Attach Your Logo

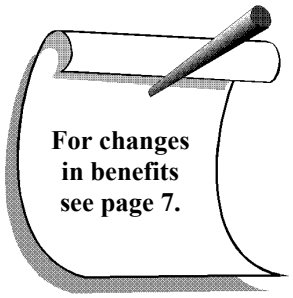
Coventry Health Care of Kansas, Inc. (Kansas City area)

http://www.chckansas.com

2003

A Health Maintenance Organization

Serving: *Kansas City Metropolitan Area*
Kansas and Missouri



Enrollment in this Plan is limited. You must live or work in our Geographic service area to enroll. See page 6 for requirements.

Enrollment codes for this Plan:

HA1 Self Only
HA2 Self and Family

Authorized for distribution by the:

United States
Office of Personnel Management
Retirement and Insurance Service
http://www.opm.gov/insure

FEHB
Federal Employees
Health Benefits Program

RI 73-128

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

OFFICE OF THE DIRECTOR

Dear Federal Employees Health Benefits Program Participant:

I am pleased to present this Federal Employees Health Benefits (FEHB) Program plan brochure for 2003. The brochure explains all the benefits this health plan offers to its enrollees. Since benefits can vary from year to year, you should review your plan's brochure every Open Season. Fundamentally, I believe that FEHB participants are wise enough to determine the care options best suited for themselves and their families.

In keeping with the President's health care agenda, we remain committed to providing FEHB members with affordable, quality health care choices. Our strategy to maintain quality and cost this year rested on four initiatives. First, I met with FEHB carriers and challenged them to contain costs, maintain quality, and keep the FEHB Program a model of consumer choice and on the cutting edge of employer-provided health benefits. I asked the plans for their best ideas to help hold down premiums and promote quality. And, I encouraged them to explore all reasonable options to constrain premium increases while maintaining a benefits program that is highly valued by our employees and retirees, as well as attractive to prospective Federal employees. Second, I met with our own FEHB negotiating team here at OPM and I challenged them to conduct tough negotiations on your behalf. Third, OPM initiated a comprehensive outside audit to review the potential costs of federal and state mandates over the past decade, so that this agency is better prepared to tell you, the Congress and others the true cost of mandated services. Fourth, we have maintained a respectful and full engagement with the OPM Inspector General (IG) and have supported all of his efforts to investigate fraud and waste within the FEHB and other programs. Positive relations with the IG are essential and I am proud of our strong relationship.

The FEHB Program is market-driven. The health care marketplace has experienced significant increases in health care cost trends in recent years. Despite its size, the FEHB Program is not immune to such market forces. We have worked with this plan and all the other plans in the Program to provide health plan choices that maintain competitive benefit packages and yet keep health care affordable.

Now, it is your turn. We believe if you review this health plan brochure and the FEHB Guide you will have what you need to make an informed decision on health care for you and your family. We suggest you also visit our web site at www.opm.gov/insure.

Sincerely,

Kay Coles James
Director

Notice of the Office of Personnel Management's

Privacy Practices

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

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

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

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

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

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

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

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

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

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

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

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

For more information on exercising your rights set out in this notice, look at www.opm.gov/insure on the web. You may also call 202-606-0191 and ask for OPM's FEHB Program privacy official for this purpose.

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

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

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

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

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Introduction

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

Coventry Health Care of Kansas, Inc.
1001 E. 101st Terrace, Suite 300
Kansas City, Missouri 64131-3368

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, 2003, unless those benefits are also shown in this brochure.

OPM negotiates benefits and rates with each plan annually. Benefit changes are effective January 1, 2003, and changes are summarized on page 7. Rates are shown at the end of this brochure.

Plain Language

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

- Except for necessary technical terms, we use common words. For instance, “you” means the enrollee or family member; "we" means Coventry Health Care of Kansas, Inc.
- We limit acronyms to ones you know. FEHB is the Federal Employees Health Benefits Program. OPM is the 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 us 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 Office of Personnel Management, Office of Insurance Planning and Evaluation Division, 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 (FEHB) 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 you can do to prevent fraud:

- Be wary of giving your plan identification (ID) number over the telephone or to people you do not know, except to your doctor, other provider, or authorized plan or OPM representative.
- Let only the appropriate medical professionals review your medical record or recommend services.
- Avoid using health care providers who say that an item or service is not usually covered, but they know how to bill us to get it paid.

