Coventry Health Care of Iowa, Inc.

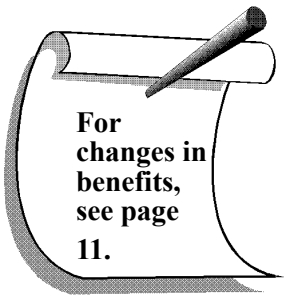
www.chciowa.com

2012

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

Serving: *Central, Eastern, and Western Iowa*

Enrollment in this plan is limited. You must live or work in our Geographic service area to enroll. See page 10 for requirements.



Enrollment codes for this Plan:

- **SV1 High Option – Self Only**
- **SV2 High Option – Self and Family**
- **SY4 Standard Option - Self Only**
- **SY5 Standard Option - Self and Family**
- **SV4 HDHP Option – Self Only**
- **SV5 HDHP Option – Self and Family**

Special Notice:

We have expanded our Service Area. Please see page 10 for a complete listing of counties located in our Service Area.

Authorized for distribution by the:

United States
Office of Personnel Management

Healthcare and Insurance
http://www.opm.gov/insure

RI 73-186

Important Notice from Coventry Health Care of Iowa About

Our Prescription Drug Coverage and Medicare

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

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

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

Please be advised

If you lose or drop your FEHB coverage and go 63 days or longer without prescription drug coverage that's as least as good as Medicare's prescription drug coverage, your monthly premium will go up a least 1% per month for every month that you did not have that coverage. For example, if you go 19 months without Medicare Part D prescription drug coverage, your premium will always be at least 19 percent higher than what many other people pay. You'll have to pay this higher premium as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the Annual Coordinated Election Period (October 15th through December 7th) to enroll in Medicare Part D.

Medicare's Low Income Benefits

For people with limited income and resources, extra help paying for a Medicare prescription drug plan is available. Information regarding this program is available through the Social Security Administration (SSA) online at www.socialsecurity.gov, or call the SSA at 1-800-772-1213 (TTY 1-877-486-2048).

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

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

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Introduction

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

Coventry Health Care of Iowa, Inc. 4320 114th Street Urbandale, Iowa 50322

This brochure is the official statement of benefits. No oral statement can modify or otherwise affect the benefits, limitations, and exclusions of this brochure. It is your responsibility to be informed about your health benefits.

If you are enrolled in this Plan, you are entitled to the benefits described in this brochure. If you are enrolled in Self and Family coverage, each eligible family member is also entitled to these benefits. You do not have a right to benefits that were available before January 1, 2012, unless those benefits are also shown in this brochure.

OPM negotiates benefits and rates with each Plan annually. Benefit changes are effective January 1, 2012, and changes are summarized on page 11.

Plain Language

All FEHB brochures are written in plain language to make them easy to understand. Here are some examples:

- Except for necessary technical terms, we use common words. For instance, "you" means the enrollee or family member, "we" means Coventry Health Care of Iowa, Inc.
- We limit acronyms to ones you know. FEHB is the Federal Employees Health Benefits Program. OPM is the United States Office of Personnel Management. If we use others, we tell you what they mean first.
- Our brochure and other FEHB Plans' brochures have the same format and similar descriptions to help you compare Plans.

If you have comments or suggestions about how to improve the structure of this brochure, let OPM know. Visit OPM's "Rate Us" feedback area at www.opm.gov/insure or e-mail OPM at fehbwebcomments@opm.gov. You may also write to OPM at the U.S. Office of Personnel Management Healthcare and Insurance, Federal Employee Insurance Operations, Program Analysis and Systems Support, 1900 E Street, NW, Washington, DC 20415-3650.

Stop Health Care Fraud!

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

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

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

- Do not give your Plan identification (ID) number over the telephone or to people you do not know, except to your 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) statements that you receive from us.
- Please review your claims history periodically for accuracy to ensure services are not being billed to your accounts that were never rendered.
- Do not ask your doctor to make false entries on certificates, bills or records in order to get us to pay for an item or service.

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

- Call the provider and ask for an explanation. There may be an error.
- If the provider does not resolve the matter, call us at 800-257-4692 and explain the situation.

- If we do not resolve the issue:

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

OR WRITE TO:

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

- Do not maintain as a family member on your policy:
  - Your former spouse after a divorce decree or annulment is final (even if a court order stipulates otherwise)
  - Your child age 26 or over (unless he/she was disabled and incapable of self-support prior to age 26)
- If you have any questions about the eligibility of a dependent, check with your personnel office if you are employed, with your retirement office (such as OPM) if you are retired, or with the National Finance Center if you are enrolled under Temporary Continuation of Coverage.
- Fraud or intentional misrepresentation of material fact is prohibited under the Plan. You can be prosecuted for fraud and your agency may take action against you. Examples of fraud include, falsifying a claim to obtain FEHB benefits, trying to or obtaining services or coverage for yourself or for someone else who is not eligible for coverage, or enrolling in the Plan when you are no longer eligible.
- You may be billed by your provider for services received. You may be prosecuted for fraud for knowingly using health insurance benefits for which you have not paid premiums. It is your responsibility to know when you or a family member is no longer eligible to use your health insurance coverage.

Preventing Medical Mistakes

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

1. Ask questions if you have doubts or concerns.

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

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

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

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

3. Get the results of any test or procedure.

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

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

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

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

- Make sure you, your doctor, and your surgeon all agree on exactly what will be done during the operation.
- Ask your doctor, "Who will manage my care when I am in the hospital?"
- Ask your surgeon:

  "Exactly what will you be doing?"

  "About how long will it take?"

  "What will happen after surgery?"

  "How can I expect to feel during recovery?"
- Tell the surgeon, anesthesiologist, and nurses about any allergies, bad reactions to anesthesia, and any medications you are taking.

Patient Safety Links

- www.ahrq.gov/consumer/. The Agency for Healthcare Research and Quality makes available a wide-ranging list of topics not only to inform consumers about patient safety but to help choose quality health care providers and improve the quality of care you receive.

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

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

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

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

Never Events

You will not be billed for inpatient services related to treatment of specific hospital acquired conditions or for inpatient services needed to correct never events, if you use Coventry Health Care of Iowa's preferred providers. This policy helps to protect you from preventable medical errors and improve the quality of care you receive.

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

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

Section 1. Facts about this HMO Plan

High Option:

The High Option is a health maintenance organization (HMO). We require you to see specific physicians, hospitals, and other providers that contract with us. These Plan providers coordinate your health care services. The Plan is solely responsible for the selection of these providers in your area. Contact the Plan for a copy of their most current provider directory. We give you a choice of enrollment in a High Option, Standard Option, or High Deductible Health Plan (HDHP).

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

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

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

Questions regarding what protections apply and what protections do not apply to a grandfathered health plan, and what might cause a plan to change status from grandfathered to non-grandfathered may be directed to us at Coventry Health Care of Iowa, Inc. 4320 114th Street Urbandale, Iowa 50322. You can also read additional information from the U.S. Department of Health and Human Services at www.healthcare.gov.

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

As a non-grandfathered health plan, this plan has also decided to follow the requirements that apply to grandfathered plans.

Questions regarding what protections apply may be directed to us at Coventry Health Care of Iowa, Inc. 4320 114th Street Urbandale, Iowa 50322. You can also read additional information from the U.S. Department of Health and Human Services at www.healthcare.gov .

General Features of our High and Standard Options

Our HMO offers Open Access benefits. This means you can receive covered services from a participating provider without required referral from your primary care physician or by another participating provider in the network.

High Deductible Health Plan:

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

• Using the most cost effective provider

• Actively pursuing a healthier lifestyle and utilizing your preventive care benefit

• Becoming an informed health care consumer so you can be more involved in the treatment of any medical condition or chronic illness.

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

General features of our High Deductible Health Plan:

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

Preventive Care Services

Preventive care services are generally paid as first dollar coverage.

Annual Deductible

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

Health Savings Account (HSA)

You are eligible for 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 enrolled in Medicare, not received VA benefits within the last three months, not covered by your own or your spouse's flexible spending account (FSA), and are not claimed as a dependent on someone else's tax return.

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

Health Reimbursement Account (HRA)

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

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

Catastrophic protection

We protect you against catastrophic out-of-pocket expenses for covered services. Your annual out-of-pocket expenses for covered services, including deductibles and coinsurance, cannot exceed $6,050 for Self-Only enrollment, or $12,100 for family coverage.

We have network providers

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

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

How we pay providers

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

Your rights

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

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

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

If you want more information about us, call 800-257-4692, or write to 4320 114th St., Urbandale, IA 50322. You may also contact us by fax at 866-602-1256 or visit our Web site at www.chciowa.com.

Your medical and claims records are confidential

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

Service Area

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

Our Service Area is: Adair, Appanoose, Benton, Black Hawk, Boone, Bremer, Buchanan, Buena Vista, Butler, Calhoun, Carroll, Cass, Cedar, Cerro Gordo, Cherokee, Chickasaw, Clark, Crawford, Dallas, Davis, Decatur, Dickinson, Emmett, Fayette, Floyd, Franklin, Fremont, Greene, Grundy, Guthrie, Hancock, Hardin, Harrison, Howard, Ida, Iowa, Jasper, Johnson, Jones, Keokuk, Kossuth, Linn, Lucas, Lyon, Madison, Marion, Marshall, Mills, Mitchell, Monona, Monroe, Montgomery, Muscatine, O'Brien, Page, Palo Alto, Plymouth, Pocahontas, Polk, Pottawattamie, Sac, Scott, Shelby, Story, Sioux, Tama, Union, Warren,Washington, Wayne, Webster, Winnebago, Winneshiek, Woodbury, Worth, and Wright counties.

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

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

Section 2. How we change for 2012

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

Program Wide Changes:

- Sections 3, 7 and 8 have changed to reflect claims processing and disputed claims requirements of the Patient Protection and Affordable Care Act, Public Law 111-148.

Changes to All Options:

- All Specialists office visit copayments are now $45 per visit. Previously, all plans had $40 specialist office visit copayments.
- Insulin is now one copayment per 30 day supply. Previously, it was one copayment per vial.
- We have expanded our Service Area to include the counties of Cass, Crawford, Fremont, Harrison, Mills, Monona, Montgomery, Page, Pottawattamie, and Shelby.

Changes to High Option only:

- Your share of the non-postal premium will decrease for Self Only and decrease for Self and Family.
- We have added a fourth tier which is a value formulary tier, to the prescription drug benefit. Retail prescription drug copayments are now $3 for value formulary, $10 for generic formulary, $40 per formulary brand name drug and $65 per non formulary drugs.
- We have added a fourth tier which is a value formulary tier, to the prescription drug benefit. Mail order prescription drug copayments are now $9 per value formulary, $30 per formulary generic drug, $120 per formulary brand name drug, and $195 per non-formulary drug. Previously, the copayments were $20 per formulary generic drug, $80 per formulary brand name drug, and $195 for non-formulary drugs.
- Catastrophic protection is provided after the deductible and coinsurance total $4,000 per person or $8,000 per family. Previously, the catastrophic protection was $3,000 per person or $6,000 per family.
- Coinsurance is now 15% for services that are payable after the deductible is satisfied. Previously, coinsurance rate was 10%.
- Calendar Year deductible is now $550 for Self, and $1,100 for Self and Family. Previously, Calendar Year deductible was $500 for Self and $1,000 for Self and Family.
- Under a family enrollment, the Family Deductible is satisfied when the expenses for any combination of Members in a family equals the Family Deductible amount. The expenses of each Member counted towards the Family Deductible is limited to their Individual Deductible amount.

Changes to Standard Option only:

- Your share of the non-postal premium will increase for Self Only and increase for Self and Family.
- Catastrophic protection is provided after the deductible and coinsurance total $5,500 per person or $11,000 per family. Previously, the catastrophic protection was $4,500 per person or $9,000 per family.
- We have added a fourth tier which is a value formulary tier, to the prescription drug benefit. Retail prescription drug copayments are now $3 per value formulary, 30% per formulary brand name drug with a member payment of $40 minimum and $65 maximum, and 30% member payment per non formulary drugs with a minimum member payment of $65 and a maximum member payment of $90. Previously, the copayments were $40 per formulary brand name drug and $65 per non formulary drugs. The generic copayment will remain $10. There is a maximum of $5,000 out of pocket for coinsurance and copayments combined.

- We have added a fourth tier which is a value formulary tier, to the prescription drug benefit. Mail order prescription drug copayments are now $9 per value formulary drug, $30 per formulary generic drug, 30% per formulary brand name drug with a member payment of $120 minimum and $195 maximum, and 30% member payment per non formulary drugs with a minimum member payment of $195 and a maximum member payment of $270. Previously, the copayments were $20 per formulary generic drug, $80 per formulary brand name drug, and $195 for non-formulary drugs.
- Coinsurance is now 20% for services that are payable after the deductible is satisfied. Previously, coinsurance rate was 10%.
- Under a family enrollment, the Family Deductible is satisfied when the expenses for any combination of Members in a family equals the Family Deductible amount. The expenses of each Member counted towards the Family Deductible is limited to their Individual Deductible amount.

Changes to our High Deductible Health Plan (HDHP) only:

- Your share of the non-postal premium will increase for Self Only and increase for Self and Family.
- We have added a fourth tier which is a value formulary tier, to the prescription drug benefit. Retail prescription drug copayments remain $10 for generic formulary, $40 per formulary brand name drug and $65 per non formulary drugs. We have added a $3 value formulary drug copayment.
- We have added a fourth tier which is a value formulary tier, to the prescription drug benefit. Mail order prescription drug copayments are now $30 per formulary generic drug, $120 per formulary brand name drug, and $195 per non-formulary drug. Previously, the copayments were $20 per formulary generic drug, $80 per formulary brand name drug, and $195 for non-formulary drugs. We have added a $9 value formulary drug copayment.
- Coinsurance is now 15% for services that are payable after the deductible is satisfied. Previously, coinsurance rate was 10%.
- Calendar Year deductible is now $2,000 for Self, and $4,000 for Self and Family. Previously, Calendar Year deductible was $1,800 for Self and $3,600 for Self and Family.
- Under a family enrollment, the Family Deductible is satisfied when the expenses for any combination of Members in a family equals the Family Deductible amount. The expenses of each Member counted towards the Family Deductible is limited to their Individual Deductible amount.

Section 3. How you get care

Identification cards

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

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

Where you get covered care

You get care from "Plan providers" and "Plan facilities." You will only pay copayments, deductibles, and/or coinsurance, and you will not have to file claims if you are on the HMO Plan. If you use our Open Access program you can receive covered services from a participating provider without a required referral from your primary care physician or by another participating provider in the network. If you are on the HDHP, you may have to file claims if you receive services from a non-Plan provider. You will also have to pay the entire amount for the services.

- **Network providers and facilities**

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

We list Plan providers in the provider directory, which we update periodically. The list is also on our Web site.

What you must do to get covered care

- **Primary care**

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

- **Specialty care**

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

- If you need to see a specialist frequently because of a chronic, complex, or serious medical condition, your primary care physician will develop a treatment plan that allows you to see your specialist for a certain number of visits without additional referrals.
- Your primary care physician will create your treatment plan. The physician may have to get an authorization or approval from us beforehand. If you are seeing a specialist when you enroll in our Plan, talk to your primary care physician. If he or she decides to refer you to a specialist, ask if you can see your current specialist. If your current specialist does not participate with us, you must receive treatment from a specialist who does. Generally, we will not pay for you to see a specialist who does not participate with our Plan.
- If you are seeing a specialist and your specialist leaves the Plan, call your primary care physician, who will arrange for you to see another specialist. You may receive services from your current specialist until we can make arrangements for you to see someone else.
- If you have a chronic and disabling condition and lose access to your specialist because we:
  - terminate our contract with your specialist for other than cause;

- drop out of the Federal Employees Health Benefits (FEHB) Program and you enroll in another FEHB program Plan; or
- reduce our service area and you enroll in another FEHB Plan.

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

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

- **Hospital care**

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

- **If you are hospitalized when your enrollment begins**

We pay for covered services from the effective date of your enrollment, However, if you are in the hospital when your enrollment in our Plan begins, call our customer service department immediately at 800-257-4692. If you are new to the FEHB Program, we will arrange for you to receive care and provide benefits for your covered services while you are in the hospital beginning on the effective date of your coverage.

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

• you are discharged, not merely moved to an alternative care center;

• the day your benefits from your former Plan runs out; or

• the 92nd day after you become a member of this Plan, whichever happens first.

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

You need prior Plan approval for certain services

Since your primary care physician arranges most referrals to specialists and inpatient hospitalizations, the pre-service claim approval process only applies to care shown under *Other services.*

- **Inpatient hospital admission**

Precertification is the process by which – prior to your inpatient hospital admission – we evaluate the medical necessity of your proposed stay and the number of days required to treat your condition.

- **Other services**

Your primary care physician has authority to refer you for most services. For certain services, however, your physician must obtain prior approval from us. Before giving approval, we consider if the service is covered, medically necessary, and follows generally accepted medical practice. You must obtain prior authorization for the following services: Hospital Inpatient Admissions, Outpatient Surgeries, Home Health Care, Home Infusion Services, Durable Medical Equipment, Orthopedic and Prosthetic Devices, Outpatient Therapies (Physical, Occupational, and Speech), Growth Hormone Therapy, Transplants, and any Out-of-Network Services.

How to request precertification for an admission or get prior authorization for Other services

First, your physician, your hospital, you, or your representative, must call us at 800-257-4692 before admission or services requiring prior authorization are rendered.

Next, provide the following information:

- enrollee's name and Plan identification number;
- patient's name, birth date, identification number and phone number;
- reason for hospitalization, proposed treatment, or surgery;

- name and phone number of admitting physician;
- name of hospital or facility; and
- number of planned days of confinement.

- **Non-urgent care claims**

For non-urgent care claims, we will then tell the physician and/or hospital the number of approved inpatient days, or the care that we approve for other services that must have prior authorization. We will make our decision within 15 days of receipt of the pre-service claim. If matters beyond our control require an extension of time, we may take up to an additional 15 days for review and we will notify you of the need for an extension of time before the end of the original 15 day period. Our notice will include the circumstances underlying the request for the extension and the date when a decision is expected.

