – 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.</li> <li>- <b>About Your Health</b> – for information about a specific condition or general preventive guidelines.</li> <li>- <b>Patient Safety</b></li> <li>- <b>WebMD</b> – our link to this health site also provides wellness and disease information to help improve health.</li> </ul> <p><b>Prescription Drug</b> educational materials are also accessible through our website, through a link to our pharmacy benefit manager, Caremark. There, you will find:</p> <ul style="list-style-type: none"> <li>- Detailed information about a wide range of prescription drugs;</li> <li>- 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;</li> <li>- Facts about why FDA-approved generic drugs should be a first choice for effective, economical treatment.</li> </ul> <p>Another key health information tool that we make available to you is our online quality tool, powered by HealthShare®. You can review the frequency of procedures performed by a provider, knowing the correlation between frequency of service and quality of outcomes. We post additional quality outcome information, such as re-admission rates within 30 days, postoperative complications, and even death rates.</p> <p>We also publish an e-newsletter to keep you informed on a variety of issues related to your good health. Visit our Web site at <a href="http://www.chcde.com">www.chcde.com</a> for back editions of this publication, <i>Living Well</i>.</p> <p>In addition, we augment our health education tools with access to our <b>Nurse Advisor Services</b>. Experienced RNs are available through an inbound call center 24x7x365 to assist you and help you to maximize your benefits, by providing clinical and economic information to make an informed decision on how to proceed with care.</p>
<p><b>Account management tools</b></p>	<p>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 <a href="http://www.chcde.com">www.chcde.com</a>.</p> <p>You will receive an <i>Explanation of Benefits</i> (EOB) after every claim.</p> <p><b><u>If you have an HSA,</u></b></p> <ul style="list-style-type: none"> <li>✓ You will receive a quarterly statement from the HSA administrator outlining your account balance and activity for the month.</li> <li>✓ You may also access your account on-line at <a href="http://www.chcde.com">www.chcde.com</a>.</li> </ul> <p><b><u>If you have an HRA,</u></b></p> <ul style="list-style-type: none"> <li>✓ Your HRA balance will be available online through <a href="http://www.chcde.com">www.chcde.com</a></li> <li>✓ Your balance will also be shown on your EOB form.</li> </ul>

<p><b>Consumer choice information</b></p>	<p>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 <a href="http://www.chcde.com">www.chcde.com</a>.</p> <p>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 <a href="http://www.chcde.com">www.chcde.com</a> is updated every week. It lets you easily search for a participating physician based on the criteria <i>you</i> choose, such as provider specialty, gender, secondary languages spoken, or hospital affiliation. You can even specify the maximum distance you're willing to travel and, in most instances, get driving directions and a map to the offices of identified providers.</p> <p>Pricing information for medical care is available at <a href="http://www.chcde.com">www.chcde.com</a>. There, you will find our <i>Health Services Pricing Tools</i>, 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.</p> <p>Pricing information for prescription drugs is available through our link to the website of our pharmacy benefit manager, Caremark (which you can access via <a href="http://www.chcde.com">www.chcde.com</a>). Through a password-protected account, you will have the ability to estimate prescription costs before ordering.</p> <p>Educational materials on the topics of HSAs, HRAs and HDHPs are available at <a href="http://www.chcde.com">www.chcde.com</a>.</p>
<p><b>Care support</b></p>	<p>Our complex case management programs offer special assistance to members with intricate, long-term medical needs. Our disease management program fosters a proactive approach to managing care from prevention through treatment and management. Your physician can help arrange for participation in these programs, or you can simply contact our member service department.</p> <p>Patient safety information is available online at <a href="http://www.chcde.com">www.chcde.com</a>.</p> <p>Care support is also available to you, in the form of a relationship that we have established with the <i>College of American Pathologists</i> for e-mail reminder notifications. We'll send a message to the e-mail address you provide on a scheduled basis, reminding you to arrange for screening tests.</p>

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## Section 7. General exclusions – things we don't cover

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The exclusions in this section apply to all benefits. **Although we may list a specific service as a benefit, we will not cover it unless your Plan doctor determines it is medically necessary to prevent, diagnose, or treat your illness, disease, injury, or condition** and we agree, as discussed under *Services requiring our prior approval* in Section 3.