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

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

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

- Do not maintain as a family member on your policy:
    - your former spouse after a divorce decree or annulment is final (even if a court order stipulates otherwise; or
    - your child over age 22 (unless he/she is disabled and incapable of self support).
- If you have any questions about the eligibility of a dependent, check with your personnel office if you are employed or with OPM if you are retired.
- You can be prosecuted for fraud and your agency may take action against you if you falsify a claim to obtain FEHB benefits or try to obtain services for someone who is not an eligible family member or who is no longer enrolled in the Plan.

Section 1. Facts about this HMO plan

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

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

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

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

How we pay providers

We contract with individual physicians, medical groups, and hospitals to provide the benefits in this brochure. These Plan providers are paid in a number of ways, including salary, capitation, per diem rates, case rates, and fee for service. You will also be responsible for unauthorized care or services not covered under this plan.

Your Rights

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

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

If you want more information about us, call 816/941-3030, or write to Coventry Health Care of Kansas, Inc., 1001 E. 101st Terrace, Suite 300, Kansas City, MO 64131-3368. You may also contact us by fax at 816/941-8516 or visit our website at www. chckansas city.com.

Service Area

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

Kansas – Anderson, Atchison, Douglas, Franklin, Jackson, Jefferson, Johnson, Leavenworth, Linn, Miami, Shawnee, and Wyandotte Counties

Missouri – Andrew, Benton, Buchanan, Caldwell, Carroll, Cass, Clay, Clinton, Daviess, DeKalb, Gentry, Grundy, Henry, Jackson, Johnson, Lafayette, Livingston, Pettis, Platte, and Ray Counties

Ordinarily, you must get your care from providers who contract with us. If you receive care outside our service area, we will pay only for emergency care benefits. We will not pay for any other health care services outside of our service area unless the services have prior plan approval. If you or a covered family member move outside of our service area, you can enroll in another plan. If your dependents live out of the area (for example, if your child goes to college in another state), you should consider enrolling in a fee-for-service plan or an HMO that has agreements with affiliates in other areas. If you or a family member move, you do not have to wait until Open Season to change plans. Contact your employer or retirement office.

Section 2. How we change for 2003

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

Program-wide changes

- A Notice of the Office of Personnel Management's Privacy Practices is included.
- A section on the Children's Equity Act describes when an employee is required to maintain Self and Family coverage.
- Program information on TRICARE and CHAMPVA explains how annuitants or former spouses may suspend their FEHB Program enrollment.
- Program information on Medicare is revised.
- By law, the DoD/FEHB Demonstration project ends on December 31, 2002.

Changes to this Plan

- Your share of the non-postal premium will increase by 30.2% for Self Only or 30.2% for Self and Family.
- The primary care physicians and specialists' office visit copayments are now $15 instead of $10 per visit.
- The inpatient hospital admission copayment is $100 per day up to $300 maximum. Previously, you paid nothing .
- Outpatient X-rays, laboratory and other diagnostic tests NOT received during a doctor's office visit are subject to $15 per visit. Previously, members paid no copayment for test not received during a doctor's office visit. You will continue to pay no copayment for these test when received as part of the doctor's visit.
- The outpatient hospital or ambulatory surgery copayment is now $50 per surgery. Previously, you paid nothing.
- Under Rehabilitative therapies, we cover Physical, Speech, Occupational and Chiropractic care for subluxation and manipulation up to 60 days per condition. You pay a $15 copayment per visit. Previously, we covered physical, speech and occupational therapies up to 32 visits per condition subject to a $10 copayment per visit; and Chiropractic care up to 20 visits subject to a $15 copayment per visit.
- The hospital emergency room visit copayment is now $75 instead of $50.
- The land ambulance coinsurance is now 30% of covered charges up to a maximum Plan benefit of $400 per trip. Previously, you paid $50 per trip.
- The air ambulance coinsurance is now 30% of covered charge. Previously, you paid $50 per trip.
- Under prescription drugs, you now pay $10 for generic drugs, $20 for formulary brand name drugs and $50 for non-formulary drugs. Previously, you paid $5 for generic drugs, $15 for formulary brand name drugs and $45 for non-formulary drugs.
- Under mail order prescription drugs, you now pay $20 for generic drugs and $40 for formulary brand name drugs. Previously, you paid $10 for generic drugs and $30 for formulary drugs.
- The out-of-pocket maximum is now $2,000 for Self Only enrollment and $4,000 for Self and Family enrollment. Previously, the out-of-pocket maximum was $1,000 for Self Only enrollment and $3,000 for Self and Family enrollment.
- We now cover a more comprehensive list of dental benefits. See Section 5(h) Dental benefits for details.
- We have expanded our **Missouri** service area to include the following counties: Andrew, Carroll, Gentry, Grundy, Livingston, and Pettis.