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

- **Urgent care claims**

If you have an urgent care claim (i.e., when waiting for the regular time limit for your medical care or treatment could seriously jeopardize your life, health, or ability to regain maximum function, or in the opinion of a physician with knowledge of your medical condition, would subject you to severe pain that cannot be adequately managed without this care or treatment), we will expedite our review and notify you of our decision within 72 hours. If you request that we review your claim as an urgent care claim, we will review the documentation you provide and decide whether it is an urgent care claim by applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine.

If you fail to provide sufficient information, we will contact you within 24 hours after we receive the claim to provide notice of the specific information we need to complete our review of the claim. We will allow you up to 48 hours from the receipt of this notice to provide the necessary information. We will make our decision on the claim within 48 hours of (1) the time we received the additional information or (2) the end of the time frame, whichever is earlier.

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

- **Emergency inpatient admission**

If you have an emergency admission due to a condition that you reasonably believe puts your life in danger or could cause serious damage to bodily function, you, your representative, the physician, or the hospital must telephone us within two business days following the day of the emergency admission, even if you have been discharged from the hospital.

- **If your treatment needs to be extended**

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

What happens when you do not follow the precertification rules when using non-network facilities

Failure to follow the precertification rules when using non-network facilities may result in reduction or denial of benefits.

Circumstances beyond our control

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

If you disagree with our pre-service claim decision

If you have a **pre-service claim** and you do not agree with our decision regarding precertification of an inpatient admission or prior approval of other services, you may request a review in accord with the procedures detailed below.

If you have already received the service, supply, or treatment, then you have a **post-service claim** and must follow the entire disputed claims process detailed in Section 8.

- **To reconsider a non-urgent care claim**

Within 6 months of our initial decision, you may ask us in writing to reconsider our initial decision. Follow Step 1 of the disputed claims process detailed in Section 8 of this brochure.

In the case of a pre-service claim and subject to a request for additional information, we have 30 days from the date we receive your written request for reconsideration to

1. Precertify your hospital stay, or, if applicable, arrange for the health care provider to give you the care or grant your request for prior approval for a service, drug, or supply; or

2. Ask you or your provider for more information.

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

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

3. Write to you and maintain our denial.

- **To reconsider an urgent care claim**

In the case of an appeal of a pre-service urgent care claim, within 6 months of our initial decision, you may ask us in writing to reconsider our initial decision. Follow Step 1 of the disputed claims process detailed in Section 8 of this brochure.

Subject to a request for additional information, we will notify you of our decision within 72 hours after receipt of your reconsideration request. We will hasten the review process, which allows oral or written requests for appeals and the exchange of information by telephone, electronic mail, facsimile, or other expeditious methods.

- **To file an appeal with OPM**

After we reconsider your **pre-service claim**, if you do not agree with our decision, you may ask OPM to review it by following Step 3 of the disputed claims process detailed in Section 8 of this brochure.

Section 4. Your costs for covered services

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

Copayments

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

High Option:

Example: When you see your primary physician you pay a copayment of $20 per visit, for your specialist you pay a copayment of $45 per visit, and when you go in the hospital, you pay 15% coinsurance after the deductible is satisfied.

Standard Option:

Example: When you see your primary physician you pay a copayment of $20 per visit, for your specialist you pay a copayment of $45 per visit, and when you go in the hospital, you pay 20% of the Plan allowance.

HDHP Option:

Example: When you see your primary physician you pay a copayment of $20 per visit, for your specialist you pay a copayment of $45 per visit, and when you go in the hospital, you pay 15% of the Plan allowance.

Cost-sharing

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

Deductible

A deductible is a fixed amount 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: The calendar year deductible is $550 per person, and $1,100 per family. Under a family enrollment, the Family Deductible is satisfied when the expenses for any combination of Members in a family equals the Family Deductible amount. The expenses of each Member counted towards the Family Deductible is limited to their Individual Deductible amount.

Standard Option: The calendar year deductible is $1,500 per person, and $3,000 per family. Under a family enrollment, the Family Deductible is satisfied when the expenses for any combination of Members in a family equals the Family Deductible amount. The expenses of each Member counted towards the Family Deductible is limited to their Individual Deductible amount.

HDHP Option: The calendar year deductible is $2,000 per person and $4,000 per family. Under a family enrollment, the Family Deductible is satisfied when the expenses for any combination of Members in a family equals the Family Deductible amount. The expenses of each Member counted towards the Family Deductible is limited to their Individual Deductible amount.

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

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

Coinsurance

Coinsurance is the percentage of our allowance that you must pay for your care.

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

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

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

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

For example, if your physician ordinarily charges $100 for a service but routinely waives your 15% coinsurance, the actual charge is $85. We will pay $72.25 (85% of the actual charge of $85).

Your catastrophic protection out-of-pocket maximum

High Option: After your deductible and coinsurance total $4,000 per person or $8,000 per family enrollment in any calendar year, you do not have to pay any more for covered services. The Out-of-Pocket Maximum includes Deductible and Coinsurance, Copayments do not apply.

Standard Option: After your medical deductible and coinsurance total $5,500 per person or $11,000 per family enrollment in any calendar year, you do not have to pay any more for covered services. The Out-of-Pocket Maximum includes Deductible and Coinsurance, Copayments do not apply. In addition, there will be an out-of-pocket maximum on prescription copayments and coinsurance of $5,000. This is separate from the medical out-of-pocket maximum and each must be satisfied separately each calendar year.

HDHP Option: After your deductible and coinsurance total $5,000 per person or $10,000 per family enrollment in any calendar year, you do not have to pay any more for covered services.

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

Differences between our allowance and the bill

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

EXAMPLE	In-network physician	Out-of-network physician
Physician's charge	$150	N/A
Our allowance	We set it at 100: 100	N/A
We pay	85% of our allowance: 85	N/A
You owe: Coinsurance	15% of our allowance: 15	N/A
+Difference up to charge?	No: 0	N/A
TOTAL YOU PAY	$15	N/A

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

When Government facilities bill us

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

Section 5. High and Standard Option Benefits

See page 11 for how our benefits changed this year. Page 116 and page 118 are a benefits summary of each option. Make sure that you review the benefits that are available under the option in which you are enrolled.

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Section 5. High and Standard Benefits Overview

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

The High and Standard Option Section 5 is divided into subsections. Please read *Important things you should keep in mind* at the beginning of the subsections. Also, read the General exclusions in Section 6, they apply to the benefits in the following subsections. To obtain claim forms, claims filling advice, or more information about High and Standard Option benefits, contact us at 800-257-4692 or at our Web site at www.chciowa.com

Each option offers unique features.

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

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan physicians must provide or arrange your care.
- Deductible and Coinsurance may apply to facility services that appear in this section but are performed in an ambulatory surgical center or the outpatient department of a hospital.
- For the High Option, the deductible is $550 for Self Only enrollment and $1,100 for Self and Family enrollment each calendar year. The Self and Family deductible can be satisfied by one or more family members. The deductible applies to all benefits in this Section unless we indicate a flat copayment only.
- For the Standard Option, the deductible is $1,500 for Self Only enrollment and $3,000 for Self and Family enrollment each calendar year. The Self and Family deductible can be satisfied by one or more family members. The deductible applies to all benefits in this Section unless we indicate a flat copayment only.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

Benefit Description	You pay	
Diagnostic and treatment services	**High Option**	**Standard Option**
Professional services of physicians • In physician's office • Office medical consultations	$20 per primary care physicians office visit: $45 per specialists office visit	$20 per primary care physicians office visit: $45 per specialists office visit
Professional services of physicians • In an urgent care center • During a hospital stay • In a skilled nursing facility • Second surgical opinion	Nothing	20% of the Plan allowance
At home	Nothing	20% of the Plan allowance
Lab, X-ray and other diagnostic tests	**High Option**	**Standard Option**
Tests, such as: • Blood tests • Urinalysis • Non-routine Pap tests • Pathology • X-rays • Non-routine mammograms	Nothing if you receive these services during your office visit; otherwise, $20 per primary care physicians office visit: $45 per specialists office visit	$20 per primary care physicians office visit: $45 per specialists office visit

Benefit Description	You pay	
High Tec Tests	**High Option**	**Standard Option**
Tests, such as: • CAT Scans/MRI • Ultrasound • Electrocardiogram and EEG	15% of Plan allowance	20% of Plan allowance
Preventive care, adult	**High Option**	**Standard Option**
Routine screenings, such as: • Total Blood Cholesterol • Colorectal Cancer Screening, including - Fecal Occult blood test - Sigmoidscopy, screening -every five years starting at age 50 - Double contract barium enema- every five years starting at age 50 - Colonoscopy screening- every ten years starting at age 50	Nothing	Nothing
Routine Prostate Specific Antigen (PSA) test – one annually for men age 40 and older	Nothing	Nothing
Routine Pap test	Nothing	Nothing
Routine mammogram regardless of place of service covered for women age 35 and older, as follows: • From age 35 through 39, one during this five year period • From age 40 through 64, one every calendar year • At age 65 and older, one every two consecutive calendar years	Nothing	Nothing
Adult routine immunizations endorsed by the Centers for Disease Control and Prevention (CDC).	Nothing	Nothing
Not covered: Physical exams and immunizations required for obtaining or continuing employment or insurance, attending schools or camp, or travel.	*All charges*	*All charges*
Preventive care, children	**High Option**	**Standard Option**
• Childhood immunizations recommended by the American Academy of Pediatrics	Nothing	Nothing
• Well-child care charges for routine examinations, immunizations and care (up to age 22) • Examinations, such as: - Eye exams through age 17 to determine the need for vision correction - Ear exams through age 17 to determine the need for hearing correction	Nothing	Nothing

Preventive care, children - continued on next page

Benefit Description	You pay	
Preventive care, children (cont.)	**High Option**	**Standard Option**
- Examinations done on the day of immunizations (up to age 26)	Nothing	Nothing
Maternity care	**High Option**	**Standard Option**
Complete maternity (obstetrical) care, such as: • Prenatal care • Delivery • Postnatal care Note: Here are some things to keep in mind: • You do not need to precertify your normal delivery; see page 14 for other circumstances, such as extended stays for you or your baby. • You may remain in the hospital up to 48 hours after a regular delivery and 96 hours after a cesarean delivery. We will extend your inpatient stay if medically necessary. • We cover routine nursery care of the newborn child during the covered portion of the mother's maternity stay. We will cover other care of an infant who requires non-routine treatment only if we cover the infant under a Self and Family enrollment. • We pay hospitalization and surgeon services for non-maternity care the same as for illness and injury.	$150 at the time of delivery; nothing there after	20% of the Plan allowance
Family planning	**High Option**	**Standard Option**
A range of voluntary family planning services, limited to: • Voluntary sterilization (See Surgical procedures Section 5 (b)) • Surgically implanted contraceptives • Injectable contraceptive drugs (such as Depo provera) • Intrauterine devices (IUDs) • Diaphragms Note: We cover oral contraceptives under the prescription drug benefit.	$20 per primary care physicians office visit: $45 per specialists office visit	50% of the Plan allowance
Not covered: • *Reversal of voluntary surgical sterilization* • *Genetic counseling*	*All charges*	*All charges*

Benefit Description	You pay	
Infertility services	**High Option**	**Standard Option**
Diagnosis and treatment of infertility such as: • Artificial insemination: - Intravaginal insemination (IVI)	50% of of the Plan allowance	50% of the Plan allowance
Not covered: • *Assisted reproductive technology (ART) procedures, such as:* • *in vitro fertilization* • *embryo transfer, gamete intra-fallopian transfer (GIFT) and zygote intra-fallopian transfer (ZIFT)* • *Services and supplies related to ART procedures* • *Cost of donor sperm* • *Cost of donor egg* • *intracervical insemination (ICI)* • *intrauterine insemination (IUI)* • *Fertility drugs*	*All charges*	*All charges*
Allergy care	**High Option**	**Standard Option**
• Testing and treatment	$20 per primary care physicians office visit: $45 per specialists office visit	$20 per primary care physicians office visit: $45 per specialists office visit
Allergy Injections	$5 per injection	20% of Plan allowance
Allergy serum	Nothing	Nothing
Not covered: • *Provocative food testing* • *Sublingual allergy desensitization*	*All charges*	*All charges*
Treatment therapies	**High Option**	**Standard Option**
• Chemotherapy and radiation therapy Note: High dose chemotherapy in association with autologous bone marrow transplants is limited to those transplants listed under Organ/Tissue Transplants on page 33. • Respiratory and inhalation therapy • Dialysis – hemodialysis and peritoneal dialysis • Intravenous (IV)/Infusion Therapy – Home IV and antibiotic therapy • Growth hormone therapy (GHT) Note: Growth hormone is covered under the prescription drug benefit.	$20 per primary care physicians office visit: $45 per specialists office visit	20% of Plan allowance

Treatment therapies - continued on next page

Benefit Description	You pay	
Treatment therapies (cont.)	**High Option**	**Standard Option**
Note: – We only cover GHT when we preauthorize the treatment. We will ask you to submit information that establishes that the GHT is medically necessary. Ask us to authorize GHT before you begin treatment. We will only cover GHT services and related service and supplies that we determine are medically necessary. See Other services under You need prior Plan approval for certain services on page 14.	$20 per primary care physicians office visit: $45 per specialists office visit	20% of Plan allowance
Physical and occupational therapies	**High Option**	**Standard Option**
60 days per condition for the services of the following: • Qualified physical therapists • Occupational therapists Note: These services are covered when determined by the Plan to be medically necessary. Cardiac rehabilitation following a heart transplant, bypass surgery or a myocardial infarction is provided for up to 60 days.	$20 per primary care physicians office visit: $45 per specialists office visit nothing per visit during covered inpatient admission	20% of Plan allowance
Not covered: • *Long-term rehabilitative therapy* • *Exercise programs*	*All charges*	*All charges*
Speech therapy	**High Option**	**Standard Option**
60 days per condition Note: These services are covered when determined by the Plan to be medically necessary.	$20 per primary care physicians office visit: $45 per specialists office visit nothing per visit during covered inpatient admission.	20% of Plan allowance
Hearing services (testing, treatment, and supplies)	**High Option**	**Standard Option**
• Hearing testing for children through age 17, as shown in *Preventive care, children* • Hearing aids, as shown in *Orthopedic and prosthetic devices*	Nothing $500 member copayment up to a $5,000 maximum Plan benefit every 24 months	Nothing 20% of Plan allowance up to a $5,000 maximum Plan benefit every 24 months
Not covered: • *Hearing services that are not shown as covered.*	*All charges*	*All charges*

Benefit Description	You pay	
Vision services (testing, treatment, and supplies)	**High Option**	**Standard Option**
• Eye exam to determine the need for vision correction • Annual eye refractions (which includes the written lens prescription) may be obtained from Plan Providers. Note: See *Preventive care, children* for eye exams for children.	Nothing to Optometrist; $20 per primary care physicians office visit: $45 per specialists office visit to an Ophthalmologist	Nothing to Optometrist; $20 per primary care physicians office visit: $45 per specialists office visit to an Opthalmologist
First corrective lens when medically necessary following an impairment directly caused by accidental ocular injury or intraocular surgery (such as cataracts).	20% of Plan allowance	50% of Plan allowance
Not covered: • *Eyeglasses or contact lenses, except as shown above* • *Eye exercises and orthoptics* • *Radial keratotomy and other refractive surgery*	*All charges*	*All charges*
Foot care	**High Option**	**Standard Option**
Routine foot care when you are under active treatment for a metabolic or peripheral vascular disease, such as diabetes. Note: See Orthopedic and prosthetic devices for information on podiatric shoe inserts.	$20 per primary care physicians office visit: $45 per specialists office visit	$20 per primary care physicians office visit: $45 per specialists office visit
Not covered: • *Cutting, trimming or removal of corns, calluses, or the free edge of toenails, and similar routine treatment of conditions of the foot, except as stated above* • *Treatment of weak, strained or flat feet or bunions or spurs; and of any instability, imbalance or subluxation of the foot (unless the treatment is by open cutting surgery)*	*All charges*	*All charges*
Orthopedic and prosthetic devices	**High Option**	**Standard Option**
• Hearing aids and testing to fit them (We limit coverage to two hearing aids every 24 months up to a $5,000 maximum Plan benefit) • Artificial limbs and eyes • Stump hose • Externally worn breast prostheses and surgical bras, including necessary replacements following a mastectomy • Corrective orthopedic appliances for non-dental treatment of temporomandibular joint (TMJ) pain dysfunction syndrome.	a $500 member copayment up to a $5,000 maximum Plan benefit every 24 months for hearing aids/testing only All other Orthopedic and prosthetic devices are 50% of Plan allowance	20% of Plan allowance up to a $5,000 maximum Plan benefit every 24 months for hearing aids/testing only All other Orthopedic and prosthetic devices are 50% of Plan allowance

Orthopedic and prosthetic devices - continued on next page

Benefit Description	You pay	
Orthopedic and prosthetic devices (cont.)	**High Option**	**Standard Option**
• Internal prosthetic devices, such as artificial joints, pacemakers, cochlear implants, and surgically implanted breast implant following mastectomy. Note: For information on the professional charges for the surgery to insert an implant, see Section 5 (b) Surgical procedures. For information on the hospital and/or ambulatory surgery center benefits, see Section 5 (c) Services provided by a hospital or other facility, and ambulance services.	a $500 member copayment up to a $5,000 maximum Plan benefit every 24 months for hearing aids/testing only All other Orthopedic and prosthetic devices are 50% of Plan allowance	20% of Plan allowance up to a $5,000 maximum Plan benefit every 24 months for hearing aids/testing only All other Orthopedic and prosthetic devices are 50% of Plan allowance
Not covered: • *Orthopedic and corrective shoes, arch supports, foot orthotics, heel pads, and heel cups.* • *Lumbosacral supports* • *Corsets, trusses, elastic stockings, support hose, and other supportive devices* • *Prosthetic replacements provided less than 3 years after the last one we covered*	*All charges*	*All charges*
Durable medical equipment (DME)	**High Option**	**Standard Option**
We cover rental or purchase of durable medical equipment, at our option, including repair and adjustment. Covered items include: • Oxygen • Dialysis equipment • Manual Hospital beds • Manual Wheelchairs • Crutches • Walkers • Blood glucose monitors • Insulin pumps	50% of Plan allowance	50% of Plan allowance
Not covered: • *Motorized wheelchairs* • *Convenience items or exercise equipment*	*All charges*	*All charges*
Home health services	**High Option**	**Standard Option**
• Home health care ordered by a Plan physician and provided by a registered nurse (R.N.), licensed practical nurse (L.P.N.), licensed vocational nurse (L.V.N.), licensed vocational nurse (L.V.N.), or home health aide. • Services include oxygen therapy, intravenous therapy and medications.	$25 per day	20% of Plan allowance