We do not cover the following:

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

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## Section 8. Filing a claim for covered services

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When you see network physicians, receive services at network hospitals and facilities, or obtain your prescription drugs at network 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 out-of-network providers. Sometimes these providers bill us directly. Check with the provider. If you need to file the claim, here is the process:

### How to claim benefits

To obtain claim forms or other claims filing advice or answers about our benefits, 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](http://www.chcde.com).

In most cases, providers and facilities file claims for you. Your physician must file on the form HCFA-1500, Health Insurance Claim Form. Your facility must file on the UB-92 form. For claims questions and assistance, call us at 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 HCFA-1500 or a claim form that includes the information shown below. Bills and receipts should be itemized and show:

- Covered member’s name and ID number;
- Name and address of the physician or facility that provided the service or supply;
- Dates you received the services or supplies;
- Diagnosis;
- Type of each service or supply;
- The charge for each service or supply; and
- Receipts, if you paid for your services. Note: Canceled checks, cash register receipts, or balance due statements are not acceptable substitutes for itemized bills.

Mail the claim to:

#### Medical & Hospital Benefits:

Coventry Health Care  
2751 Centerville Road  
Wilmington, DE 19808

#### Prescription Drugs:

Caremark  
P.O. Box 6559574  
San Antonio, TX 78265  
800-378-7040

#### Mental Health Benefits:

APS HealthCare, Inc.  
P.O. Box 1246  
Rockville, MD 20849

### Preventive care

Coventry Health Care  
2751 Centerville Road  
Wilmington, DE 19808

### Traditional Medical

Coventry Health Care

**Coverage subject to the deductible**

2751 Centerville Road  
Wilmington, DE 19808

**After you reach the catastrophic out-of-pocket maximum**

Coventry Health Care  
2751 Centerville Road  
Wilmington, DE 19808

**Records**

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

**Deadline for filing your claim**

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

**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; 2751 Centerville Road; Wilmington, DE 19808. 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.

**When we need more information**

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

## Section 9. The disputed claims process

Follow this Federal Employees Health Benefits Program disputed claims process if you disagree with our decision on your claim or a request for services, drugs, or supplies – including a request for preauthorization/prior approval. Disagreements between you and the HDHP fiduciary regarding the administration of an HSA or HRA are not subject to the disputed claims process.

Step	Description
<b>1</b>	<p>Ask us in writing to reconsider our initial decision. You must:</p> <ul style="list-style-type: none"> <li>a) Write to us within 6 months from the date of our decision; and</li> <li>b) Send your request to us at: Coventry Health Care, 2751 Centerville Road, Suite 400, Wilmington, DE 19808, and</li> <li>c) Include a statement about why you believe our initial decision was wrong, based on specific benefit provisions in this brochure; and</li> <li>d) Include copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms.</li> </ul>
<b>2</b>	<p>We have 30 days from the date we receive your request to:</p> <ul style="list-style-type: none"> <li>a) Pay the claim (or, if applicable, arrange for the health care provider to give you the care); or</li> <li>b) Write to you and maintain our denial – go to step 4; or</li> <li>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.</li> </ul>
<b>3</b>	<p>You or your provider must send the information so that we receive it within 60 days of our request. We will then decide within 30 more days.</p> <p>If we do not receive the information within 60 days, we will make a decision within 30 days of the date the information was due. We will base our decision on the information we already have.</p> <p>We will write to you with our decision.</p>
<b>4</b>	<p>If you do not agree with our decision, you may ask OPM to review it.</p> <p>You must write to OPM within:</p> <ul style="list-style-type: none"> <li>• 90 days after the date of our letter upholding our initial decision; or</li> <li>• 120 days after you first wrote to us -- if we did not answer that request in some way within 30 days; or</li> <li>• 120 days after we asked for additional information.</li> </ul> <p>Write to OPM at: United States Office of Personnel Management, Insurance Services Programs, Health Insurance Group III, 1900 E Street, NW, Washington, DC 20415-3620.</p>

## The disputed claims process (*continued*)

Send OPM the following information:

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

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

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

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

**5**

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

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

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

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

Note: **If you have a serious or life threatening condition** (one that may cause permanent loss of bodily functions or death if not treated as soon as possible), and

- a) We haven't responded yet to your initial request for care or preauthorization/prior approval, then call us at 800-727-9951 and we will expedite our review; or
- b) We denied your initial request for care or preauthorization/prior approval, then:
  - If we expedite our review and maintain our denial, we will inform OPM so that they can give your claim expedited treatment too, or
  - You may call OPM's Health Insurance Group III at 202/606-0737 between 8 a.m. and 5 p.m. eastern time.