Clarification

- We show coverage for surgical treatment of morbid obesity. See section 5(b).

Section 3. How you get care

Identification cards

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

If you do not receive your ID card within 30 days after the effective date of your enrollment, or if you need replacement cards, call us at 1-800-969-3343 or write to us at Coventry Health Care of Kansas, Inc., 1001 E. 101st Terrace, Suite 300, Kansas City, MO, 64131. You may also request replacement cards through our website at www.chckansas.com.

Where you get covered care

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

- **Plan providers**

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

We list Plan providers in the provider directory, which we update periodically. The list is also on our website www.chckansas.com

- **Plan facilities**

Plan facilities are hospitals and other facilities in our service area that we contract with to provide covered services to our members. We list these in the provider directory, which we update periodically.

What you must do to get covered care

It depends on the type of care you need. First, you and each family member must choose a primary care physician. This decision is important since your primary care physician provides or arranges for most of your health care.

- **Primary care**

Your primary care physician can be a family practitioner, internist, or pediatrician. Your primary care physician will provide most of your health care, or give you a referral to see a specialist. You may choose a primary care physician for the entire family or a different primary care physician may be selected for individual family members.

If you want to change primary care physicians or if your primary care physician leaves the Plan, call us at 800/969-3343 or visit our website at www.chckansas.com to change your PCP. We will help you select a new one.

- **Specialty care**

Your primary care physician will refer you to a specialist for a consultation. If after the consultation, the specialist requires additional visits, then the specialist must obtain pre-certification of services that require authorization. Some lab, radiology, and therapy services may require authorization by our utilization management department. Your participating specialist must obtain this authorization. However, you may see an OB/Gyn or a mental health provider without a referral.

Here are other things you should know about specialty care:

- If you need to see a specialist frequently because of a chronic, complex, or serious medical condition, your primary care physician will develop a treatment plan that allows you to see your specialist for a certain number of visits without additional referrals. Your primary care physician will use our criteria when creating your

treatment plan (the physician may have to get an authorization or approval beforehand).

- If you are seeing a specialist when you enroll in our Plan, talk to your primary care physician. Your primary care physician will decide what treatment you need. If he or she decides to refer you to a specialist, ask if you can see your current specialist. If your current specialist does not participate with us, you must receive treatment from a specialist who does. Generally, we will not pay for you to see a specialist who does not participate with our Plan.

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

- If you have a chronic or disabling condition and lose access to your specialist because we:

  - terminate our contract with your specialist for other than cause; or
  - drop out of the Federal Employees Health Benefits (FEHB) Program and you enroll in another FEHB 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 60 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 60 days.

• Hospital care

Your Plan primary care physician or specialist will make necessary hospital arrangements and supervise your care. This includes admission to a skilled nursing or other type of facility. Be sure to tell the hospital you are a Coventry Health Care HMO member and remember to present your identification card when you are admitted. This will ensure we are notified.

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

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

- You are discharged, not merely moved to an alternative care center; or
- The day your benefits from your former plan run out; or
- The 92nd day after you become a member of this Plan, whichever happens first.

These provisions apply only to the benefits of the hospitalized person.

Circumstances beyond our control

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

Services requiring our prior approval

Your primary care physician has authority to refer you for most services. For certain services, however, your physician must obtain approval from us. Before giving approval, we consider if the service is covered, medically necessary, and follows generally accepted medical practice.

We call this review and approval process prior authorization of services. Your physician must obtain authorization for the following services: hospitalization, referral to a specialist outside of the network, or recommendations for follow-up-care.

You are responsible for ensuring that your physician has obtained authorization for a planned hospital admission or surgery.