Home health services - continued on next page

Benefit Description	You pay	
Home health services (cont.)	**High Option**	**Standard Option**
Note: We cover self-administered injectables under the prescription drug benefit.	$25 per day	20% of Plan allowance
Not covered: • *Nursing care requested by, or for the convenience of, the patient or the patient's family* • *Home care primarily for personal assistance that does not include a medical component and is not diagnostic, therapeutic, or rehabilitative*	*All charges*	*All charges*
Chiropractic	**High Option**	**Standard Option**
20 visits per year • Manipulation of the spine and extremities • Adjunctive procedures such as ultrasound, electrical muscle stimulation, vibratory therapy, and cold pack application	$20 per primary care physicians office visit: $45 per specialists office visit	20% of Plan allowance
Alternative treatments	**High Option**	**Standard Option**
No benefit	*All charges*	*All charges*
Educational classes and programs	**High Option**	**Standard Option**
Coverage is provided for: • Tobacco cessation programs, including individual group telephone counseling and for physician prescribed over the counter (OTC) and prescription drugs approved by the FDA to treat tobacco dependence Note: Call us at 1-800-257-4692 for benefit guidelines	Nothing for counseling for up to two quit attempts per year. Nothing for physician prescribed OTC and prescription drugs approved by the FDA to treat tobacco dependence.	Nothing for counseling for up to two quit attempts per year. Nothing for physician prescribed OTC and prescription drugs approved by the FDA to treat tobacco dependence.
• Diabetes self management	$20 per primary care physicians office visits; $45 per specialists office; 15% of plan allowance after plan deductible for inpatient or outpatient services	$20 per primary care physicians office visits; $45 per specialists office; 20% of plan allowance after plan deductible for inpatient or outpatient services

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

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan physicians must provide or arrange your care.
- For the High Option, the deductible is $550 for Self Only enrollment and $1,100 for Self and Family enrollment each calendar year. The Self and Family deductible can be satisfied by one or more family members. The deductible applies to all benefits in this Section unless we indicate a flat copayment only.
- For the Standard Option, the deductible is $1,500 for Self Only enrollment and $3,000 for Self and Family enrollment each calendar year. The Self and Family deductible can be satisfied by one or more family members. The deductible applies to all benefits in this Section unless we indicate a flat copayment only.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost-sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- The amounts listed below are for the charges billed by a physician or other health care professional for your surgical care. Look in Section 5(c) for charges associated with the facility (i.e. hospital, surgical center, etc.).

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

Benefit Description	You pay	
Surgical procedures	**High Option**	**Standard Option**
A comprehensive range of services, such as: • Operative procedures • Treatment of fractures, including casting • Normal pre- and post-operative care by the surgeon • Correction of amblyopia and strabismus • Endoscopy procedures • Biopsy procedures • Removal of tumors and cysts • Correction of congenital anomalies (see *Reconstructive surgery*) • Surgical treatment of morbid obesity (bariatric surgery) – - The patient is an adult (≥ 18 years of age) with morbid obesity that has persisted for at least 3 years, and for which there is no treatable metabolic cause for the obesity;	$20 per primary care physicians office visit: $45 per specialists office visit; nothing as an inpatient	$20 per primary care physicians office visit: $45 per specialists office visit; 20% of Plan allowance as an inpatient

Surgical procedures - continued on next page

Benefit Description	You pay	
Surgical procedures (cont.)	**High Option**	**Standard Option**
- There is presence of morbid obesity, defined as a body mass index (BMI) exceeding 40, or greater than 35 with documented co-morbid conditions (cardiopulmonary problems e.g., severe apnea, Pickwickian Syndrome, and obesity-related cardiomyopathy, severe diabetes mellitus, hypertension, or arthritis). (BMI is calculated by dividing a patient's weight (in kilograms) by height (in meters) squared. To convert pounds to kilograms, multiply pounds by 0.45. To convert inches to meters, multiply inches by .0254); - The patient has failed to lose weight (approximately 10% from baseline) or has regained weight meters, multiply inches by .0254); - The patient has failed to lose weight (approximately 10% from baseline) or has regained weight despite participation in a three month physician-supervised multidisciplinary program within the past six months that included dietary therapy, physical activity and behavior therapy and support; - The patient has been evaluated for restrictive lung disease and received surgical clearance by a pulmonologist, if clinically indicated; has received cardiac clearance by a cardiologist if there is a history of prior phen-fen or redux use, and the patient has agreed, following surgery, to participate in a multidisciplinary program that will provide guidance on diet, physical activity and social support; and, - The patient has completed a psychological evaluation and has been recommended for bariatric surgery by a licensed mental health professional (this must be documented in the patient's medical record) and the patient's medical record reflects documentation by the treating psychotherapist that all psychosocial issues have been identified and addressed; and the psychotherapist indicates that the patient is likely to be compliant with the post-operative diet restrictions; • Voluntary sterilization (e.g., Tubal ligation, Vasectomy) • Treatment of burns	$20 per primary care physicians office visit: $45 per specialists office visit; nothing as an inpatient	$20 per primary care physicians office visit: $45 per specialists office visit; 20% of Plan allowance as an inpatient
• Insertion of internal prosthetic devices. See 5(a) – Orthopedic and prosthetic devices for device coverage information	Nothing	20% of Plan allowance

Surgical procedures - continued on next page

Benefit Description	You pay	
Surgical procedures (cont.)	**High Option**	**Standard Option**
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.	Nothing	20% of Plan allowance
Not covered: • *Reversal of voluntary sterilization* • *Routine treatment of conditions of the foot; see Foot care*	*All charges*	*All charges*
Reconstructive surgery	**High Option**	**Standard Option**
• Surgery to correct a functional defect • Surgery to correct a condition caused by injury or illness if - the condition produced a major effect on the member's appearance and - the condition can reasonably be expected to be corrected by such surgery • Surgery to correct a condition that existed at or from birth and is a significant deviation from the common form or norm. Examples of congenital anomalies are: protruding ear deformities; cleft lip; cleft palate; birth marks; webbed fingers; and webbed toes. • All stages of breast reconstruction surgery following a mastectomy, such as: - Surgery to produce a symmetrical appearance of breasts; - treatment of any physical complications, such as lymphedemas; - breast prostheses and surgical bras and replacements (see Prosthetic devices) Note: If you need a mastectomy, you may choose to have the procedure performed on an inpatient basis and remain in the hospital up to 48 hours after the procedure.	$20 per primary care physicians office visit: $45 per specialists office visit; nothing as an inpatient	$20 per primary care physicians office visit: $45 per specialists office visit; 20% of Plan allowance as an inpatient
Not covered: • *Cosmetic surgery – any surgical procedure (or any portion of a procedure) performed primarily to improve physical appearance through change in bodily form, except repair of accidental injury* • *Surgeries related to sex transformation*	*All charges*	*All charges*

Benefit Description	You pay	
Oral and maxillofacial surgery	**High Option**	**Standard Option**
Oral surgical procedures, limited to: • Reduction of fractures of the jaws or facial bones; • Surgical correction of cleft lip, cleft palate or severe functional malocclusion; • Removal of stones from salivary ducts; • Excision of leukoplakia or malignancies; • Excision of cysts and incision of abscesses when done as independent procedures; and • Other surgical procedures that do not involve the teeth or their supporting structures.	$20 per primary care physicians office visit: $45 per specialists office visit; nothing as an inpatient	$20 per primary care physicians office visit: $45 per specialists office visit; 20% of Plan allowance as an inpatient
Not covered: • *Oral implants and transplants* • *Procedures that involve the teeth or their supporting structures (such as the periodontal membrane, gingiva, and alveolar bone)*	*All charges*	*All charges*
Organ/tissue transplants	**High Option**	**Standard Option**
These **solid organ transplants** are covered. Solid organ transplants limited to: • Cornea • Heart • Heart/lung • Intestinal transplants - Small intestine - Small intestine with the liver - Small intestine with multiple organs, such as the liver, stomach, and pancreas • Kidney • Liver • Lung: single/bilateral • Pancreas • Autologous pancreas islet cell transplant (as an adjunct to total or near total pancreatectomy) only for patients with chronic pancreatitis These **tandem blood or marrow stem cell transplants for covered transplants** are subject to medical necessity review by the Plan. Refer to *Other services* in Section 3 for prior authorization procedures. • Autologous tandem transplants for - AL Amyloidosis - Multiple myeloma (de novo and treated)	Nothing	20% of Plan allowance

Organ/tissue transplants - continued on next page

Benefit Description	You pay	
Organ/tissue transplants (cont.)	**High Option**	**Standard Option**
- Recurrent germ cell tumors (including testicular cancer)	Nothing	20% of Plan allowance
Blood or marrow stem cell transplants limited to the stages of the following diagnoses. For the diagnoses listed below, the medical necessity limitation is considered satisfied if the patient meets the staging description. Allogeneic transplants for • Acute lymphocytic or non-lymphocytic (i.e., myelogeneous) leukemia • Chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL) • Advanced Hodgkin's lymphoma with reoccurrence (relapsed) • Advanced non-Hodgkin's lymphoma with reoccurrence (relapsed) • Acute myeloid leukemia • Advanced Myeloproliferative Disorders (MPDs) • Advanced neuroblastoma • Amyloidosis • Hemoglobinopathy • Infantile malignant osteopetrosis • Kostmann's syndrome • Leukocyte adhesion deficiencies • Marrow failure and Related Disorders (i.e. Fanconi's PNH, pure red cell aplasia) • Mucolipidosis (e.g.Gaucher's disease, metachromatic leukodystrophy, adrenoleukodystrophy) • Mucopolysaccharidosis (e.g. Hunter's syndrome, Hurler's syndrome, Sanfillippo's syndrome, Maroteaux-Lamy syndrome variants) • Myelodysplasia/Myelodysplastic syndromes • Paroxysmal Nocturnal Hemoglobinuria • Chronic myelogenous leukemia • Phagocytic/Hemophagocytic deficiency diseases (e.g., Wiskott-Aldrich syndrome) • Severe combined immunodeficiency • Severe or very severe aplastic anemia • Sickle cell anemia • X-linked lynphoproliferative syndrome Autologous transplant for	Nothing	20% of Plan allowance

Organ/tissue transplants - continued on next page

Benefit Description	You pay	
Organ/tissue transplants (cont.)	**High Option**	**Standard Option**
• Acute lymphocytic or nonlymphocytic (i.e., myelogenous) leukemia • Advanced Hodgkin's lymphoma with reoccurrence (relapsed) • Advanced non-Hodgkin's lymphoma with reoccurrence (relapsed) • Advanced Neuroblastoma • Amyloidosis • Breast Cancer • Ependymoblastoma • Epithelial ovarian cancer • Ewing's sarcoma • Multiple myeloma • Medulloblastoma • Pineoblastoma • Neuroblastoma • Testicular, Mediastinal, Retroperitoneal, and ovarian germ cell tumors	Nothing	20% of Plan allowance
Mini-transplants performed in a clinical trial setting (non-myeloablative, reduced intensity conditioning or RIC) for members with a diagnosis listed below are subject to medical necessity review by the Plan. Refer to *Other services* in Section 3 for prior authorization procedures: • Allogeneic transplants for: - Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia - Advanced Hodgkin's lymphoma with reoccurrence (relapsed) - Advanced non-Hodgkin's lymphoma with reoccurrence (relapsed) - Acute myeloid leukemia - Advanced Myeloproliferative Disorders (MPDs) - Amyloidosis - Chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL) - Hemoglobinopathy - Marrow failure and related disorders (i.e., Fanconi's, PNH, Pure Red Cell Aplasia) - Myelodysplasia/Myelodysplastic syndromes - Paroxysmal Nocturnal Hemoglobinuria - Severe combined immunodeficiency	Nothing	20% of Plan allowance

Organ/tissue transplants - continued on next page

Benefit Description	You pay	
Organ/tissue transplants (cont.)	**High Option**	**Standard Option**
- Severe or very severe aplastic anemia • Autologous transplants for - Acute lymphocytic or nonlymphocytic (i.e., myelogenous) leukemia - Advanced Hodgkin's lymphoma with reoccurrence (relapsed) - Advanced non-Hodgkin's lymphoma with reoccurrence (relapsed) - Amyloidosis - Neuroblastoma	Nothing	20% of Plan allowance
These blood or marrow stem cell transplants are covered only in a National Cancer Institute or National Institutes of health **approved clinical trial** or a Plan-designated center of excellence and if approved by the Plan's medical director in accordance with the Plan's protocols. If you are a participant in a clinical trial, the Plan will provide benefits for related routine care that is medically necessary (such as doctor visits, lab tests, x-rays and scans, and hospitalization related to treating the patient's condition) if it is not provided by the clinical trial.Section 9 has additional information on costs related to clinical trials.We encourage you to contact the Plan to discuss specific services if you participate in a clinical trial. • Allogeneic transplants for - Advanced Hodgkin's lymphoma - Advanced non-Hodgkin's lymphoma - Beta Thalassemia Major - Early stage (indolent or non-advanced) small cell lymphocytic lymphoma - Multiple myeloma - Multiple sclerosis - Sickle Cell anemia Mini-transplants (non-myeloablative allogeneic, reduced intensity conditioning or RIC) for • Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia • Advanced Hodgkin's lymphoma • Advanced non-Hodgkin's lymphoma • Breast cancer • Chronic lymphocytic leukemia • Chronic myelogenous leukemia	Nothing	20% of Plan allowance

Organ/tissue transplants - continued on next page

Benefit Description	You pay	
Organ/tissue transplants (cont.)	**High Option**	**Standard Option**
• Colon cancer • Chronic lymphocytic lymphoma/small lymphocytic lymphoma (CLL/SLL) • Early stage (indolent or non-advanced) small cell lymphocytic lymphoma • Multiple myeloma • Multiple sclerosis • Myeloproliferative disorders (MSDs) • Non-small cell lung cancer • Ovarian cancer • Prostate cancer • Renal cell carcinoma • Sarcomas • Sickle cell anemia Autologous Transplants for • Advanced Childhood kidney cancers • Advanced Ewing sarcoma Breast Cancer • Advanced Hodgkin's lymphoma • Advanced non-Hodgkin's lymphoma • Breast Cancer • Childhood rhabdomyosarcoma • Chronic myelogenous leukemia • Chronic lymphocyticlymphoma/small lymphocytic lymphoma (CLL/SLL) • Early stage (indolent or non-advanced) small cell lymphocytic lymphoma • Epithelial Ovarian Cancer • Mantle Cell (Non-Hodgkin lymphoma) • Multiple sclerosis • Small cell lung cancer • Systemic lupus erythematosus • Systemic sclerosis Note: We cover related medical and hospital expenses of the donor when we cover the recipient. We cover donor testing for the actual solid organ donor or up to four bone marrow/stem cell transplant donors in addition to the testing of family members.	Nothing	20% of Plan allowance
Not covered: • *Donor screening tests and donor search expenses, except as shown above* • *Implants of artificial organs*	*All charges*	*All charges*

Organ/tissue transplants - continued on next page

Benefit Description	You pay	
Organ/tissue transplants (cont.)	**High Option**	**Standard Option**
• *Transplants not listed as covered*	*All charges*	*All charges*
Anesthesia	**High Option**	**Standard Option**
Professional services provided in – • Hospital (inpatient)	Nothing	20% of Plan allowance
Professional services provided in – • Hospital outpatient department • Skilled nursing facility • Ambulatory surgical center • Office	Nothing	20% of Plan allowance

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

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan physicians must provide or arrange your care and you must be hospitalized in a Plan facility.
- For the High Option, the deductible is $550 for Self Only enrollment and $1,100 for Self and Family enrollment each calendar year. The Self and Family deductible can be satisfied by one or more family members. The deductible applies to all benefits in this Section unless we indicate a flat copayment only.
- For the Standard Option, the deductible is $1,500 for Self Only enrollment and $3,000 for Self and Family enrollment each calendar year. The Self and Family deductible can be satisfied by one or more family members. The deductible applies to all benefits in this Section unless we indicate a flat copayment only.
- Be sure to read Section 4, *Your costs for covered services* for valuable information about how cost-sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- The amounts listed below are for the charges billed by the facility (i.e., hospital or surgical center) or ambulance service for your surgery or care. Any costs associated with the professional charge (i. e., physicians, etc.) are in Sections 5(a) or (b).

YOUR PHYSICIAN MUST GET PRECERTIFICATION FOR HOSPITAL STAYS. Please refer to Section 3 to be sure which services require precertification.