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## Section 10. Coordinating benefits with other coverage

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### When you have other health coverage

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

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

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

When we are the secondary payer, we will determine our allowance. After the primary plan pays, we will pay what is left of our allowance, up to our regular benefit. We will not pay more than our allowance. The difference between the benefit payments that We actually paid or provided shall be recorded as a benefit reserve for You or Your Covered Dependent and used by Us to pay any Allowable expenses, not otherwise paid during the Claim Determination Period. As each claim is submitted, We will:

- Determine Our obligation to pay provide benefits under its contract;
- Determine whether a benefit reserve has been recorded for You a or Your Covered Dependent:
- Determine whether there are any unpaid Allowable expenses during the Claim Determination Period.

If there is a benefit reserve, the Secondary Plan will use the Member’s benefit reserve to pay up to 100% of total Allowable Expenses incurred during the Claim Determination Period. At the end of the Claims Determination Period, the benefit reserve returns to zero. A new benefit reserve must be created for each new Claim Determination Period.

### What is Medicare?

Medicare is a Health Insurance Program for:

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

Medicare has two parts:

- Part A (Hospital Insurance). Most people do not have to pay for Part A. If you or your spouse worked for at least 10 years in Medicare-covered employment, you should be able to qualify for premium-free Part A insurance. (Someone who was a Federal employee on January 1, 1983 or since automatically qualifies.) Otherwise, if you are age 65 or older, you may be able to buy it. Contact 1-800-MEDICARE for more information.
- Part B (Medical Insurance). Most people pay monthly for Part B. Generally, Part B premiums are withheld from your monthly Social Security check or your retirement check.

- **Should I enroll in Medicare?**

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

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

Everyone is charged a premium for Medicare Part B coverage. The Social Security Administration can provide you with premium and benefit information. Review the information and decide if it makes sense for you to buy the Medicare Part B coverage.

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

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

The Original Medicare Plan (Original Medicare) is available everywhere in the United States. It is the way everyone used to get Medicare benefits and is the way most people get their Medicare Part A and Part B benefits now. You may go to any doctor, specialist, or hospital that accepts Medicare. The Original Medicare Plan pays its share and you pay your share. Some things are not covered under Original Medicare, such as most prescription drugs (but coverage through private prescription drug plans will be available starting in 2006).

When you are enrolled in Original Medicare along with this Plan, you still need to follow the rules in this brochure for us to cover your care. Are listed in Section 3 must still be preauthorized.

Please note, if your Plan physician does not participate in Medicare, you will have to file a claim with Medicare.

**Claims process when you have the Original Medicare Plan** – You probably will never have to file a claim form when you have both our Plan and the Original Medicare Plan.

- When we are the primary payer, we process the claim first.
- When Original Medicare is the primary payer, Medicare processes your claim first. In most cases, your claim will be coordinated automatically and we will then provide secondary benefits for covered charges. You will not need to do anything. To find out if you need to do something to file your claim, call us at 302-283-6500 or 800-833-7423 or see our Web site at [www.chcde.com](http://www.chcde.com).

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

Medicare always makes the final determination as to whether they are the primary payer. The following chart illustrates whether Medicare or this Plan should be the primary payer for you according to your employment status and other factors determined by Medicare. It is critical that you tell us if you or a covered family member has Medicare coverage so we can administer these requirements correctly.