In addition, we may retract or refuse to pay an authorization, referral, or claim if:

- You make a material misrepresentation or omission about your health condition or the cause for your health condition.
- You permit someone else to use your health plan identification card, you use another person's card or you deface the card in order to obtain services at a higher level of benefits. Except when the member is unaware another person is using their Identification card (i.e. lost or stolen card)
- Your group terminates its contract before your health care services are provided; or
- Your coverage under the group agreement terminates before the health care services are provided.

Section 4. Your costs for covered services

You must share the cost 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.

  Example: When you see your primary care physician you pay a copayment of $15 per office visit.

- **Deductible** — We have no deductible.

- **Coinsurance** — Coinsurance is the percentage of our negotiated fee that you must pay for your care.

  Example: In our Plan, you pay 50% of our allowance for infertility services and allergy testing.

Your catastrophic protection out-of-pocket maximum for copayments and coinsurance

After your copayments and coinsurance total $2,000 per person or $4,000 per family enrollment in any calendar year, you do not have to pay any more for covered services. However, copayments or coinsurance for the following services do not count toward your catastrophic protection out-of-pocket maximum, and you must continue to pay copayments or coinsurance for these services:

- Extended care services
- Durable medical equipment
- External prostheses and braces
- Chiropractic services
- Dental care services
- Prescription drugs

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

Section 5. Benefits -- OVERVIEW

(See page 7 for how our benefits changed this year and page 58 for a benefits summary.)

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

(a) Medical services and supplies provided by physicians and other health care professionals 13-23

- Diagnostic and treatment services
- Lab, X-ray, and other diagnostic tests
- Preventive care, adult
- Preventive care, children
- Maternity care
- Family planning
- Infertility services
- Allergy care
- Treatment therapies
- Physical and occupational therapies
- Speech therapy
- Hearing services (testing, treatment, and supplies)
- Vision services (testing, treatment, and supplies)
- Foot care
- Orthopedic and prosthetic devices
- Durable medical equipment (DME)
- Home health services
- Chiropractic
- Alternative treatments
- Educational classes and programs

(b) Surgical and anesthesia services provided by physicians and other health care professionals..... 24-27

- Surgical procedures
- Reconstructive surgery
- Oral and maxillofacial surgery
- Organ/tissue transplants
- Anesthesia

(c) Services provided by a hospital or other facility, and ambulance services 28-31

- Inpatient hospital
- Outpatient hospital or ambulatory surgical center
- Extended care benefits/skilled nursing care facility benefits
- Hospice care
- Ambulance

(d) Emergency services/accidents..... 32-33

- Medical emergency
- Ambulance

(e) Mental health and substance abuse benefits..... 34-35

(f) Prescription drug benefits..... 36-38

(g) Special features 39

- 24 Hour Nurse Line
- Services for the deaf and hearing impaired
- Transplant Network for transplants/heart surgery/etc.
- Flexible Benefits Option

(h) Dental benefits 40-41

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

IMPORTANT

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

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan physicians must provide or arrange your care.
- We have no calendar year deductible.
- Be sure to read Section 4, *Your costs for covered services,* for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

IMPORTANT

Benefit Description	You pay
Diagnostic and treatment services	
Professional services of physicians • In physician's office	$15 per office visit
Professional services of physicians • In an urgent care center • During a hospital stay • In a skilled nursing facility • Office medical consultations • Second surgical opinion	$15 per office visit
• At home	Nothing

Diagnostic and treatment services -- continued on next page

Lab, X-ray and other diagnostic tests	You pay
Tests, such as: • Blood tests • Urinalysis • Non-routine pap tests • Pathology • X-rays • Non-routine Mammograms • CAT Scans/MRI • Ultrasound • Electrocardiogram and EEG	$15 when the test is not performed during your office visit. You only pay the office visit copayment when the test is performed during your office visit.
Preventive care, adult	
Routine screenings, such as: • Total Blood Cholesterol – once every three years • Chlamydia Infection • Colorectal Cancer Screening, including - Fecal occult blood test - Sigmoidoscopy screening – every five years starting at age 50	$15 per office visit
Routine Prostate Specific Antigen (PSA) test – one annually for men age 40 and older	$15 per office visit
Routine pap test Note: The office visit is covered if pap test is received on the same day; see *Diagnosis and Treatment*, above.	$15 per office visit
Routine mammogram –covered for women age 35 and older, as follows: • From age 35 through 39, one during this five year period • From age 40 through 64, one every calendar year • At age 65 and older, one every two consecutive calendar years Note: In addition to routine screening, we cover mammograms when medically necessary to diagnose or treat your illness.	$15 per office visit
Not covered: Physical exams required for obtaining or continuing employment or insurance, attending schools or camp, or travel.	*All charges.*