Benefit Description	You pay	
Inpatient hospital	**High Option**	**Standard Option**
Room and board, such as • Ward, semiprivate, or intensive care accommodations • General nursing care • Meals and special diets Note: If you want a private room when it is not medically necessary, you pay the additional charge above the semiprivate room rate.	15% of Plan allowance	20% of Plan allowance
Other hospital services and supplies, such as: • Operating, recovery, maternity, and other treatment rooms • Prescribed drugs and medicines • Diagnostic laboratory tests and X-rays • Dressings , splints , casts , and sterile tray services • Medical supplies and equipment, including oxygen • Anesthetics, including nurse anesthetist services • Take-home items	15% of Plan allowance	20% of Plan allowance

Inpatient hospital - continued on next page

Benefit Description	You pay	
Inpatient hospital (cont.)	**High Option**	**Standard Option**
Note: We cover hosiptal services and supplies related to dental procedures when necessitated by non-dental physical impairment. We do not cover the dental procedure.	15% of Plan allowance	20% of Plan allowance
Not covered: • *Custodial care* • *Non-covered facilities, such as nursing homes, schools* • *Personal comfort items, such as telephone, television, barber services, guest meals and beds* • *Private nursing care*	*All charges*	*All charges*
Outpatient hospital or ambulatory surgical center	**High Option**	**Standard Option**
• Operating, recovery, and other treatment rooms • Prescribed drugs and medicines • Diagnostic laboratory tests, X-rays , and pathology services • Administration of blood, blood plasma, and other biologicals • Blood and blood plasma , if not donated or replaced • Pre-surgical testing • Dressings, casts , and sterile tray services • Medical supplies, including oxygen • Anesthetics and anesthesia service 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. Note: Copayment does not apply to diagnostic laboratory tests drawn in an office setting and sent to an outpatient facility.	15% of Plan allowance	20% of Plan allowance
Not covered: Blood and blood derivatives not replaced by the member	*All charges*	*All charges*
Extended care benefits/Skilled nursing care facility benefits	**High Option**	**Standard Option**
Extended care benefit: We cover a comprehensive range of benefits up to 62 days per calendar year when full-time skilled nursing is necessary and confinement is a skilled nursing facility is medically appropriate as determined by a Plan doctor and approved by the Plan.	Nothing	20% of Plan allowance
Not covered: Custodial care	*All charges*	*All charges*

Benefit Description	You pay	
Hospice care	**High Option**	**Standard Option**
Supportive and palliative care for a terminally ill member is covered in the home or hospice facility. Services include inpatient and outpatient care and family counseling; these services are provided under the direction of the Plan doctor who certifies that the patient is in the terminal stages of illness, with a life expectancy of approximately six months or less.	Nothing	20% of Plan allowance
Not covered: Independent nursing, homemaker services	*All charges*	All charges
Ambulance	**High Option**	**Standard Option**
Local professional ambulance service when medically appropriate	$250 member copayment	20% of Plan allowance

Section 5(d). Emergency services/accidents

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- For the High Option, the deductible is $550 for Self Only enrollment and $1,100 for Self and Family enrollment each calendar year. The Self and Family deductible can be satisfied by one or more family members. The deductible applies to all benefits in this Section unless we indicate a flat copayment only.
- For the Standard Option, the deductible is $1,500 for Self Only enrollment and $3,000 for Self and Family enrollment each calendar year. The Self and Family deductible can be satisfied by one or more family members. The deductible applies to all benefits in this Section unless we indicate a flat copayment only.

Be sure to read Section 4, *Your costs for covered services,* for valuable information about how cost-sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

What is a medical emergency?

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

What to do in case of emergency:

Emergencies within our service area: If you are in an emergency situation, please contact your doctor. In extreme emergencies, if you are unable to contact your doctor, go to the nearest hospital emergency room. Be sure to tell the emergency room personnel that you are a Plan member so they can notify the Plan.

You or a family member must notify your doctor as soon as possible and/or contact the Plan within 48 hours of the emergency room visit. It is your responsibility to ensure that the Plan has been timely notified.

If you need to be hospitalized, the Plan must be notified within 48 hours or on the first working day following your admission, unless it is not reasonably possible to notify the Plan within that time. If you are hospitalized in non-Plan facilities and Plan doctors believe care can be better provided in a Plan hospital, you will be transferred when medically feasible and any ambulance charges are covered in full.

Benefits are available for care from non-Plan providers in a medical emergency only if delay in reaching a Plan provider would result in death, disability, or significant jeopardy to your condition.

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

For the High Option, the Plan pays reasonable charges for emergency services to the extent the services would have been covered if received from Plan providers. You pay $250 copayment or 50% of the covered charges, whichever is less, per hospital emergency room visit or $50 copayment per urgent care center visit for emergency services which are covered benefits of this Plan. The copayment or coinsurance will be waived if you are admitted as a result of your condition.

For the Standard Option, the Plan pays reasonable charges for emergency services to the extent the services would have been covered if received from Plan providers. You pay $250 copayment which is not subject to the deductible of the covered charges per hospital emergency room visit or $100 copayment which is not subject to the deductible, per emergency room physician visit for emergency services which are covered benefits of this Plan. For Urgent Care Facility services you will pay 20% of the Plan allowance, after the deductible has been met.

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

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

The High Option Plan pays reasonable charges for emergency services to the extent the services would have been covered if received from Plan providers. You pay a $250 copayment or 50% of covered charges, whichever is less, per hospital emergency room visit for emergency services received at a non-Plan facility. The copayment or coinsurance will be waived if you are admitted to the hospital as a result of your condition.

Benefit Description	You pay	
Emergency within our service area	**High Option**	**Standard Option**
Emergency care at a doctor's office Emergency care at an urgent care center	$20 per primary care physicians office visit; $45 per specialists office visit	$20 per primary care physicians office visit; $45 per specialists office visit
Emergency care as an outpatient at a hospital, including doctors' services	$50 per Urgent care visit	20% of Plan allowance
Note: We waive the ER copay if you are admitted to the hospital.	$250 per visit or 50% of allowable charges, whichever is less. Emergency Room physician copayment is $100 per visit	$250 per visit not subject to the deductible; $100 physician visit not subject to the deductible
Not covered: Elective care or non-emergency care	*All charges*	*All charges*
Emergency outside our service area	**High Option**	**Standard Option**
Emergency care at a doctor's office Emergency care at an urgent care center Emergency care as an outpatient at a hospital, including doctors' services Note: We waive the ER copay if you are admitted to the hospital.	$250 per visit or 50% of allowable charges, whichever is less. Emergency Room physician copayment is $100	$250 per visit not subject to the deductible. Emergency Room physician copayment is $100 not subject to the deductible
Not covered: • *Elective care or non-emergency care* • *Emergency care provided outside the service area if the need for care could have been foreseen before leaving the service area* • *Medical and hospital costs resulting from a normal full-term delivery of a baby outside the service area*	*All charges*	*All charges*

Benefit Description	You pay	
Ambulance	**High Option**	**Standard Option**
Professional ambulance service when medically appropriate. Note: Air ambulance covered only when medically necessary. Note: For non-emergency service refer to that section.	$250 member copayment	20% of Plan allowance

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

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

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- The calendar year deductible or, for facility care, the inpatient deductible applies to almost all benefits in this Section. We added "(No deductible)" to show when a deductible does not apply.
- For the High Option, the deductible is $550 for Self Only enrollment and $1,100 for Self and Family enrollment each calendar year. The Self and Family deductible can be satisfied by one or more family members. The deductible applies to all benefits in this Section unless we indicate a flat copayment only.
- For the Standard Option, the deductible is $1,500 for Self Only enrollment and $3,000 for Self and Family enrollment each calendar year. The Self and Family deductible can be satisfied by one or more family members. The deductible applies to all benefits in this Section unless we indicate a flat copayment only.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost-sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

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

Benefit Description	You pay	
Mental health and substance abuse benefits	**High Option**	**Standard Option**
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. 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.	Your cost-sharing responsibilities are no greater than for other illnesses or conditions.	Your cost-sharing responsibilities are no greater than for other illnesses or conditions
• Professional services, including individual or group therapy by providers such as psychiatrists, psychologists, or clinical social workers • Medication management	$20 per primary care physicians office visit; $45 per specialists office visit	$20 per primary care physicians office visit; $45 per specialists office visit
Diagnostic test • Services provided by a hospital or other facility • Services in approved alternative care settings such as partial hospitalization, half-way house, residential treatment, full-day hospitalization, facility based intensive outpatient treatment	Nothing, if you receive these services during your office visit; otherwise $20 per primary care physician office visit; $45 per specialist office visit	20% of Plan allowance
Not covered: Services we have not approved.	*All charges*	All charges

Mental health and substance abuse benefits - continued on next page

Benefit Description	You pay	
Mental health and substance abuse benefits (cont.)	**High Option**	**Standard Option**
Note: OPM will base its review of disputes about treatment plans on the treatment plan's clinical appropriateness. OPM will generally not order us to pay or provide one clinically appropriate treamtment plan in favor of another.	*All charges*	All charges

Preauthorization

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

All mental conditions/substance abuse services are coordinated by our mental health vendor. To access your mental conditions/substance abuse benefits, please refer to the number on your ID card.

Section 5(f). Prescription drug benefits

Important things you should keep in mind about these benefits:

- We cover prescribed drugs and medications, as described in the chart beginning on the next page.
- All benefits are subject to the definitions, limitations and exclusions in this brochure and are payable only when we determine they are medically necessary.
- For the High Option, the deductible is $550 for Self Only enrollment and $1,100 for Self and Family enrollment each calendar year. The Self and Family deductible can be satisfied by one or more family members. The deductible applies to all benefits in this Section unless we indicate a flat copayment only.
- For the Standard Option, the medical deductible is $1,500 for Self Only enrollment and $3,000 for Self and Family enrollment each calendar year. The Self and Family deductible can be satisfied by one or more family members. The deductible applies to all benefits in this Section unless we indicate a flat copayment only. In addition, there will be an out-of-pocket maximum on prescription copayments and coinsurance of $5,000 per calendar year. This is separate from the medical out-of-pocket maximum and each must be satisfied separately.

Be sure to read Section 4, *Your costs for covered services,* for valuable information about how cost-sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

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

- **Who can write your prescription.** A licensed physician must write the prescription .
- **Where you can obtain them.** You may fill the prescription at a Plan pharmacy, or by mail for a maintenance medication
- **We have an open formulary**. If your physician believes a name brand product is necessary or there is no generic available, your physician may prescribe a name brand drug from a formulary list. This list of name brand drugs is a preferred list of drugs that we selected to meet patient needs at a lower cost. To order a prescription drug brochure, call 800-257-4692
- **Value Formulary.** You can locate a copy of the value formulary drug listing at www.chciowa.com. This is a select list of non-formulary drugs which can be purchased at $3 retail, and $9 mail order.
- **Prior Authorizations**. Some drugs require Prior Authorization in order for them to be a Covered Service. These prescriptions include, but are not limited to, those that are not suggested for first-line therapy, may require special tests before starting them, or have limited approval for use. These drugs requiring prior authorization are identified in our formulary with a "PA" next to the name. The list of the drugs are posted on the website, www.chciowa.com. Before you can fill a prescription order or refill for a drug requiring Prior Authorization the member must obtain approval from us.
- **These are the dispensing limitations.** One copayment is due each time a prescription is filled or refilled up to a thirty-one (31) day supply. Maintenance drugs obtained through a mail order pharmacy designated by the Plan, may be dispensed with two (2) copayments for up to a ninety-three (93) day supply. Drugs that are not listed on the maintenance listing are not eligible for the mail order program
- **A generic equivalent will be dispensed if it is available**, unless your physician specifically requires a name brand. If you receive a name brand drug when a Federally-approved generic drug is available, and your physician has not specified Dispense as Written for the name brand drug, you have to pay the difference in cost between the name brand drug and the generic.

Why use generic drugs?

Generic drugs offer a safe and economic way to meet your prescription drug needs. The generic name of a drug is its chemical name. The name brand is the name under which the manufacturer advertises and sells a drug. Under Federal Law, generic and name brand drugs must meet the same standards for safety, purity, strength and effectiveness. A generic prescription cost you – and us – less than a name brand prescription.

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

Benefit Description	You pay	
Covered medications and supplies	**High Option**	**Standard Option**
We cover the following medications and supplies prescribed by a Plan physician and obtained from a Plan pharmacy or through our mail order program: • Drugs and medicines that by Federal law of the United States require a physician's prescription for their purchase, except those listed as *Not covered.* • Insulin - One copayment per 30 day supply • Disposable needles and syringes for the administration of covered medications • Maintenance Drugs • Drugs for sexual dysfunction are limited to four tablets per month. Prior approval is required by the Plan (See Prior Authorization) • Contraceptive drugs and devices • Medication used for maintenance of Multiple Sclerosis require prior authorization • Growth hormone Note: There is a maximum of $5,000 out-of-pocket for coinsurance and copayments on the Standard Option for prescription drugs only per calendar year. This is separate, and does not apply to the medical out-of-pocket expense. Please see page 47 for an explanation. Note: If there is no generic equivalent available, you will still have to pay the brand name copayment. Note: Our value formulary drug listing is available on our website at www.chciowa.com.	**Retail Pharmacy (31-day supply)** $3 per value formulary drug $10 per formulary generic drug and brand name insulin $40 per formulary brand name drug $65 per non-formulary drug **Mail Order maintenance medications only (93-day supply)** $9 per value formulary drug $30 per formulary generic drug and brand name insulin $120 per formulary brand name drug $195 per non-formulary drug	**Retail Pharmacy (31-day supply)** $3 per value formulary drug $10 per formulary generic drug and brand name insulin 30% per formulary brand name drug (minimum $40 copayment, maximum $65 copayment) 30% per non-formulary drug (minimum $65 copayment, maximum $90 copayment) **Mail Order maintenance medications only (93-day supply)** $9 per value formulary drug $30 per formulary generic drug and brand name insulin 30% per formulary brand name drug (minimum $120 copayment, maximum $195 copayment) 30% per non-formulary drug (minimum $195 copayment, maximum $270 copayment)
• Self administered injectables	$10 Tier 1 $75 Tier 2 $100 Tier 3	$10 Tier 1 $75 Tier 2 $100 Tier 3
Not covered: • *Drugs and supplies for cosmetic purposes* • *Drugs to enhance athletic performance* • *Drugs obtained at a non-Plan pharmacy; except for out-of-area emergencies* • *Vitamins, nutrients and food supplements even if a physician prescribes or administers them* • *Nonprescription medicines* • *Fertility drugs*	*All charges*	*All charges*

Covered medications and supplies - continued on next page

Benefit Description	You pay	
Covered medications and supplies (cont.)	**High Option**	**Standard Option**
Note: Physician prescribed over-the-counter and prescription drugs approved by the FDA to treat tobacco dependence are covered under the Tobacco cessation benefit, and require a written prescription by an approved provider. (See page 29)		

Section 5(g). Dental benefits

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- If you are enrolled in a Federal Employees Dental/Vision Insurance Program (FEDVIP) Dental Plan, your FEHB Plan will be First/Primary payor of any Benefit payments and your FEDVIP Plan is secondary to your FEHB Plan. See Section 10 Coordinating benefits with other coverage.
- Plan dentists must provide or arrange your care.
- For the High Option, the deductible is $550 for Self Only enrollment and $1,100 for Self and Family enrollment each calendar year. The Self and Family deductible can be satisfied by one or more family members. The deductible applies to all benefits in this Section unless we indicate a flat copayment only.
- For the Standard Option, the deductible is $1,500 for Self Only enrollment and $3,000 for Self and Family enrollment each calendar year. The Self and Family deductible can be satisfied by one or more family members. The deductible applies to all benefits in this Section unless we indicate a flat copayment only.
- We cover hospitalization for dental procedures only when a non-dental physical impairment exists which makes hospitalization necessary to safeguard the health of the patient. See Section 5(c) for inpatient hospital benefits. We do not cover the dental procedure unless it is described below.
- Be sure to read Section 4, *Your costs for covered services,* for valuable information about how cost-sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

Benefit Desription	You Pay	
Accidental injury benefit	**High Option**	**Standard Option**
We cover restorative services and supplies necessary to promptly repair (but not replace) sound natural teeth. The need for these services must result from an accidental injury.	15% of allowable charges	20% of allowable charges
Dental benfits	**High Option**	**Standard Option**
We have no other dental benefits.	*All charges*	*All charges*

Section 5(h). Special features

Feature	Description
Flexible benefits option	Under the flexible benefits option, we determine the most effective way to provide services. • We may identify medically appropriate alternatives to regular contract benefits as a less costly alternative. If we identify a less costly alternative, we will ask you to sign an alternative benefits agreement that will include all of the following terms in addition to other terms as necessary. Until you sign and return the agreement, regular contract benefits will continue. • Alternative benefits will be made available for a limited time period and are subject to our ongoing review. You must cooperate with the review process. • By approving an alternative benefit, we do not guarantee you will get it in the future. • The decision to offer an alternative benefit is solely ours, and except as expressly provided in the agreement, we may withdraw it at any time and resume regular contract benefits. • If you sign the agreement, we will provide the agreed-upon alternative benefits for the stated time period (unless circumstances change).You may request an extension of the time period, but regular contract benefits will resume if we do not approve your request. • Our decision to offer or withdraw alternative benefits is not subject to OPM review under the disputed claims process. However, if at the time we make a decision regarding alternative benefits, we also decide that regular contract benefits are not payable, then you may dispute our regular contract benefits decision under the OPM disputed claim process (see Section 8).
Services for deaf and hearing impaired	For details, call 866-285-1864
High risk pregnancies	Members identified as having high risk pregnancies will be assigned to a nurse within our organization who will work with them to monitor their care.
Centers of Excellence	Coventry Health Care of Iowa, Inc. utilizes a network of centers of excellence for transplant care.
Travel benefit/services overseas	Anytime you are outside of the service area, you and your covered dependents are always covered for true emergency situations.

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Section 5. High Deductible Health Plan Benefits Overview

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

HDHP Section 5. which describes the HDHP benefits is divided into subsections. Please read *Important things you should keep in mind about these benefits* at the beginning of each subsection. Also read the General Exclusions in Section 6; they apply to benefits in the following subsections. To obtain claim forms, claims filing advice, or information about HDHP benefits, contact us at 800-257-4692 or at our Web site at www.chciowa.com.

Summary:

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

When you enroll in this HDHP option, we will 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. **If we establish an HRA for you, we will credit your HRA or HSA monthly.**

With this Plan preventive care is covered without having to meet the deductible. As you receive other non-preventive medical care, you must meet the Plan's deductible before we pay benefits according to the benefit chart on page 57. You can choose to use the funds available in your HSA to make payments toward the deductible or you can pay towards the deductible entirely out-of-pocket, allowing your savings to continue to grow.