<b>Primary Payer Chart</b>		
<b>A. When you - or your covered spouse - are age 65 or over and have Medicare and you...</b>	<b>The primary payer for the individual with Medicare is...</b>	
	<b>Medicare</b>	<b>This Plan</b>
1) Have FEHB coverage on your own as an active employee or through your spouse who is an active employee		✓
2) Have FEHB coverage on your own as an annuitant or through your spouse who is an annuitant	✓	
3) Are a reemployed annuitant with the Federal government and your position is excluded from the FEHB (your employing office will know if this is the case) and you are not covered under FEHB through your spouse under #1 above	✓	
4) Are a reemployed annuitant with the Federal government and your position is not excluded from the FEHB (your employing office will know if this is the case) and ...		✓
<ul style="list-style-type: none"> <li>• You have FEHB coverage on your own or through your spouse who is also an active employee</li> <li>• You have FEHB coverage through your spouse who is an annuitant</li> </ul>	✓	
5) Are a Federal judge who retired under title 28, U.S.C., or a Tax Court judge who retired under Section 7447 of title 26, U.S.C. (or if your covered spouse is this type of judge) and you are not covered under FEHB through your spouse under #1 above	✓	
6) Are enrolled in Part B only, regardless of your employment status	✓ for Part B services	✓ for other services
7) Are a former Federal employee receiving Workers' Compensation and the Office of Workers' Compensation Programs has determined that you are unable to return to duty	✓*	
<b>B. When you or a covered family member...</b>		
1) Have Medicare solely based on end stage renal disease (ESRD) and...		✓
<ul style="list-style-type: none"> <li>• It is within the first 30 months of eligibility for or entitlement to Medicare due to ESRD (30-month coordination period)</li> <li>• It is beyond the 30-month coordination period and you or a family member are still entitled to Medicare due to ESRD</li> </ul>	✓	
2) Become eligible for Medicare due to ESRD while already a Medicare beneficiary and...		✓ for 30-month coordination period
<ul style="list-style-type: none"> <li>• This Plan was the primary payer before eligibility due to ESRD</li> <li>• Medicare was the primary payer before eligibility due to ESRD</li> </ul>	✓	
<b>C. When either you or a covered family member are eligible for Medicare solely due to disability and you...</b>		
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	✓	
<b>D. When you are covered under the FEHB Spouse Equity provision as a former spouse</b>	✓	

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

- **Medicare Advantage**

If you are eligible for Medicare, you may choose to enroll in and get your Medicare benefits from a Medicare Advantage plan. These are private health care choices (like HMOs) in some areas of the country. In most Medicare Advantage plans, you can only go to doctors, specialists, or hospitals that are part of the plan. Medicare Advantage plans provide all the benefits that Original Medicare covers. Some cover extras, like prescription drugs. To learn more about enrolling in a Medicare Advantage plan, contact Medicare at 1-800-MEDICARE (1-800-633-4227) or at [www.medicare.gov](http://www.medicare.gov).

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

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

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

## **TRICARE and CHAMPVA**

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

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

## **Workers' Compensation**

We do not cover services that:

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

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

## **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.

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## Section 11. Definitions of terms we use in this brochure

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<b>Calendar year</b>	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.
<b>Coinsurance</b>	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
<b>Copayment</b>	A copayment is a fixed amount of money you pay when you receive covered services. See Section 4.
<b>Covered services</b>	Services we provide benefits for, as described in this brochure.
<b>Deductible</b>	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.
<b>Experimental or investigational services</b>	<p>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:</p> <ul style="list-style-type: none"><li>• Not approved by the U.S. Food and Drug Administration (“FDA”) to be lawfully marketed for the proposed use and not identified in the <i>American Hospital Formulary Service</i>, the <i>United States Pharmacopoeia Dispensing Information</i>, or in the medical literature as appropriate for the proposed use; or</li><li>• Subject to review and approval by the institutional review board of the treating facility for the proposed use; or</li><li>• 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</li><li>• 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.</li></ul> <p>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:</p> <ul style="list-style-type: none"><li>• Is safe with promising efficacy; and</li><li>• Is provided in a clinically controlled research setting; and</li><li>• Uses a specific research protocol that meets standards equivalent to those defined by the National Institute of Health.</li></ul> <p>(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.)</p> <p>This definition does not include Covered Health Services in a Medical Clinical Trial.</p>

**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.

**Us/We**

“Us” and “We” refer to Coventry Health Care.

**You**

“You” refers to the enrollee and each covered family member.