Preventive care – adult--continued on next page

Preventive care, adult *(continued)*	**You pay**
Routine immunizations, limited to: • Tetanus-diphtheria (Td) booster – once every 10 years, ages 19 and over (except as provided for under Childhood immunizations) • Influenza vaccine, annually • Pneumococcal vaccine, age 65 and over	$15 per office visit
Preventive care, children	
• Childhood immunizations recommended by the American Academy of Pediatrics	Nothing
• Well-child care charges for routine examinations, immunizations and care (through 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 – Examinations done on the day of immunizations (through age 22)	$15 per office visit
Not covered: Physical exams required for obtaining or continuing employment or insurance, attending schools or camp, or travel	*All charges.*

Maternity care	You pay
Complete maternity (obstetrical) care, such as: • Prenatal care • Delivery • Postnatal care • Physician ordered sonograms Note: Here are some things to keep in mind: • You need to precertify your normal delivery; see page 30 for other circumstances, such as extended stays for you or your baby. • You may remain in the hospital up to 48 hours after a regular delivery and 96 hours after a cesarean delivery. We will extend your inpatient stay if medically necessary. • We cover routine nursery care of the newborn child during the covered portion of the mother's maternity stay. We will cover other care of an infant who requires non-routine treatment only if we cover the infant under a Self and Family enrollment. (Surgical benefits, not maternity benefits, apply towards circumcision of the newborn; see page 24) • We pay hospitalization and surgeon services (delivery) the same as for illness and injury. See Hospital benefits (Section 5c) and Surgery benefits (Section 5b).	$15 for initial office visit to confirm pregnancy. All other copayments for prenatal visits during the course of pregnancy are waived.
Not covered: Routine sonograms to determine fetal age, size or sex	*All charges.*
Family planning	
A range of voluntary family planning services, limited to: • Surgically implanted contraceptives (such as Norplant) • Injectable contraceptive drugs (such as Depo provera) • Intrauterine devices (IUDs) • Diaphragms NOTE: We cover oral contraceptives under the prescription drug benefit.	$15 per office visit
• Voluntary Sterilization (See surgical procedures Section 5(b))	$100 per procedure
Not covered: reversal of voluntary surgical sterilization, genetic counseling	*All charges.*

Infertility services	You pay
Diagnosis and treatment of infertility, such as: • Artificial insemination: – *intravaginal insemination (IVI)* – *intracervical insemination (ICI)* – *intrauterine insemination (IUI)*	50% of our allowance per procedure
Not covered: • *Assisted reproductive technology (ART) procedures, such as:* – *in vitro fertilization* – *embryo transfer, gamete GIFT and zygote ZIFT* – *Zygote transfer* • *Services and supplies related to excluded ART procedures* • *Cost of donor sperm* • *Cost of donor egg* • *Drugs and supplies for the treatment of infertility*	*All charges.*
Allergy care	
Testing and treatment Allergy injection	50% of our allowance per visit
Allergy serum	Nothing
Not covered: provocative food testing and sublingual allergy desensitization	*All charges.*

Treatment therapies	You pay
• 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 26. • 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. Note: – We will only cover GHT when we pre-authorize the treatment. Call 1-800-969-3343 for preauthorization. We will ask you to submit information that establishes that the GHT is medically necessary. Ask us to authorize GHT before you begin treatment; otherwise, we will only cover GHT services from the date you submit the information. If you do not ask or if we determine GHT is not medically necessary, we will not cover the GHT or related services and supplies. See *Services requiring our prior approval* in Section 3.	$15 per office visit
Physical and occupational therapies and chiropractic	
• 60 days per condition for the services of each of the following: – qualified physical therapists – occupational therapists – chiropractor (coverage limited to subluxation and manipulation) • Cardiac rehabilitation following a heart transplant, bypass surgery or myocardial infarction Note: We only cover therapy to restore bodily function when there has been a total or partial loss of bodily function due to illness or injury.	$15 for each outpatient session; Nothing per visit during covered inpatient admission
Not covered: • *exercise programs* • *Non-neuroskelatal disorders* • *Vocational rehabilitation services* • *Thermography* • *Long-term rehabilitative therapy*	*All charges.*