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

- **In-network preventive care**

  The Plan covers preventive care services, such as periodic health evaluations (e.g., annual physicals), screening services (e.g., mammograms), routine prenatal and well-child care, child and adult immunizations. These services are described in Section 5 (a). *You do not have to meet the deductible before using these services.*

- **Traditional in-network medical care**

  After you have paid the Plan's deductible, we pay benefits under traditional in-network coverage. The Plan typically pays 90% 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

- **Savings**

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

Health Savings Accounts (HSA)

By law HSAs are available to members who are not eligible for Medicare or do not have other health insurance coverage. In 2012, for each member you are eligible for an HSA premium pass through, we will contribute to your HSA $66.67 per month for Self enrollment or $133.34 per month for 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 the total contribution does not exceed the limit established by law, which is $3,100 for individual and $6,250 for a family. You can use the funds in your HSA to help pay your health Plan deductible. You own your HSA, so the funds can go with you if you change Plans or employment.

Federal tax tip: There are tax advantages to fully funding your HSA as quickly as possible. Your HSA contribution payments are fully deductible on your Federal tax return. By fully funding your HSA early in the year, you have the flexibility of paying medical expenses from tax-free HSA dollars or after tax-free 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 Health Equity
- Your contributions to the HSA are tax deductible
- You may establish pre-tax HSA deductions from your paycheck to fund your HSA up to IRS limits using the same method that you use to establish other deductions (i.e., Employee Express, MyPay, etc.)
- Your HSA earns tax-free interest
- You can make tax-free withdrawals for qualified medical expenses for you, your spouse and dependents (see IRS publication 502 for a complete list of eligible expenses)
- Your unused HSA funds and interest accumulate from year to year
- It's portable - the HSA is owned by you and is yours to keep, even when you leave Federal employment or retire.
- When you need it, funds up to the actual HSA balance are available

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

Health Reimbursement Arrangements (HRA)

For members who are not eligible for an HSA, are eligible for Medicare or have another health Plan, we will administer and provide an HRA.

In 2012, we will give your HRA credit of $800 per year for a Self-Only enrollment and $1,600 for a Self and Family enrollment. You can use funds in your HRA to help pay your health Plan deductible and/or for certain expenses that don't count toward the deductible.

HRA features include:

- For our HDHP option, the HRA is administered by Coventry Consumer Choice.
- Tax-free credit can be used to pay for qualified medical expenses for you and any individuals covered by the HDHP.
- Unused credits carryover from year to year.
- HRA credit does not earn interest.

- HRA credit is forfeited if you leave Federal employment or switch health insurance Plans.
- An HRA does not affect your ability to participate in an FSAFEDS Health Care Flexible Spending Account (HCFSA). However, you must meet FSAFEDS eligibility requirements.

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

When you use network providers, your annual maximum for out-of-pocket expenses (deductibles, and coinsurance) 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 continue to pay these expenses once you reach your out-of-pocket maximum (such as expenses in excess of the Plan's allowable amount or benefit maximum). Refer to Section 4 Your catastrophic protection out-of-pocket maximum and HDHP Section 5 *Traditional medical coverage subject to the deductible* for more details.

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

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

Section 5. Savings – HSAs and HRAs

Feature Comparison	Health Savings Account (HSA)	Health Reimbursement Arrangement (HRA) Provided when you are ineligible for an HSA
Administrator	The Plan will establish an HSA for you with Coventry Consumer Choice, this HDHP's fiduciary (an administrator, trustee or custodian as defined by Federal tax code and approved by IRS.) ***HealthEquity*** ***15 West Scenic Pointe Drive*** ***Suite 400*** ***Draper, UT 84020*** ***Please refer to the number on your ID card***	The Plan will establish an HRA for you with Coventry Consumer Choice There is no fiduciary for the HRA's. To reach Coventry Consumer Choice: ***Please refer to the number on your ID card.***
Fees	Set-up fee is paid by the HDHP.	None.
Eligibility	You must: • Enroll in this HDHP • Have no other health insurance coverage (does not apply to specific injury, accident, disability, dental, vision or long-term care coverage) • Not be enrolled in Medicare • Not be claimed as a dependent on someone else's tax return • Not have received VA benefits in the last three months • Complete and return all banking paperwork	You must enroll in this HDHP. Eligibility is determined on the first day of the month following your effective day of enrollment and will be prorated for length of enrollment.
Funding	If you are eligible for HSA contributions, a portion of your monthly health Plan premium is deposited to your HSA each month. Premium pass through contributions are based on the effective date of your enrollment in the HDHP. In addition, you may establish pre-tax HSA deductions from your paycheck to fund your HSA up to IRS limits using the same method that you use to establish other deductions (i.e., Employee Express, MyPay, etc.).	Eligibility for the annual credit will be determined on the first day of the month and will be prorated for length of enrollment. The entire amount of your HRA will be available to you upon your enrollment.
• **Self Only enrollment**	For 2012, a monthly premium pass through of $66.67 will be made by the HDHP directly into your HSA each month.	For 2012, your HRA annual credit is $800 (prorated for mid-year of enrollment).

• **Self and Family enrollment**	For 2012, a monthly premium pass through of $133.34 will be made by the HDHP directly into your HSA each month.	For 2012, your HRA annual credit is $1,600 (prorated for length of enrollment).
Contributions / credits	The maximum that can be contributed to your HSA is an annual contribution of HDHP premium pass through and enrollee contribution funds, which when combined, does not exceed the maximum contribution amount set by the IRS of $3,100 for an individual and $6,250 for a family. If you enroll during the Open Season you are eligible to fund your account up to the maximum contribution limit set by the IRS. To determine the amount you may contribute, subtract the amount the Plan will contribute to your account for the year from the maximum allowable contribution. You are eligible to contribute up to the IRS limit for partial year coverage as long as you maintain your HDHP enrollment for 12 months following the month of the year of your first year of eligibility. To determine the amount you may contribute take the IRS limit and subtract the amount the Plan will contribute to your account for the year. If you do not meet 12 months requirement, the maximum contribution amount is reduced by 1/12 for any month you were ineligible to contribute to an HSA. If you exceed the maximum contribution a 10% penalty is imposed. There is an exception for death and disability. You may rollover funds you have in other HSAs to this HDHP HSA (rollover funds do not affect your annual maximum contribution under this HDHP). HSA earn tax-free interest (does not affect your annual maximum contribution). Catch up contributions discussed on page 61.	The full HRA credit will be available subject to proration on the effective date of enrollment. The HRA does not earn interest.
Self Only enrollment	You may make an annual maximum contribution of $2,300.	You cannot contribute to the HRA.
Self and Family enrollment	You may make an annual maximum contribution of $4,650.	You cannot contribute to the HRA.
Access funds	You can access your HSA by the following methods: • Debit card • Withdrawal form (there is a fee associated with this)	For qualified medical expenses under your HDHP, you will be automatically reimbursed when claims are submitted through the HDHP. For expenses not covered by the HDHP, such as orthodontia, a reimbursement form will be sent to you upon your request.

Distributions/ withdrawals • **Medical**	You can pay the out-of-pocket expenses for yourself, your spouse or your dependents (even if they are not covered by the HDHP) from the funds available in your HSA. See IRS Publication 502 for alist of eligible medical expenses.	You can pay the out-of-pocket expenses for qualified medical expenses for individuals covered under the HDHP. Non-reimbursed qualified medical expenses are allowable if they occur after the effective date of your enrollment in this Plan. See *Availability of funds* below for information on when funds are available in the HRA. See IRS Publication 502 for a list of eligible medical expenses. Physician prescribed over-the-counter drugs and Medicare premiums are also reimbursable. Most other types of medical insurance premiums are not reimbursable.
· **Non-medical**	If you are under age 65, withdrawal of funds for non-medical expenses will create a 20% income tax penalty in addition to any other income taxes you may owe on the withdrawn funds. When you turn age 65, distributions can be used for any reason without being subject to the 20% penalty, however they will be subject to ordinary income tax.	Not applicable – distributions will not be made for anything other than non-reimbursed qualified medical expenses.
Availability of funds	Funds are not available for withdrawals until all the following steps are completed: -Your enrollment in the HDHP Plan is effective (effective date is determined by your agency in accord with the event permitting the enrollment change). -The HDHP receives record of your enrollment and initially establishes your HSA account with the fiduciary by providing information it must furnish and by contributing the minimum amount required to establish an HSA. -The fiduciary sends you HSA paperwork for you to complete and the fiduciary receives the completed paperwork back from you.	The entire amount of your HRA will be available to you upon your enrollment in the HDHP.
Account owner	FEHB enrollee	HDHP
Portable	You can take the account with you when you change Plans, separate or retire. If you do not enroll in another HDHP, you can no longer contribute to your HSA. See page 57 for HSA eligibility.	If you receive and remain in this HDHP, you may continue to use and accumulate credits in your HRA. If you terminate employment or change health Plans, only eligible expenses incurred while covered under the HDHP will be eligible for reimbursement subject to timely filing requirements. Unused funds are forfeited.

Annual rollover	Yes, accumulates without a maximum cap.	Yes, accumulates without a maximum cap.

If you have an HSA

- **Contributions**

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

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

- **Catch up contribution**

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

- **If you die**

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

- **Qualified expenses**

  You can pay for "qualified medical expenses," as defined by IRS code 231(d). These expenses include, but are not limited to, medical Plan deductibles, diagnostic services covered by your Plan, long-term care premiums, health insurance premiums if you are receiving Federal unemployment compensation, physician prescribed over-the-counter drugs, LASIK surgery, and some nursing services.

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

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

- **Non-qualified expenses**

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

- **Tracking your HSA balance**

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

- **Minimum reimbursement from your HSA**

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

If you have an HRA

- **Why an HRA is established**

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

- **How an HRA differs**

  Please review the chart on page 57 which details the differences between an HRA and an HSA.

  The major differences are:

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

Section 5. Preventive care

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

- The Plan pays 100% for the preventive care services listed in this Section
- For all other covered expenses, please see Traditional Medical Coverage.
- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.

Benefit Description	You pay
Preventive care, adult	
Professional services, such as: • Routine physicals • Routine screenings • Adult routine immunizations endorsed by Centers for Disease Control and prevention (CDC).	Nothing
Routine mammogram regardless of place of service covered for women age 35 and older, as follows: • From age 35 through 39, one during this five year period • From age 40 through 64, one every calendar year • At age 65 and older, one every two consecutive calendar years	Nothing
Not covered: • *Physical exams and immunizations required for obtaining or continuing employment or insurance, attending schools or camp, athletic exams or travel.* • *Immunizations, boosters, and medications for travel or work-related exposure.*	*All Charges*
Preventive care, children	
Professional services, such as: • Well-child care charges for routine examinations, immunizations and care (up to age 22) • Childhood immunizations recommended by the American Academy of Pediatrics • Examinations, such as: • Eye exam through age 17 to determine the need for vision correction • Hearing exams through age 17 to determine the need for hearing correction	Nothing
Not covered: • *Physical exams and immunizations required for obtaining or continuing employment or insurance, attending schools or camp, or travel.* • *Immunizations, boosters, and medications for travel.*	*All Charges*

Section 5. Traditional medical coverage subject to the deductible

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- In-network preventive care is covered at 100% (see page 63)
- We have no out-of-network benefits
- The deductible is $2,000 per person or $4,000 per family enrollment. The family deductible can be satisfied by one or more family members. The deductible applies to almost all benefits under Traditional medical coverage. You must pay your deductible before your Traditional medical coverage may begin.
- When you use network providers, you are protected by an annual catastrophic maximum on out-of-pocket expenses for covered services. After your coinsurance, copayments and deductibles total $5,000 per person or $10,000 per family enrollment in any calendar year, you do not have to pay any more for covered services from network providers. However, certain expenses do not count toward your out-of-pocket maximum and you must continue to pay these expenses once you reach your out-of-pocket maximum (such as expenses in excess of the Plan's benefit maximum, or if you use out-of-network providers, amounts in excess of the Plan allowance).
- Be sure to read Section 4, Your costs for covered services, for valuable information about how cost-sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

Benefit Description	You pay
Deductible before Traditional medical coverage begins	
The deductible applies to almost all benefits in this Section. In the **You pay** column, we say "No deductible" when it does not apply. When you receive covered services from network providers, you are responsible for paying the allowable charges until you meet the deductible.	100% of allowable charges until you meet the deductible of $2,000 per person or $4,000 per family enrollment
After you meet the deductible, we pay the allowable charge (less your coinsurance or copayment) until you meet the annual catastrophic out-of-pocket maximum.	In-network: After you meet the deductible, you pay the indicated coinsurance or copayments for covered services. You may choose to pay the coinsurance and copayments from your HSA or HRA, or you can pay for them out-of-pocket. Out-of-network: We have no out-of-network benefits.

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

Important things you should keep in mind about these benefits:

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

Benefit Description	You pay
Diagnostic and treatment services	
Professional services of physicians • In physician's office • In an urgent care center • During a hospital stay • In a skilled nursing facility	$20 per primary care physicians office; $45 per specialist office visit
Lab, X-ray and other diagnostic tests	
Tests, such as: • Blood tests • Urinalysis • Pathology • X-rays • Non-routine mammograms • CAT Scans/MRI • Ultrasound • Electrocardiogram and EEG	$20 per primary care physicians office; $45 per specialists office visit
Maternity care	
Complete maternity (obstetrical) care, such as: • Prenatal care • Delivery • Postnatal care Note: Here are some things to keep in mind:	15% of the Plan allowance

Maternity care - continued on next page

Benefit Description	You pay
Maternity care (cont.)	
• You do not need to precertify your normal delivery; see page 14 for other circumstances, such as extended stays for you or your baby. • You may remain in the hospital up to 48 hours after a regular delivery and 96 hours after a cesarean delivery. We will cover an extended inpatient stay if medically necessary but you, your representatives, your doctor, or your hospital must recertify the extended stay. • We cover routine nursery care of the newborn child during the covered portion of the mother's maternity stay. We will cover other care of an infant who requires non-routine treatment only if we cover the infant under a Self and Family enrollment. Surgical benefits, not maternity benefits, apply to circumcision. • We pay hospitalization and surgeon services for non-maternity care the same as for illness and injury.	15% of the Plan allowance
Not covered: Routine sonograms to determine fetal age, size, or sex.	*All charges*
Family planning	
A range of voluntary family planning services, limited to: • Voluntary sterilization (See Surgical procedures Section 6 (d)) • Surgically implanted contraceptives • Injectable contraceptive drugs (such as Depo provera) • Intrauterine devices (IUDs) • Diaphragms Note: We cover oral contraceptives under the prescription drug benefit.	50% of the Plan allowance
Not covered: • *Reversal of voluntary surgical sterilization* • *Genetic counseling.*	*All Charges*

Benefit Description	You pay
Infertility services	
Diagnosis and treatment of infertility such as: • Artificial insemination: - Intravaginal insemination (IVI)	50% of the Plan allowance
Not covered: • *Infertility services after voluntary sterilization* • *Assisted reproductive technology (ART) procedures, such as:* - *In vitro fertilization* - *Embryo transfer, gamete intra-fallopian transfer (GIFT) and zygote intra-fallopian transfer (ZIFT)* • *Services and supplies related to ART procedures* • *Cost of donor sperm* • *Cost of donor egg.* • *Intracervical insemination (ICI)* • *Intrauterine insemination (IUI)* • *Fertility drugs*	*All charges*
Allergy care	
• Testing and treatment • Allergy injections	$20 per primary care physician office visit; $45 per specialist office visit.
Allergy serum	Nothing
Not covered: Proactive food testing and sublingual allergy desensitization	*All charges*
Treatment therapies	
• Chemotherapy and radiation therapy Note: High dose chemotherapy in association with autologous bone marrow transplants is limited to those transplants listed under Organ/Tissue Transplants on page 75. • Respiratory and inhalation therapy • Dialysis – hemodialysis and peritoneal dialysis • Intravenous (IV)/Infusion Therapy – Home IV and antibiotic therapy • Growth hormone therapy (GHT)	In-network: $20 per visit at a primary care physicians office, and $45 copayment per visit at a specialists office.