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## Section 12. FEHB Facts

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### 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](http://www.opm.gov/insure/health) for enrollment as well as:

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

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

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

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

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

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

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

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

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

- **Children’s Equity Act**

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

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

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

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

- **When benefits and premiums start**

The benefits in this brochure are effective January 1. If you joined this Plan during Open Season, your coverage begins on the first day of your first pay period that starts on or after January 1. If you changed plans or plan options during Open Season and you receive care between January 1 and the effective date of coverage under your new plan or option, your claims will be paid according to the 2005 benefits of your old plan or option. However, if your old plan left the FEHB Program at the end of the year, you are covered under that plan’s 2004 benefits until the effective date of your coverage with your new plan. Annuitants’ coverage and premiums begin on January 1. If you joined at any other time during the year, your employing office will tell you the effective date of coverage.

- **When you retire**

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

### **When you lose benefits**

- **When FEHB coverage ends**

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

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

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

- **Spouse equity coverage** If you are divorced from a Federal employee or annuitant, you may not continue to get benefits under your former spouse’s enrollment. This is the case even when the court has ordered your former spouse to provide health coverage to you. But, you may be eligible for your own FEHB coverage under the spouse equity law or Temporary Continuation of Coverage (TCC). If you are recently divorced or are anticipating a divorce, contact your ex-spouse’s employing or retirement office to get RI 70-5, the *Guide To Federal Employees Health Benefits Plans for Temporary Continuation of Coverage and Former Spouse Enrollees*, or other information about your coverage choices. You can also download the guide from OPM’s Web site, [www.opm.gov/insure](http://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 your retire, if you lose your Federal job, if you are a covered dependent child and you turn 22 or marry, etc.

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

**Enrolling in TCC.** Get the RI 79-27, which describes TCC, and the RI 70-5, the *Guide to Federal Employees Health Benefits Plans for Temporary Continuation of Coverage and Former Spouse Enrollees*, from your employing or retirement office or from [www.opm.gov/insure](http://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 there will be no waiting period or limit to 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](http://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.

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## Section 13. Two Federal Programs complement FEHB benefits

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### Important information

OPM wants to make sure you are aware of two Federal programs that complement the FEHB Program. First, the **Federal Flexible Spending Account (FSA) Program**, also known as **FSAFEDS**, lets you set aside pre-tax money to pay for health and dependent care expenses. The result can be a discount of 20% to more than 40% on services you routinely pay for out-of-pocket. Second, the **Federal Long Term Care Insurance Program (FLTCIP)** helps cover long term care costs, which are not covered under the FEHB.

### The Federal Flexible Spending Account Program – *FSAFEDS*

#### What is an FSA?

It is a tax-favored benefit that allows you to set aside pre-tax money from your paychecks to pay for a variety of eligible expenses. *By using an FSA, you can reduce your taxes while paying for services you would have to pay for anyway, producing a discount that can be over 40%.*

There are two types of FSAs offered by FSAFEDS:

#### Health Care Flexible Spending Account (HCFSA)

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

#### Dependent Care Flexible Spending Account (DCFSA)

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

#### Enroll during Open Season

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

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

#### What is SHPS?

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

## Who is eligible to enroll?

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

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

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

## How much should I contribute to my FSA?

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

The FSAFEDS Calculator at [www.FSAFEDS.com](http://www.FSAFEDS.com) will help you plan your FSA allocations and provide an estimate of your tax savings based on your individual situation.

## What can my HCFSA pay for?

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

Under the High Option of this plan, typical out-of-pocket expenses include: Physician office visit copayments, prescription drug copayments, outpatient surgery coinsurance, eyewear, Lasik eye surgery, and alternative health care visits.

Under the Standard Option of this plan, typical out-of-pocket expenses include: Physician office visit copayments, prescription drug copayments, outpatient surgery coinsurance, eyewear, Lasik eye surgery, and alternative health care visits.

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

## Tax savings with an FSA

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

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

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

### **Tax credits and deductions**

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

### **Health care expenses**

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

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

### **Dependent care expenses**

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

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

### **Does it cost me anything to participate in FSAFEDS?**

No. Section 1127 of the National Defense Authorization Act (Public Law 108-136) requires agencies that offer FSAFEDS to employees to cover the administrative fee(s) on behalf of their employees. However, remember that participating in FSAFEDS can cost you money if you don't spend your entire account balance by the end of the Plan Year, resulting in the forfeiture of funds remaining in your account (the IRS "use-it-or-lose-it" rule).