Treatment therapies - continued on next page

Benefit Description	You pay
Treatment therapies (cont.)	
Note: – We only cover GHT when we preauthorize the treatment. We will ask you to submit information that establishes that the GHT is medically necessary. Ask us to authorize GHT before you begin treatment. We will only cover GHT services and related services and supplies that we determine are medically necessary. See *Other services under You need prior Plan approval for certain services* on page 14.	In-network: $20 per visit at a primary care physicians office, and $45 copayment per visit at a specialists office.
Physical and occupational therapies	
60 days per condition for the following services: • Qualified physical therapists • Occupational therapists Note: These services are covered when determined by the Plan to be medically necessay.	15% of the Plan allowance
Not covered: • *Long-term rehabilitative therapy* • *Exercise programs*	*All charges*
Speech therapy	
60 days per condition Note: These services are covered when determined by the Plan to be medically necessary.	15% of the Plan allowance
Pulmonary and cardiac rehabilitation	
60 days per condition for services of the following: Note: These services are covered when determined by the Plan to be medically necessary.	15% of the Plan allowance
Hearing services (testing, treatment, and supplies)	
• Hearing exams for children through age 17, *as shown in Preventive care, children;* • Hearing aids, *as shown in Orthopedic and prosthetic devices.*	15% of the Plan allowance 15% of the Plan allowance up to $5,000 maximum Plan benefit every 24 months
Not covered: • *Hearing services that are not shown as covered.*	*All charges*

Benefit Description	You pay
Vision services (testing, treatment, and supplies)	
• First corrective lens when medically necessary following an impairment directly caused by accidental ocular injury or intraocular surgery (such as for cataracts) • Annual eye refractions Note: *See Preventive care, children* for eye exams for children under age 17	15% of the Plan allowance
Not covered: • *Eyeglasses or contact lenses, except as shown above* • *Eye exercises and orthoptics* • *Radial keratotomy and other refractive surgery*	*All charges*
Foot care	
Routine foot care when you are under active treatment for a metabolic or peripheral vascular disease, such as diabetes.	15% of the Plan allowance
Not covered: • *Cutting, trimming or removal of corns, calluses, or the free edge of toenails, and similar routine treatment of conditions of the foot, except as stated above* • *Treatment of weak, strained or flat feet or bunions or spurs; and of any instability, imbalance or subluxation of the foot (unless the treatment is by open cutting surgery)*	*All charges*
Orthopedic and prosthetic devices	
• Hearing aids and testing to fit them • Artificial limbs and eyes • Stump hose • Externally worn breast prostheses and surgical bras, including necessary replacements following a mastectomy • Corrective orthopedic appliances for non-dental treatment of temporomandibular joint (TMJ) pain dysfunction syndrome • Internal prosthetic devices, such as artificial joints, pacemakers, cochlear implants, and surgically implanted breast implant following mastectomy.	15% of Plan allowance up to $5,000 maximum Plan benefit every 24 months for hearing aids/testing only 15% of Plan allowance for all other Orthopedica and prosthetic devices

Orthopedic and prosthetic devices - continued on next page

Benefit Description	You pay
Orthopedic and prosthetic devices (cont.)	
Note: For information on the professional charges for the surgery to insert an implant, see Section 5(b) Surgical and anesthesia services. For information on the hospital and/or ambulatory surgery center benefits, see Section 5(c) Services provided by a hospital or other facility, and ambulance services.	15% of Plan allowance up to $5,000 maximum Plan benefit every 24 months for hearing aids/testing only 15% of Plan allowance for all other Orthopedica and prosthetic devices
Not covered: • *Orthopedic and corrective shoes, arch supports, foot orthotics, heel pads, and heel cups.* • *Lumbosacral supports* • *Corsets, trusses, elastic stockings, support hose, and other supportive devices* • *Prosthetic replacements provided less than three (3) years after the last one we covered*	*All charges*
Durable medical equipment (DME)	
We cover rental or purchase of durable medical equipment, at our option, including repair and adjustment. Covered items include: • Oxygen • Dialysis equipment • Manual Hospital beds • Manual Wheelchairs • Crutches • Walkers • Blood glucose monitors • Insulin pumps Note: All purchases over $100 and rentals require prior authorization or payment is denied	15% of the Plan allowance
Not covered: • *Motorized wheelchairs* • *Convenience items or exercise equipment*	*All charges*
Home health services	
• Home health care ordered by a Plan physician and provided by a registered nurse (R.N.), licensed practical nurse (L.P.N.), licensed vocational nurse (L.V.N.), or home health aide. • Services include oxygen therapy, intravenous therapy and medications.	15% of the Plan allowance
Not covered: • *Nursing care requested by, or for the convenience of, the patient or the patient's family;*	*All charges*

Home health services - continued on next page

Benefit Description	You pay
Home health services (cont.)	
• *Home care primarily for personal assistance that does not include a medical component and is not diagnostic, therapeutic, or rehabilitative.*	*All charges*
Chiropractic	
20 visits per year • Manipulation of the spine and extremities • Adjunctive procedures such as ultrasound, electrical muscle stimulation, vibratory therapy, and cold pack application	15% of the Plan allowance
Alternative treatments	
No benefit	*All charges*
Educational classes and programs	
Coverage is provided for: • Tobacco cessation programs, including individual group telephone counseling and for physician prescribed over the counter (OTC) and prescription drugs approved by the FDA to treat tobacco dependence Note: Call us at 1-800-257-4692 for benefit guidelines	Nothing for counseling for up to two quit attempts per year. Nothing for physician prescribed OTC and prescription drugs approved by the FDA to treat tobacco dependence.
• Diabetes self management	15% of the Plan allowance

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

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- The deductible is $2,000 for Self Only enrollment and $4,000 for Self and Family enrollment each calendar year. The Self and Family deductible can be satisfied by one or more family members. The deductible applies to almost all benefits in this Section.
- After you have satisfied your deductible, your Traditional medical coverage begins.
- Under your Traditional medical coverage, you will be responsible for your coinsurance amounts or copayments for eligible medical expenses and prescriptions.
- The amounts listed below are for the charges billed by a physician or other health care professional for your surgical care.Look in Section 5(c) for charges associated with the facility (i.e. hospital, surgical center, etc.).

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

Benefit Description	You pay
Surgical procedures	
A comprehensive range of services, such as: • Operative procedures • Treatment of fractures, including casting • Normal pre- and post-operative care by the surgeon • Correction of amblyopia and strabismus • Endoscopy procedures • Biopsy procedures • Removal of tumors and cysts • Correction of congenital anomalies (see *Reconstructive surgery*) • Surgical treatment of morbid obesity (bariatric surgery) - The patient is an adult (≥ 18 years of age) with morbid obesity that has persisted for at least 3 years, and for which there is no treatable metabolic cause for the obesity	15% of the Plan allowance

Surgical procedures - continued on next page

Benefit Description	You pay
Surgical procedures (cont.)	
- There is presence of morbid obesity, defined as a body mass index (BMI) exceeding 40, or greater than 35 with documented co-morbid conditions (cardiopulmonary problems e.g., severe apnea, Pickwickian Syndrome, and obesity-related cardiomyopathy, severe diabetes mellitus, hypertension, or arthritis). (BMI is calculated by dividing a patient's weight (in kilograms) by height (in meters) squared. To convert pounds to kilograms, multiply pounds by 0.45. To convert inches to meters, multiply inches by .0254) - The patient has failed to lose weight (approximately 10% from baseline) or has regained weight despite participation in a three month physician-supervised multidisciplinary program within the past six months that included dietary therapy, physical activity and behavior therapy and support - The patient has been evaluated for restrictive lung disease and received surgical clearance by a pulmonologist, if clinically indicated; has received cardiac clearance by a cardiologist if there is a history of prior phen-fen or redux use, and the patient has agreed, following surgery, to participate in a multidisciplinary program that will provide guidance on diet, physical activity and social support - The patient has completed a psychological evaluation and has been recommended for bariatric surgery by a licensed mental health professional (this must be documented in the patient's medical record) and the patient's medical record reflects documentation by the treating psychotherapist that all psychosocial issues have been identified and addressed; and the psychotherapist indicates that the patient is likely to be compliant with the post-operative diet restrictions • Insertion of internal prosthetic devices . See 6(c) *Orthopedic and prosthetic devices* for device coverage information • Voluntary sterilization (e.g., tubal ligation, vasectomy) • Treatment of burns Note: Generally, we pay for internal prostheses (devices) according to where the procedure is done. For example, we pay Hospital benefits for a pacemaker and Surgery benefits for insertion of the pacemaker.	15% of the Plan allowance

Surgical procedures - continued on next page

Benefit Description	You pay
Surgical procedures (cont.)	
Not covered: • *Reversal of voluntary sterilization* • *Routine treatment of conditions of the foot; see Foot care*	*All charges*
Reconstructive surgery	
• Surgery to correct a functional defect • Surgery to correct a condition caused by injury or illness if: - the condition produced a major effect on the member's appearance and - the condition can reasonably be expected to be corrected by such surgery • Surgery to correct a condition that existed at or from birth and is a significant deviation from the common form or norm. Examples of congenital anomalies are: protruding ear deformities; cleft lip; cleft palate; birth marks; and webbed fingers and toes. • All stages of breast reconstruction surgery following a mastectomy, such as: - surgery to produce a symmetrical appearance of breasts - treatment of any physical complications, such as lymphedemas - breast prostheses and surgical bras and replacements (see Prosthetic devices) Note: If you need a mastectomy, you may choose to have the procedure performed on an inpatient basis and remain in the hospital up to 48 hours after the procedure.	15% of the Plan allowance
Not covered: • *Cosmetic surgery – any surgical procedure (or any portion of a procedure) performed primarily to improve physical appearance through change in bodily form, except repair of accidental injury* • *Surgeries related to sex transformation*	*All charges*

Benefit Description	You pay
Oral and maxillofacial surgery	
Oral surgical procedures, limited to: • Reduction of fractures of the jaws or facial bones • Surgical correction of cleft lip, cleft palate or severe functional malocclusion • Removal of stones from salivary ducts • Excision of leukoplakia or malignancies • Excision of cysts and incision of abscesses when done as independent procedures • Other surgical procedures that do not involve the teeth or their supporting structures • Surgical treatment of temporomandibular joint (TMJ) syndrome	15% of the Plan allowance
Not covered: • *Oral implants and transplants* • *Procedures that involve the teeth or their supporting structures (such as the periodontal membrane, gingiva, and alveolar bone)*	*All charges*
Organ/tissue transplants	
These **solid organ transplants** are covered. Solid organ transplants limited to: • Cornea • Heart • Heart/lung • Intestinal transplants - Small intestine - Small intestine with the liver - Small intestine with multiple organs, such as the liver, stomach, and pancreas • Kidney • Liver • Lung: single/bilateral • Pancreas • Autologous pancreas islet cell transplant (as an adjunct to total or near total pancreatectomy) only for patients with chronic pancreatitis These **tandem blood or marrow stem cell transplants for covered transplants** are subject to medical necessity review by the Plan. Refer to *Other services* in Section 3 for prior authorization procedures. • Autologous tandem transplants for - AL Amyloidosis	15% of the Plan allowance

Organ/tissue transplants - continued on next page

Benefit Description	You pay
Organ/tissue transplants (cont.)	
- Multiple myeloma (de novo and treated) - Recurrent germ cell tumors (including testicular cancer)	15% of the Plan allowance
Blood or marrow stem cell transplants limited to the stages of the following diagnoses. For the diagnoses listed below, the medical necessity limitation is considered satisfied if the patient meets the staging description. Allogeneic transplants for • Acute lymphocytic or non-lymphocytic (i.e., myelogeneous) leukemia • Chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL) • Advanced Hodgkin's lymphoma with reoccurrence (relapsed) • Advanced non-Hodgkin's lymphoma with reoccurrence (relapsed) • Acute myeloid leukemia • Advanced Myeloproliferative Disorders (MPDs) • Advanced neuroblastoma • Amyloidosis • Hemoglobinopathy • Infantile malignant osteopetrosis • Kostmann's syndrome • Leukocyte adhesion deficiencies • Marrow failure and Related Disorders (i.e. Fanconi's PNH, pure red cell aplasia) • Mucolipidosis (e.g., Gaucher's disease, metachromatic leukodystrophy, adrenoleukodystropy) • Mucopolysaccharidosis (e.g. Hunter's syndrome, Hurler's syndrome, Sanfillippo's syndrome, Maroteaux-Lamy syndrome variants) • Myelodysplasia/Myelodysplastic syndromes • Paroxysmal Nocturnal Hemoglobinuria • Chronic myelogenous leukemia • Phagocytic/Hemophagocytic deficiency diseases (e.g., Wiskott-Aldrich syndrome) • Severe combined immunodeficiency • Severe or very severe aplastic anemia • Sickle cell anemia • X-linked lymphoproliferative syndrome	15% of Plan allowance

Organ/tissue transplants - continued on next page

Benefit Description	You pay
Organ/tissue transplants (cont.)	
Autologous transplant for • Acute lymphocytic or nonlymphocytic (i.e., myelogenous) leukemia • Advanced Hodgkin's lymphoma with reoccurrence (relapsed) • Advanced non-Hodgkin's lymphoma with reoccurrence (relapsed) • Advanced Neuroblastoma • Amyloidosis • Breast Cancer • Ependymoblastoma • Epithelial ovarian cancer • Ewing's sarcoma • Multiple myeloma • Medulloblastoma • Pineoblastoma • Neuroblastoma • Testicular, Mediastinal, Retroperitoneal, and ovarian germ cell tumors	15% of Plan allowance
Mini-transplants performed in a clinical trial setting (non-myeloablative, reduced intensity conditioning or RIC) for members with a diagnosis listed below are subject to medical necessity review by the Plan. Refer to *Other services* in Section 3 for prior authorization procedures: • Allogeneic transplants for: - Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia - Advanced Hodgkin's lymphoma with reoccurrence (relapsed) - Advanced non-Hodgkin's lymphoma with reoccurrence (relapsed) - Acute myeloid leukemia - Advanced Myeloproliferative Disorders (MPDs) - Amyloidosis - Chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL) - Hemoglobinopathy - Marrow failure and related disorders (i.e., Fanconi's, PNH, Pure Red Cell Aplasia) - Myelodysplasia/Myelodysplastic syndromes	15% of Plan allowance

Organ/tissue transplants - continued on next page

Benefit Description	You pay
Organ/tissue transplants (cont.)	
- Paroxysmal Nocturnal Hemoglobinuria - Severe combined immunodeficiency - Severe or very severe aplastic anemia • Autologous transplants for - Acute lymphocytic or nonlymphocytic (i.e., myelogenous) leukemia - Advanced Hodgkin's lymphoma with reoccurrence (relapsed) - Advanced non-Hodgkin's lymphoma with reoccurrence (relapsed) - Amyloidosis - Neuroblastoma	15% of Plan allowance
These blood or marrow stem cell transplants are covered only in a National Cancer Institute or National Institutes of health **approved clinical trial** or a Plan-designated center of excellence and if approved by the Plan's medical director in accordance with the Plan's protocols. If you are a participant in a clinical trial, the Plan will provide benefits for related routine care that is medically necessary (such as doctor visits, lab tests, x-rays and scans, and hospitalization related to treating the patient's condition) if it is not provided by the clinical trial.Section 9 has additional information on costs related to clinical trials.We encourage you to contact the Plan to discuss specific services if you participate in a clinical trial. • Allogeneic transplants for - Advanced Hodgkin's lymphoma - Advanced non-Hodgkin's lymphoma - Beta Thalassemia Major - Early stage (indolent or non-advanced) small cell lymphocytic lymphoma - Multiple myeloma - Multiple sclerosis - Sickle Cell anemia • Mini-transplants (non-myeloablative allogeneic, reduced intensity conditioning or RIC) for - Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia - Advanced Hodgkin's lymphoma - Advanced non-Hodgkin's lymphoma - Breast cancer	15% of Plan allowance

Organ/tissue transplants - continued on next page

Benefit Description	You pay
Organ/tissue transplants (cont.)	
- Chronic lymphocytic leukemia - Chronic myelogenous leukemia - Colon cancer - Chronic lymphocytic lymphoma/small lymphocytic lymphoma (CLL/SLL) - Early stage (indolent or non-advanced) small cell lymphocytic lymphoma - Multiple myeloma - Multiple sclerosis - Myeloproliferative disorders (MSDs) - Non-small cell lung cancer - Ovarian cancer - Prostate cancer - Renal cell carcinoma - Sarcomas - Sickle cell anemia Autologous Transplants for • Advanced Childhood kidney cancers • Advanced Ewing sarcoma • Advanced Hodgkin's lymphoma • Advanced non-Hodgkin's lymphoma • Breast Cancer • Childhood rhabdomyosarcoma • Chronic myelogenous leukemia • Chronic lymphocyticlymphoma/small lymphocytic lymphoma (CLL/SLL) • Early stage (indolent or non-advanced) small cell lymphocytic lymphoma • Epithelial Ovarian Cancer • Mantle Cell (Non-Hodgkin lymphoma) • Multiple sclerosis • Small cell lung cancer • Systemic lupus erythematosus • Systemic sclerosis Note: We cover related medical and hospital expenses of the donor when we cover the recipient. We cover donor testing for the actual solid organ donor or up to four bone marrow/stem cell transplant donors in addition to the testing of family members.	15% of Plan allowance

Organ/tissue transplants - continued on next page

Benefit Description	You pay
Organ/tissue transplants (cont.)	
Not covered: • *Donor screening tests and donor search expenses, except as shown above* • *Implants of artificial organs* • *Transplants not listed as covered*	*All charges*
Anesthesia	
Professional services provided in – • Hospital (inpatient)	15% of the Plan allowance
Professional services provided in – • Hospital outpatient department • Skilled nursing facility • Ambulatory surgical center • Office	15% of the Plan allowance

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

Important things you should keep in mind about these benefits:

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

·Plan physicians must provide or arrange your care and you must be hospitalized in a Plan facility.

·The deductible is $2,000 for Self Only enrollment and $4,000 for Self and Family enrollment each calendar year.The Self and Family deductible can be satisfied by one or more family members.The deductible applies to all benefits in this Section.

·After you have satisfied your deductible, your Traditional medical coverage begins.

·Under your Traditional medical coverage, you will be responsible for your coinsurance amounts or copayments for eligible medical expenses and prescriptions.

·Be sure to read Section 4, *Your costs for covered services* for valuable information about how cost-sharing works.Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

·The amounts listed below are for the charges billed by the facility (i.e., hospitalor surgical center) or ambulance service for your surgery or care.Any costs associated with the professional charge (i.e., physicians, etc.) are in Sections 5(a) or (b).

YOUR .PHYSICIAN MUST GET PRECERTIFICATION FOR HOSPITAL STAYS. Please refer to Section 3 to be sure which services require precertification

Benefit Description	You Pay
Inpatient hospital	
Room and board, such as • Ward, semiprivate, or intensive care accommodations • General nursing care • Meals and special diets Note: If you want a private room when it is not medically necessary, you pay the additional charge above the semiprivate room rate.	15% of the Plan allowance
Other hospital services and supplies, such as: • Operating, recovery, maternity, and other treatment rooms • Prescribed drugs and medicines • Diagnostic laboratory tests and X-rays • Adminstration of blood and blood products • Blood or blood plasma, if not donated or replaced • Dressings , splints , casts , and sterile tray services • Medical supplies and equipment, including oxygen • Anesthetics, including nurse anesthetist services • Take-home items	15% of the Plan allowance

Inpatient hospital - continued on next page

Benefit Description	You Pay
Inpatient hospital (cont.)	
• Medical supplies, appliances, medical equipment, and any covered items billed by a hospital for use at home (Note: calendar year deductible applies.)	15% of the Plan allowance
Not covered: • *Custodial care* • *Non-covered facilities, such as nursing homes, schools* • *Personal comfort items, such as telephone, television, barber services, guest meals and beds* • *Private nursing care*	*All charges*
Outpatient hospital or ambulatory surgical center	
• Operating, recovery, and other treatment rooms • Prescribed drugs and medicines • Diagnostic laboratory tests, X-rays , and pathology services • Administration of blood, blood plasma, and other biologicals • Pre-surgical testing • Dressings, casts, and sterile tray services • Medical supplies, including oxygen • Anesthetics and anesthesia service Note: We cover hospital services and supplies related to dental procedures when necessitated by a non-dental physical impairment. We do not cover the dental procedures.	15% of the Plan allowance
Not covered: Blood and blood derivatives not replaced by the member	*All charges*
Extended care benefits/Skilled nursing care facility benefits	
Extended care benefit: We cover a comprehensive range of benefits up to 62 days per calendar year when full-time skilled nursing is necessary and confinement in a skilled nursing facility is medically appropriate as determined by a Plan doctor and approved by the Plan.	15% of the Plan allowance
Not covered: Custodial care	*All charges*

Benefit Description	You Pay
Hospice care	
Supportive and palliative care for a terminally ill member is covered in the home or hospice facility. Services include inpatient and outpatient care and family counseling; these services are provided under the direction of the Plan doctor who certifies that the patient is in the terminal stages of illness, with a life expectancy of approximately six months or less	15% of the Plan allowance
Not covered: Independent nursing, homemaker services	*All charges*
Ambulance	
Local professional ambulance service when medically appropriate	15% of the Plan allowance

Section 5(d). Emergency services/accidents

What is a medical emergency?

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

What to do in case of emergency:

Emergencies within our service area: *If you are in an emergency situation, please contact your doctor. In extreme emergencies, if you are unable to contact your doctor, go to the nearest hospital emergency room. Be sure to tell the emergency room personnel that you are a Plan member so they can notify the Plan.*

You or a family member must notify your doctor as soon as possible and/or contact the Plan within 48 hours of the emergency room visit. It is your responsibility to ensure that the Plan has been timely notified.

If you need to be hospitalized, the Plan must be notified within 48 hours or on the first working day following your admission, unless it is not reasonably possible to notify the Plan within that time. If you are hospitalized in non-Plan facilities and Plan doctors believe care can be better provided in a Plan hospital, you will be transferred when medically feasible and any ambulance charges are covered in full.

Benefits are available for care from non-Plan providers in a medical emergency only if delay in reaching a Plan provider would result in death, disability, or significant jeopardy to your condition.

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

The Plan pays reasonable charges for emergency services to the extent the services would have been covered if received from Plan providers. You pay deductible and 15% of the covered charges, per hospital emergency room visit or urgent care center visit for emergency services which are covered benefits of this Plan.

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

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

The Plan pays reasonable charges for emergency services to the extent the services would have been covered if received from Plan providers. You pay deductible and 15% of the covered charges, per hospital emergency room visit for emergency services received at a non-Plan facility.

Benefit Description	You pay
Emergency within our service area	
• Emergency care at a doctor's office	$20 primary care doctor's office visit; $45 copayment at a specialist office
• Emergency care at an urgent care center • Emergency care as an outpatient in a hospital, including doctors' services	15% of Plan allowance
Not covered: Elective care or non-emergency care	*All charges*
Emergency outside our service area	
• Emergency care at a doctor's office	$20 primary care doctor's office visit; $45 copayment per visit at a specialists office
• Emergency care at an urgent care center • Emergency care as an outpatient in a hospital, including doctors' services	15% of the Plan allowance
Not covered: • *Elective care or non-emergency care* • *Emergency care provided outside the service area if the need for care could have been foreseen before leaving the service area* • *Medical and hospital costs resulting from a normal full-term delivery of a baby outside the service area*	*All Charges*
Ambulance	
Professional ambulance service when medically appropriate. Note: Air ambulance covered only when medically necessary Note: Refer to benefits for non emergency services	15% of the Plan allowance

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

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

Important things to keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- The calendar year deductible or, for facility care, the inpatient deductible applies to almost all benefits in this Section. We added "(No deductible)" to show when a deductible does not apply.
- The deductible is $2,000 for Self Only enrollment and $4,000 for Self and Family enrollment each calendar year. The Self and Family deductible can be satisfied by one or more family members. The deductible applies to all benefits in this Section.
- After you have satisfied your deductible, your Traditional medical coverage begins.
- Under your Traditional medical coverage, you will be responsible for your coinsurance amounts and copayments for eligible medical expenses and prescriptions.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost-sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- **YOU MUST GET PREAUTHORIZATION FOR THESE SERVICES.** See the instructions after the benefits description below.

Benefit Description	You pay
Mental health and substance abuse benefits	
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. 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.	Your cost-sharing responsibilities are no greater than for other illnesses or conditions.
• Professional services, including individual or group therapy by providers such as psychiatrists, psychologists, or clinical social workers • Medication management	15% of the Plan allowance
Diagnostic tests • Services provided by a hospital or other facility • Services in approved alternative care settings such as partial hospitalization, half-way house, residential treatment, full-day hospitalization, facility based intensive outpatient treatment	15% of the Plan allowance
Not covered: Services we have not approved.	*All charges*

Mental health and substance abuse benefits - continued on next page

Benefit Description	You pay
Mental health and substance abuse benefits (cont.)	
Note: OPM will base its review of disputes about treatment plans on the treatment plan's clinical appropriateness. OPM will generally not order us to pay or provide one clinically appropriate treamtment plan in favor of another.	*All charges*

Preauthorization

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

All mental conditions/substance abuse services are coordinated by our mental health vendor. To access your mental conditions/substance abuse benefits, please refer to the number on your ID card.

Section 5(f). Prescription drug benefits

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

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

• **Who can write your prescription.** A licensed physician must write the prescription

• **Where you can obtain them.** You must fill the prescription at a Plan pharmacy, or by mail for a maintenance medication.

• **We have an open formulary**. If your physician believes a name brand product is necessary or there is no generic available, your physician may prescribe a name brand drug from a formulary list. This list of name brand drugs is a preferred list of drugs that we selected to meet patient needs at a lower cost. To order a prescription drug brochure, call 800-257-4692.

• **Prior Authorizations**. Some drugs require Prior Authorization in order for them to be Covered Services. These prescriptions include, but are not limited to, those that are not suggested for first-line therapy, may require special tests before starting them, or have limited approval for use. These drugs requiring a prior authorization are identified in our formulary with a "PA" next to the name. The list of the of the drugs are posted on the website, www.chciowa.com. Before you can fill a prescription order or refill for a drug requiring Prior Authorization, the member must obtain approval from us.

- **Value Formulary.** You can locate a copy of the value formulary drug listing at www.chciowa.com. This is a select list of non-formulary drugs which can be purchased at $3 retail, and $9 mail order.

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

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

Why use generic drugs? Generic drugs offer a safe and economic way to meet your prescription drug needs. The generic name of a drug is its chemical name, the name brand is the name under which the manufacturer advertises and sells a drug. Under Federal Law, generic and name brand drugs must meet the same standards for safety, purity, strength and effectiveness. A generic prescription costs you – and us – less than a name brand prescription.

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

Benefit Description	You pay
Covered medications and supplies	
We cover the following medications and supplies prescribed by a Plan physician and obtained from a Plan pharmacy or through our mail order program: •Drugs and medicines that by Federal law of the United States require a physician's prescription for their purchase, except those listed as *Not covered* •Insulin-one copayment per 30 day supply •Disposable needles and syringes for the administration of covered medications •Maintenance drugs •Drugs for sexual dysfunction are limited to four tablets per month. Prior approval is required by the Plan (see Prior authorization) •Contraceptive drugs and devices •Medication used for maintenance of Multiple Sclerosis require prior authorization •Growth hormone Note: Our value formulary drug listing is available on our website at www.chciowa.com.	**In network** **Retail Pharmacy (31-day supply)** $3 per value formulary drug $10 per formulary generic drug and brand name insulin $40 per formulary brand name drug $65 per non-formulary drug **Mail Order maintenance medications only (90-day supply)** $9 per value formulary drug $30 per formulary generic drug and brand name insulin $120 per formulary brand name drug $195 per non-formulary brand name drug **Note:** If there is no generic equivalent available, you will still have to pay the brand name copay. **Out of network: we do not have out-of-network prescription drug benefits.**
• Self administered injectables	$10 Tier 1 $75 Tier 2 $100 Tier 3
Not covered: • *Drugs and supplies for cosmetic purposes* • *Drugs to enhance athletic performance* • *Drugs obtained at a non-Plan pharmacy; except for out-of-area emergencies* • *Vitamins, nutrients and food supplements even if a physician prescribes or administers them* • *Nonprescription medicines* • *Fertility drugs* *Note: Physician prescribed over-the-counter and prescription drugs approved by the FDA to treat tobacco dependence are covered under the Tobacco cessation benefit, and require a written prescription by an approved provider. (See page 71).*	*All charges*

Section 5(g). Dental benefits

Important things you should keep in mind about these benefits:

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

Benefit Description	You pay
Accidental injury benefit	
We cover restorative services and supplies necessary to promptly repair (but not replace) sound natural teeth. The need for these services must result from an accidental injury.	15% of Plan allowance
Dental benefits	
We have no other dental benefits.	*All charges*

Section 5(h). Special features

Feature	Description
Feature	
Flexible benefits option	Under the flexible benefits option, we determine the most effective way to provide services. • We may identify medically appropriate alternatives to regular contract benefits as a less costly alternative. If we identify a less costly alternative, we will ask you to sign an alternative benefits agreement that will include all of the following terms in addition to other terms as necessary. Until you sign and return the agreement, regular contract benefits will continue. • Alternative benefits will be made available for a limited time period and are subject to our ongoing review. You must cooperate with the review process. • By approving an alternative benefit, we do not guarantee you will get it in the future. • The decision to offer an alternative benefit is solely ours, and except as expressly provided in the agreement, we may withdraw it at any time and resume regular contract benefits. • If you sign the agreement, we will provide the agreed-upon alternative benefits for the stated time period (unless circumstances change). You may request an extension of the time period, but regular contract benefits will resume if we do not approve your request. • Our decision to offer or withdraw alternative benefits is not subject to OPM review under the disputed claims process. However, if at the time we make a decision regarding alternative benefits, we also decide that regular contract benefits are not payable, then you may dispute our regular contract benefits decision under the OPM disputed claim process (see Section 8).
Services for deaf and hearing impaired	For details, call 866-285-1864
High risk pregnancies	Members identified as having high risk pregnancies will be assigned to a nurse within our organization who will work with them to monitor their care.
Centers of excellence	Coventry Health Care of Iowa, Inc. utilizes a network of centers of excellence for transplant care.
Travel benefit/services overseas	Anytime you are outside of the service area, you and your covered dependents are always covered for true emergency situation.

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

Special features	Description
Health education resources	We publish an e-newsletter to keep you informed on a variety of issues related to your good health. Visit our Web site at ***www.chciowa.com*** for the ***Living Well newsletter.*** Visit the "Member" section on our Web site at ***www.chciowa.com*** for information on: • General health topics • Links to health care news • Cancer and other specific diseases • Drugs/medication interactions • Kids' health • Patient safety information • Helpful Web site links
Account management tools	For each HSA and HRA account holder, we maintain a complete claims payment history online. Your balance will also be shown on your explanation of benefits (EOB) form. You will receive an EOB after every claim. If you have an **HSA:** • You may access your account on-line at ***www.chciowa.com*** If you have an **HRA:** • Your HRA balance will be available online through ***www.chciowa.com*** • Your balance will also be shown on your EOB form.
Consumer choice information	As a member of this HDHP, you may choose any network provider. Our provider search function on our website (www.chciowa.com) is updated every month. It lets you easily search for a participating physician based on the criteria You choose, such as provider specialty, gender, secondary languages spoken, or hospital affiliation. You can even specify the maximum distance you're willing to travel and, in most instances, get driving direction and a map to the offices of identified providers. Pricing information for medical care is available at ***www.chciowa.com***. Pricing information for prescription drugs is available through our link to the website of our pharmacy benefit manager, MEDCO Health Solutions, which you can assess via www.chciowa.com. Educational materials on the topics of HSAs, HRAs and HDHPs are available at www.chciowa.com
Care support	Our Complex Case Management programs offer special assistance to members with intricate, long-term medical needs. Our Disease Management program fosters a proactive approach to managing care from prevention through treatment and management. Your physician can help arrange for participation in these programs, or you can simply contact our Member Service Department. Patient safety information is available online at www.chciowa.com.

	Care support is also available to you, in the form of a relationship that we have established wih the *College of American Pathologists* 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.

Non-FEHB benefits available to Plan members

The benefits on this page are not part of the FEHB contract or premium, **and you cannot file an FEHB disputed claim about them.** Fees you pay for these services do not count toward FEHB deductibles or catastrophic protection out-of-pocket maximums. These programs and materials are the responsibility of the Plan, and all appeals must follow their guidelines. For additional information contact the Plan at 800-257-4692 or visit their website at www.chciowa.com.

Coventry*One* plans offer a smart choice for individual and family health insurance coverage. Coventry*One* specializes in offering superior coverage with a range of deductibles and coinsurances. Coventry*One* plans are easy to use and ideal for those who do not have access to group health care coverage.

Features and benefits available with Coventry*One* in Iowa include:

- Competitive rates
- Wide selection of deductible and copay options
- First dollar preventive care
- Routine wellness exams
- Immunizations
- Hospital care
- Outpatient care
- Urgent and emergency care
- Prescription drug benefits
- Short-term therapies
- Password-protected online access to your personal account information through My Online Services
- Fast and accurate claims payment processing

For more information, please call Coventry at 1-800-470-6352.

Medicare Advantage Plans. Advantra Plans from Coventry Health Care include not only the benefits provided by Original Medicare, but also a range of preventive screenings and other services that can help seniors live life their way. We offer a broad range of plans that include features such as:

- Monthly Premiums as low as $0
- Prescription drug coverage
- A Health Club Membership
- Preventive Benefits
- Chronic Disease Management Programs
- Out of Pocket Cost Protection
- PPO plans with in and out of network coverage

For more information, please call Coventry at 1-800-470-6352.

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

The exclusions in this section apply to all benefits. There may be other exclusions and limitations listed in Section 5 of this brochure. **Although we may list a specific service as a benefit, we will not cover it unless it is medically necessary to prevent, diagnose, or treat your illness, disease, injury, or condition.** For information on obtaining prior approval for specific services, such as transplants, see Section 3 *When you need prior Plan approval for certain services.*

We do not cover the following:

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

Section 7. Filing a claim for covered services

This section primarily deals with post-service claims (claims for services, drugs or supplies you have already received). See Section 3 for information on pre-service claims procedures (services, drugs or supplies requiring prior Plan approval), including urgent care claims procedures. When you see Plan physicians, receive services at Plan hospitals and facilities, or obtain your prescription drugs at Plan pharmacies, you will not have to file claims. Just present your identification card and pay your copayment, coinsurance, or deductible.

You will only need to file a claim when you receive emergency services from non-Plan providers. Sometimes these providers bill us directly. Check with the provider.

If you need to file the claim, here is the process:

Medical and Hospital benefits

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

In most cases, providers and facilities file claims for you. Your physician must file on the form CMS-1500, Health Insurance Claim Form. Your facility must file on the UB-04 form. For claims questions and assistance, call us at 800-257-4692

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

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

Note: Canceled checks, cash register receipts, or balance due statements are not acceptable substitutes for itemized bills.

Submit your claims to: *Coventry Health Care of Iowa, Inc.*

P.O. Box 7709

London , KY 40742

Prescription drugs

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

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

Submit your claims to: *MEDCO HEALTH SOLUTIONS*

100 Parsons Pond Drive,

Franklin Lakes, NJ 07417

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.
Post-service claims procedures	We will notify you of our decision within 30 days after we receive your post-service claim. If matters beyond our control require an extension of time, we may take up to an additional 15 days for review and we will notify you before the expiration of the original 30-day period. Our notice will include the circumstances underlying the request for the extension and the date when a decision is expected. If we need an extension because we have not received necessary information from you, our notice will describe the specific information required and we will allow you up to 60 days from the receipt of the notice to provide the information. If you do not agree with our initial decision, you may ask us to review it by following the disputed claims process detailed in Section 8 of this brochure.
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 of Iowa, Inc.; P.O. Box 7709; London, KY 40742. Obtain Overseas Claim Form from: 800-257-4692 or our website at www.chciowa.com. Send any written inquiries concerning the processing of overseas claims to the following address. Coventry Health Care of Iowa, Inc. 4320 114th Street., Urbandale, IA 50322.
When we need more information	Please reply promptly when we ask for additional information. We may delay processing or deny benefits for your claim if you do not respond. Our deadline for responding to your claim is stayed while we await all of the additional information needed to process your claim.
Authorized Representative	You may designate an authorized representative to act on your behalf for filing a claim or to appeal claims decisions to us. For urgent care claims, we will permit a health care professional with knowledge of your medical condition to act as your authorized representative without your express consent. For the purposes of this section, we are also referring to your authorized representative when we refer to you.

Section 8. The disputed claims process

You may be able to appeal directly to the Office of Personnel Management (OPM) if we do not follow required claims processes. For more information about situations in which you are entitled to immediately appeal to OPM, including additional requirements not listed in Sections 3, 7 and 8 of this brochure, please visit www.chciowa.com.

Please follow this Federal Employees Health Benefits Program disputed claims process if you disagree with our decision on your post-service claim (a claim where services, drugs or supplies have already been provided). In Section 3 *If you disagree with our pre-service claim decision,* we describe the process you need to follow if you have a claim for services, referrals, drugs or supplies that must have prior Plan approval, such as inpatient hospital admissions.