## Contact us

To learn more or to enroll, please visit the **FSAFEDS Web site** at [www.FSAFEDS.com](http://www.FSAFEDS.com), or contact SHPS directly via email or by phone. FSAFEDS Benefits Counselors are available Monday through Friday, from 9:00 a.m. until 9:00 p.m. Eastern Time.

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

## The Federal Long Term Care Insurance Program

- **It's important protection** Why should you consider applying for coverage under the Federal Long Term Care Insurance Program (FLTCIP)?
  - **FEHB plans do not cover the cost of long-term care.** Also called “custodial care,” long term care is help you receive to perform activities of daily living – such as bathing or dressing yourself - or supervision you receive because of a severe cognitive impairment. The need for long-term care can strike anyone at any age and the cost of care can be substantial.
  - **The Federal Long Term Care Insurance Program can help protect you from the potentially high cost of long-term care.** This coverage gives you options regarding the type of care you receive and where you receive it. With FLTCIP coverage, you won't have to worry about relying on your loved ones to provide or pay for your care.
  - **It's to your advantage to apply sooner rather than later.** In order to qualify for coverage under the FLTCIP, you must apply and pass a medical screening (called underwriting). Certain medical conditions, or combinations of conditions, will prevent some people from being approved for coverage. By applying while you're in good health, you could avoid the risk of having a future change in your health disqualify you from obtaining coverage. Also, the younger you are when you apply, the lower your premiums.
  - **You don't have to wait for an open season to apply.** The Federal Long Term Care Insurance Program accepts applications from eligible persons at any time. You will have to complete a full underwriting application, which asks a number of questions about your health. However, if you are a new or newly eligible employee, you (and your spouse, if applicable) have a limited opportunity to apply using the abbreviated underwriting application, which asks fewer questions. Newly married spouses of employees also have a limited opportunity to apply using abbreviated underwriting.
  - **Qualified relatives are also eligible to apply.** Qualified relatives include spouses and adult children of employees and annuitants, and parents, parents-in-law, and stepparents of employees.
- **To find out more and to request an application** Call 1-800-LTC-FEDS (1-800-582-3337) (TTY 1-800-843-3557) or visit [www.ltcfeds.com](http://www.ltcfeds.com).

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## Summary of benefits for Coventry Health Care High Option – 2005

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**Do not rely on this chart alone.** All benefits are subject to the definitions, limitations, and exclusions in this brochure. On this page we summarize specific expenses we cover; for more detail, look inside.

If you want to enroll or change your enrollment in this Plan, be sure to put the correct enrollment code from the cover on your enrollment form.

Under this Plan, most traditional medical care (other than some preventive care) is subject to a deductible. After you meet the deductible, you pay the indicated copayments or coinsurance up to the annual catastrophic protection maximum for out-of-pocket expenses. And, after we pay, you generally pay any difference between our allowance and the billed amount if you use an out-of-network provider.

Benefits	You pay	Page
Medical services provided by physicians:		
<ul style="list-style-type: none"> <li>• Diagnostic and treatment services provided in the office .....</li> </ul>	\$10 PCP copayment or \$20 Specialist copayment	21
Services provided by a hospital:		
<ul style="list-style-type: none"> <li>• Inpatient .....</li> </ul>	Nothing	36
<ul style="list-style-type: none"> <li>• Outpatient .....</li> </ul>	\$30 per visit to an ambulatory surgical center; 10% of charges for surgery in an outpatient department of a hospital	37
Emergency benefits		
<ul style="list-style-type: none"> <li>• In area .....</li> </ul>	\$30 per urgent care visit; \$50 per hospital emergency room visit	39
<ul style="list-style-type: none"> <li>• Out-of-area.....</li> </ul>	\$30 per urgent care visit; \$50 per hospital emergency room visit	40
Mental health and substance abuse treatment .....	Regular cost sharing.	41
Prescription drugs .....	<u>Retail &amp; Specialty Pharmacy:</u> \$10 per prescription or refill for generic formulary drugs; \$20 per prescription or refill for formulary drugs (brand name), & \$45 per prescription or refill for non-formulary drugs (brand name).  <u>Mail Order (Maintenance Drugs):</u> \$20 per	45

	prescription or refill for a 90 consecutive day supply for maintenance generic formulary drugs & \$40 per prescription or refill for a 90 consecutive day supply for maintenance preferred drugs (brand name drugs); \$90 per prescription for a refill for a 90 consecutive day supply for non-preferred drugs) brand name drugs).	
Dental Care (Accidental injury only) .....	\$10 PCP copayment or \$20 Specialist copayment; Nothing during a covered inpatient admission.	48
Protection against catastrophic costs (your catastrophic protection 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 Coventry Health Care High Deductible Health Plan – 2005

**Do not rely on this chart alone.** All benefits are subject to the definitions, limitations, and exclusions in this brochure. On this page we summarize specific expenses we cover; for more detail, look inside.

If you want to enroll or change your enrollment in this Plan, be sure to put the correct enrollment code from the cover on your enrollment form.

Under this Plan, most traditional medical care (other than some preventive care) is subject to a deductible. After you meet the deductible, you pay the indicated copayments or coinsurance up to the annual catastrophic protection maximum for out-of-pocket expenses. And, after we pay, you generally pay any difference between our allowance and the billed amount if you use an out-of-network provider.

Benefits	You pay	Page
Medical services provided by physicians: <ul style="list-style-type: none"> <li>• Diagnostic and treatment services provided in the office .....</li> </ul>	\$15 PCP copayment or \$25 Specialist copayment	57
Services provided by a hospital: <ul style="list-style-type: none"> <li>• Inpatient .....</li> <li>• Outpatient .....</li> </ul>	15% of Plan allowance  15% of Plan allowance	70  71
Emergency benefits <ul style="list-style-type: none"> <li>• In area .....</li> <li>• Out-of-area.....</li> </ul>	15% of Plan allowance  15% of Plan allowance	73  74
Mental health and substance abuse treatment .....	Regular cost sharing.	75
Prescription drugs .....	<u>Retail &amp; Specialty Pharmacy:</u> \$10 per prescription or refill for generic formulary drugs; \$20 per prescription or refill for formulary drugs (brand name), & \$45 per prescription or refill for non-formulary drugs (brand name).  <u>Mail Order (Maintenance Drugs):</u> \$20 per prescription or refill for a 90 consecutive day supply for maintenance generic formulary drugs, \$40 per prescription or refill for a 90 consecutive day supply for maintenance preferred drugs (brand name drugs), & \$90 fir a 90 consecutive day supply of non-preferred drugs (brand name drugs).	79

Dental Care (Accidental injury only) .....	15% of Plan allowance	81
Protection against catastrophic costs (your catastrophic protection out-of-pocket maximum) .....	Nothing after \$5,000/Self Only or \$10,000/Family enrollment per year  Some costs do not count toward this protection	18

## 2005 Rate Information for Coventry Health Care

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

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

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

Type of Enrollment	Code	Non-Postal Premium				Postal Premium	
		Biweekly		Monthly		Biweekly	
		Gov't Share	Your Share	Gov't Share	Your Share	USPS Share	Your Share
<b>ALL OF DELAWARE AND SELECTED COUNTIES IN NEW JERSEY</b>							
High Option Self Only	2J1	\$131.08	\$62.24	\$284.01	\$134.85	\$154.74	\$38.58
High Option Self & Family	2J2	\$298.23	\$189.90	\$646.17	\$411.45	\$352.08	\$136.05
HDHP Self Only	2J4	\$119.55	\$39.85	\$259.03	\$86.34	\$141.47	\$17.93
HDHP Self & Family	2J5	\$293.90	\$97.97	\$636.79	\$212.26	\$347.78	\$44.09
<b>ALL OF MARYLAND</b>							
High Option Self Only	IG1	\$131.08	\$61.67	\$284.01	\$133.62	\$154.74	\$38.01
High Option Self & Family	IG2	\$298.23	\$188.45	\$646.17	\$408.30	\$352.08	\$134.60
HDHP Self Only	IG4	\$115.10	\$38.36	\$249.38	\$83.12	\$136.20	\$17.26
HDHP Self & Family	IG5	\$282.68	\$94.22	\$612.47	\$204.15	\$334.50	\$42.40

## NOTES