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

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

Step	Description
1	Ask us in writing to reconsider our initial decision. You must: a) Write to us within 6 months from the date of our decision; and b) Send your request to us at: 4320 114th St. Urbandale, Iowa 50322; and c) Include a statement about why you believe our initial decision was wrong, based on specific benefit provisions in this brochure; and d) Include copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms. e) Include your email address (optional for member), if you would like to receive our decision via email. Please note that by giving us your email, we may be able to provide our decision more quickly. We will provide you, free of charge and in a timely manner, with any new or additional evidence considered, relied upon, or generated by us or at our direction in connection with your claim and any new rationale for our claim decision. We will provide you with this information sufficiently in advance of the date that we are required to provide you with our reconsideration decision to allow you a reasonable opportunity to respond to us before that date. However, our failure to provide you with new evidence or rationale in sufficient time to allow you to timely respond shall not invalidate our decision on reconsideration. You may respond to that new evidence or rationale at the OPM review stage described in step 4.
2	In the case of a post-service claim, we have 30 days from the date we receive your request to: a) Pay the claim or b) Write to you and maintain our denial or c) Ask you or your provider for more information. You or your provider must send the information so that we receive it within 60 days of our request. We will then decide within 30 more days. If we do not receive the information within 60 days we will decide within 30 days of the date the information was due. We will base our decision on the information we already have. We will write to you with our decision.
3	If you do not agree with our decision, you may ask OPM to review it. You must write to OPM within: • 90 days after the date of our letter upholding our initial decision; or • 120 days after you first wrote to us -- if we did not answer that request in some way within 30 days; or

- 120 days after we asked for additional information.

Write to OPM at: United States Office of Personnel Management, Healthcare and Insurance, Federal Employee Insurance Operations, Health Insurance 3, 1900 E Street, NW, Washington, DC 20415-3650.

Send OPM the following information:

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

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

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

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

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

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

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

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

Note: **If you have a serious or life threatening condition** (one that may cause permanent loss of bodily functions or death if not treated as soon as possible), and you did not indicate that your claim was a claim for urgent care, then call us at (800) 257-4692. We will hasten our review (if we have not yet responded to your claim); or we will inform OPM so they can quickly review your claim on appeal. You may call OPM's Health Insurance (HI3) at (202) 606-3818 between 8 a.m. and 5 p. m. eastern time.

Section 9. Coordinating benefits with other coverage

When you have other health coverage

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

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

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

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

What is Medicare?

Medicare is a health insurance program for:

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

Medicare has four parts:

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

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

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

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

- **Should I enroll in Medicare?**

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

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

Everyone is charged a premium for Medicare Part B coverage. The Social Security Administration can provide you with premium and benefit information. Review the information and decide if it makes sense for you to buy the Medicare Part B coverage. If you do not sign up for Medicare Part B when you are first eligible, you may be charged a Medicare Part B late enrollment penalty of a 10 % increase in premium for every 12 months you are not enrolled. If you didn't take Part B at age 65 because you were covered under FEHB as an active employee (or you were covered under your spouse's group health insurance plan and he/she was an active employee), you may sign up for Part B (generally without an increased premium) within 8 months from the time you or your spouse stop working or are no longer covered by the group plan. You also can sign up at any time while you are covered by the group plan.

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

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

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

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

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

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

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

When Original Medicare is the primary payor, Medicare processes your claim first. In most cases, your claim will be coordinated automatically and we will then provide secondary benefits for covered charges. To find out if you need to do something to file your claim, call us at 800-257-4692 or see our Web site at chciowa.com.

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

You can find more information about how our plan coordinates benefits with Medicare in Coventry Health Care of Iowa at www.chciowa.com.

- **Tell us about your Medicare coverage**

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

- **Medicare Advantage (Part C)**

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

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

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

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

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

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

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

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

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

TRICARE and CHAMPVA

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

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

Workers' Compensation

We do not cover services that:

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

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

Medicaid

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

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

When other Government agencies are responsible for your care

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

When others are responsible for injuries

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

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

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

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

Coverage Clinical Trials

This health plan covers care for clinical trials according to definitions listed below and as stated on specific pages of this brochure:

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

- Extra care costs – costs related to taking part in a clinical trial such as additional tests that a patient may need as part of the trial, but not as part of the patient's routine care. This Plan covers some of these costs, providing the Plan determines the services are Medically Necessary. For more specific information, see page 106.
- Research costs-costs related to conducting the clinical trial such as research physician and nurse time, analysis of results, and clinical tests performed only for research purposes. This Plan does not cover these costs.

Section 10. Definitions of terms we use in this brochure

Calendar year

January 1 through December 31 of the same year. For new enrollees, the calendar year begins on the effective date of their enrollment and ends on December 31 of the same year.

Clinical Trials Cost Categories

- Routine care costs – costs for routine services such as doctor visits, lab tests, x-rays and scans, and hospitalizations related to treating the patient's cancer, whether the patient is in a clinical trial or is receiving standard therapy
- Extra care costs – costs related to taking part in a clinical trial such as additional tests that a patient may need as part of the trial, but not as part of the patient's routine care
- Research costs – costs related to conducting the clinical trial such as research physician and nurse time, analysis of results, and clinical tests performed only for research purposes

Coinsurance

Coinsurance is the percentage of our allowance that you must pay for your care. You may also be responsible for additional amounts. See page 17.

Copayment

A copayment is a fixed amount of money you pay when you receive covered services. See page 17.

Cost-sharing

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

Covered services

Care we provide benefits for, as described in this brochure.

Deductible

A deductible is a fixed amount of covered expenses you must incur for certain covered services and supplies before we start paying benefits for those services. See page 17.

Experimental or investigational service

Any treatment, procedure, facility, equipment, drug or drug usage, device or supply that is not accepted as standard medical practice by the general medical community or us, or does not have Federal government agency approval for its use or application.

The Plan's experimental/investigational determination process is based on authoritative information obtained from medical literature, medical consensus bodies, health care standards, database searches, evidence from national medical organizations, State and Federal government agencies and research organizations. The review and approval process for medical policies and clinical practice guidelines includes clinical input from doctors with specialty expertise in the subject.

Health care professional

A physician or other health care professional licensed, accredited, or certified to perform specified health services consistent with state law.

Medical necessity

A service or supply for prevention, diagnosis, or treatment that as determined by us, is, consistent with the illness or injury and is consistent with the approved, and generally accepted medical or surgical practice.

Plan allowance

Our Plan allowance is the amount we use to determine our payment and your coinsurance for covered services. Providers that participate with us agree to accept our Plan allowance as payment in full, minus any copayment or coinsurance.

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

Post-service claims

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

Pre-service claims

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

Urgent care claims

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

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

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

If you believe your claim qualifies as an urgent care claim, please contact our Customer Service Department at 800-257-4692 or at our Web site at www.chciowa.com . You may also prove that your claim is an urgent care claim by providing evidence that a physician with knowledge of your medical condition has determined that your claim involves urgent care.

Us/We

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

You

You refers to the enrollee and each covered family member.

Section 11. FEHB Facts

Coverage information

- **No pre-existing condition limitation**

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

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

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

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

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

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

We don't determine who is eligible for coverage and, in most cases, cannot change your enrollment status without information from your employing or retirement office. For information on your premium deductions, you must also contact your employing or retirement office.

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

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

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

Your employing or retirement office will **not** notify you when a family member is no longer eligible to receive benefits, nor will we. Please tell us immediately of changes in family member status, including your marriage, divorce, annulment, or when your child reaches age 26.

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

- **Family member coverage**

Family members covered under your Self and Family enrollment are your spouse (including a valid common law marriage) and children as described in the chart below.

Children	Coverage
Natural, adopted children, and stepchildren	Natural, adopted children and stepchildren are covered until their 26th birthday.
Foster Children	Foster children are eligible for coverage until their 26th birthday if you provide documentation of your regular and substantial support of the child and sign a certification stating that your foster child meets all the requirements. Contact your human resources office or retirement system for additional information.
Children Incapable of Self-Support	Children who are incapable of self-support because of a mental or physical disability that began before age 26 are eligible to continue coverage. Contact your human resources office or retirement system for additional information.
Married Children	Married children (but **NOT** their spouse or their own children) are covered until their 26th birthday.
Children with or eligible for employer-provided health insurance	Children who are eligible for or have their own employer-provided health insurance are covered until their 26th birthday.

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

- **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
- If you are enrolled in an HMO that does not serve the area where the children live, your employing office will change your enrollment to Self and Family in the Blue Cross and Blue Shield Service Benefit Plan's Basic Option

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

- **When benefits and premiums start**

The benefits in this brochure are effective January 1. If you joined this Plan during Open Season, your coverage begins on the first day of your first pay period that starts on or after January 1. **If you changed Plans or Plan options during Open Season and you receive care between January 1 and the effective date of coverage under your new Plan or option, your claims will be paid according to the 2012 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 2011 benefits until the effective date of your coverage with your new Plan. Annuitants' coverage and premiums begin on January 1. If you joined at any other time during the year, your employing office will tell you the effective date of coverage.

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

When you retire

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

When you lose benefits

- **When FEHB coverage ends**

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

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

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

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

- **Upon divorce**

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

- **Temporary Continuation of Coverage (TCC)**

If you leave Federal service, or if you lose coverage because you no longer qualify as a family member, you may be eligible for Temporary Continuation of Coverage (TCC). For example, you can receive TCC if you are not able to continue your FEHB enrollment after you retire, if you lose your Federal job, if you are a covered dependent child and you turn 26, 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 Benefits for Temporary Continuation of Coverage and Former Spouse Enrollees,* from your employing or retirement office or from www.opm.gov/insure. It explains what you have to do to enroll.

- **Converting to individual coverage**

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

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

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

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

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

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

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

Section 12. Other Federal Programs

Important information about three Federal programs that complement the FEHB Program

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

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

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

The Federal Flexible Spending Account Program – *FSAFEDS*

What is an FSA?

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

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

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

Where can I get more information about FSAFEDS?

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

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

Important Information

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

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

Dental Insurance

All dental Plans provide a comprehensive range of services, including:

• Class A (Basic) services, which include oral examinations, prophylaxis, diagnostic evaluations, sealants and x-rays.

• Class B (Intermediate) services, which include restorative procedures such as fillings, prefabricated stainless steel crowns, periodontal sealing, tooth extractions, and denture adjustments.

• Class C (Major) services, which include endodontic services such as root canals, periodontal services such as gingivectomy, major restorative services such as crowns, oral surgery, bridges and prosthodontic services such as complete dentures.

• Class D (Orthodontics) services with 24 month waiting period for dependent children up to age 19.

Vision Insurance

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

Additional Information

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

How do I enroll?

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

The Federal Long Term Care Insurance Program – *FLTCIP*

It's important protection

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

Pre-existing Condition Insurance Program (PCIP)

Do you know someone who needs health insurance but can't get it? The Pre-Existing Condition Insurance Plan (PCIP) may help.

An individual is eligible to buy coverage in PCIP if:

- He or she has a pre-existing medical condition or has been denied coverage because of the health condition;
- He or she has been without health coverage for at least the last six months. (If the individual currently has insurance coverage that does not cover the pre-existing condition or is enrolled in a state high risk pool then that person is not eligible for PCIP.);
- He or she is a citizen or national of the United States or resides in the U.S. legally.

The Federal government administers PCIP in the following states: Alabama, Arizona, District of Columbia, Delaware, Florida, Georgia, Hawaii, Idaho, Indiana, Kentucky, Louisiana, Massachusetts, Minnesota, Mississippi, North Dakota, Nebraska, Nevada, South Carolina, Tennessee, Texas, Vermont, Virginia, West Virginia, and Wyoming. To find out about eligibility, visit www.pcip.gov and/or www.healthcare.gov or call 1-866-717-5826 (TTY): 1-866-561-1604).

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

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Summary of benefits for the High Option - 2012

- **Do not rely on this chart alone.** All benefits are provided in full unless indicated and are subject to the definitions , limitations, and exclusions in this brochure. On this page we summarize specific expenses we cover; for more detail, look inside.
- If you want to enroll or change your enrollment in this Plan, be sure to put the correct enrollment code from the cover on your enrollment form.
- We only cover services provided or arranged by Plan physicians, except in emergencies.
- Below, an asterisk (*) means the item is subject to the $550 Self Only or the $1,100 Self and Family calendar year deductible.

High Option Benefits	You pay	Page
Medical services provided by physicians:		
Diagnostic and treatment services provided in the office	Office visit copay: $20 primary care; $45 specialist	22
Services provided by a hospital:		
• **Inpatient ***	15% of Plan allowance	39
• **Outpatient ***	15% of Plan allowance	40
Emergency benefits:		
• **In-area**	$250 copayment per emergency room visit; $100 copayment per emergency room physician visit	43
• **Out-of-area**	$250 copayment per emergency room visit; $100 copayment per emergency room physician visit	43
Mental health and substance abuse treatment:	Regular cost-sharing	45
Prescription drugs: Note: A listing of our Value Formulary prescription drugs can be found at www.chciowa.com	**Retail Pharmacy (31-day supply)** $3 per value formulary drug ; $10 per formulary generic drug and brand name insulin; $40 per formulary brand name drug; and $65 per non-formulary drug **Mail Order maintenance medications only (93-day supply)** $9 per value formulary drug ; $30 per formulary generic drug and brand name insulin; $120 per formulary brand name drug; and $195 per non-formulary drug	48
Dental care * (Accidental injury only)	15% of Allowable Charges	50
Vision care:	No benefit	
Special features:	Flexible benefits option; Services for deaf and hearing impaired; High risk pregnancies: centers for excellence: Travel benefits/ services overseas	51
Protection against catastrophic costs (out-of-pocket maximum)	Nothing after $4,000/ Self Only or $8,000/ Family Enrollment	18

	Pharmacy benefits, office visits, and copayments do not count towards this protection	

Summary of benefits for the Standard Option - 2012

- Do not rely on this chart alone. All benefits are provided in full unless indicated and are subject to the definitions, limitations, and exclusions in this brochure. On this page we summarize specific expenses we cover; for more detail, look inside.
- If you want to enroll or change your enrollment in this Plan, be sure to put the correct enrollment code from the cover on your enrollment form.
- We only cover services provided or arranged by Plan physicians, except in emergencies.
- Below, an asterisk (*) means the item is subject to the $1,500 Self Only or $3,000 Self and Family calendar year deductible.

Standard Option Benefits	You pay	Page
Medical services provided by physicians:		
Diagnostic and treatment services provided in the office	Office visit copay: $20 primary care; $45 specialist	22
Services provided by a hospital:		
• Inpatient *	20% of Plan allowance	39
• Outpatient *	20% of Plan allowance	40
Emergency benefits:		
• In-area	$250 copayment per emergency room visit; $100 copayment per emergency room physician visit	43
• Out-of-area	$250 copayment per emergency room visit; $100 copayment per emergency room physician visit	43
Mental health and substance abuse treatment:	Regular cost-sharing	45
Prescription drugs:		
• **Prescription drugs:** Note: A listing of our Value Formulary prescription drugs can be found at www.chciowa.com Note: There is a maximum of $5,000 out-of-pocket for coinsurance and copayments on the Standard Option for prescription drugs only, per calendar year. This is separate, and does not apply to the medical out-of-pocket expense.	**Retail Pharmacy (31-day supply)** $3 per value formulary drug; $10 per formulary generic drug and brand name insulin; 30% coinsurance per formulary brand name drug, minimum of $40 copayment and maximum of $65 copayment; 30% coinsurance per non-formulary drug, minimum of $65 copayment and maximum of $90 copayment. **Mail Order maintenance medications only (93-day supply)** $9 per value formulary drug; $30 per formulary generic drug and brand name insulin; 30% coinsurance per formulary brand name drug; minimum of $120 copayment and maximum of $195 copayment; 30% coinsurance per non-formulary drug minimum of $195 copayment, maximum of $270 copayment.	48
Dental care:* (Accidental Injury Only)	20% of Plan allowance	50

Standard Option Benefits	You pay	Page
Vision care:	No benefit	
Special features:	Flexible Benefits Option; Services for the deaf and hearing impaird; High risk pregnancies; centers for excellence; Travel benefits/services overseas.	51
Protection against catastrophic costs (out-of-pocket maximum)**:**	Nothing after $5,500 Self Only or $11,000 Self and Family enrollment	18

Summary of benefits for the HDHP Option - 2012

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

In 2012 for each month you are eligible for the Health Savings Account (HSA), we will deposit $66.67 per month for Self Only enrollment or $133.34 per month for Self and Family enrollment to your HSA. For the HSA, you may use your HSA or pay out of pocket to satisfy your calendar year deductible of $2,000 for Self Only and $4,000 for Self and Family. Once you satisfy your calendar year deductible, Traditional medical coverage begins.

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

Under this Plan, most traditional medical care (other than some preventative care) is subject to a deductible. After you meet the deductible, you pay the indicated copayments or coinsurance.

HDHP Option Benefits	You Pay	Page
Medical services provided by physicians		
Diagnostic and treatment services provided in the office	In-network office visit copay: $20 primary care; $45 specialists Out-of-network: No benefit	65
Services provided by a hospital:		
• Inpatient • Outpatient	In-network: 20% of Plan allowance Out-of-network: No benefit	81
Emergency benefits:		
• In-area • Out-of-area	In-network: 20% of Plan allowance Out-of-network: No benefit	85
Mental health and substance abuse treatment	In-network: Regular cost-sharing Out-of-network: No benefit	86
Prescription drugs:		
• **Prescription drugs:** Note: A listing of our Value Formulary prescription drugs can be found at www.chciowa.com	**In network** **Retail Pharmacy (31-day supply)** $3 per value formulary drug,$10 per formulary generic drug and brand name insulin; $40 per formulary brand name drug; $65 per non-formulary drug Out of Network: No benefit **Mail Order maintenance medications only (90-day supply)** $9 per value formulary drug, $20 per formulary generic drug and brand name insulin; $80 per formulary brand name drug, and $195 per non-formulary brand name drug. Out-of-Network: No benefit	89

HDHP Option Benefits	You Pay	Page
Dental care(Accidental injury only)	20% of Plan Allowance	90
Protection against catastrophic costs (out-of-pocket maximum)**:**	Nothing after $5,000/Self Only or $10,000/ Family Enrollment per year Pharmacy, office visit and inpatient copayments do not count toward this protection	18

2012 Rate Information

For 2012 health premium information, please see http://www.opm.gov/insure/health/tribes/rates/ or contact your tribe's Human Resources department.