Speech therapy	You pay
• 60 days per condition	$15 copay for each outpatient session; Nothing per visit during covered inpatient admission
Hearing services (testing, treatment, and supplies)	
• First hearing aid and testing only when necessitated by accidental injury • Hearing testing for children through age 17 (see *Preventive care, children*)	$15 per office visit
Not covered: • *all other hearing testing* • *hearing aids, testing and examinations for them*	*All charges.*
Vision services (testing, treatment, and supplies)	
• One pair of eyeglasses or contact lenses to correct an impairment directly caused by accidental ocular injury or intraocular surgery (such as for cataracts) • Eye exam to determine the need for vision correction for children through age 17 (see Preventive care, children) • Annual eye refraction's (see Preventive care, children)	$15 per office visit
Not covered: • *Eyeglasses or contact lenses and, after age 17, examinations for them* • *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. See orthopedic and prosthetic devices for information on podiatric shoe inserts.	$15 per office visit
Not covered: • *Cutting, trimming or removal of corns, calluses, or the free edge of toenails, ingrown 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	You pay
Our maximum allowance is $1,000. • Artificial limbs and eyes; stump hose • Externally worn breast prostheses and surgical bras, including necessary replacements, following a mastectomy • Internal prosthetic devices, such as artificial joints, pacemakers, and surgically implanted breast implant following mastectomy. Note: See 5(b) for coverage of the surgery to insert the device Note: External devices are limited to one each per member per lifetime, except if a bilateral mastectomy is performed	20% of covered charges up to a maximum Plan allowance of $1,000.
Not covered: • *orthopedic and corrective shoes* • *arch supports* • *orthotics (regular or custom, including but not limited to ankle foot orthotics or podiatric orthotics)* • *heel pads and heel cups* • *lumbosacral supports* • *corsets, trusses, elastic stockings, support hose, and other supportive devices* • *dental braces, devices, and appliances* • *braces for aid in sports activities* • *internally implanted devices, equipment, and prosthetics related to treatment of sexual dysfunction* • *repair and replacement of orthopedic and prosthetic devices, unless necessitated by normal growth* • *doc bands (Dynamic Orthotic Cranial Bands)*	*All charges.*

Durable medical equipment (DME)	You pay
Our maximum allowance is $1,000. Rental or purchase, at our option, including repair and adjustment, of durable medical equipment prescribed by your Plan physician, such as oxygen and dialysis equipment. Under this benefit, we also cover: • hospital beds; • wheelchairs; • crutches; • walkers; • ostomy and urological supplies; • prosthetic and orthotic supplies; • blood glucose monitors; and • insulin pumps, and syringes for insulin pumps • apnea monitor • cane; • orthopedic braces for scoliosis; • pads, wires, tubing, electrodes, and masks • equipment required as a part of acute primary care such as back braces, rib belts, slings, and hard cervical collars; • replacement due to anatomical growth; • repair and replacement of DME determined to be medically necessary. Note: Call us at 1-800-969-3343 as soon as your Plan physician prescribes this equipment. We will arrange with a health care provider to rent or sell you durable medical equipment at discounted rates and will tell you more about this service when you call.	20% of covered charges up to a maximum Plan allowance of $1,000.
Not covered: • *Motorized wheel chairs* • *Comfort, convenience, or luxury items or features* • *Electric monitors of bodily functions, except for apnea monitors* • *Devices to perform medical testing of bodily fluids, excretions, or substances* • *Disposable supplies* • *Replacement of lost equipment* • *Repair, adjustment, or replacement necessitated by wear, tear, or misuse* • *More than one piece of durable medical equipment serving essentially the same function, except for replacement due to anatomical growth; spare equipment or alternate use equipment is not provided*	*All charges.*

Home health services	You pay
Home health care ordered by a Plan physician and approved by the primary care physician provided by a registered nurse (R.N.), licensed practical nurse (L.P.N.), licensed vocational nurse (L.V.N.), physical therapist, speech therapist, occupational therapist. • The agency rendering services is Medicare certified and licensed by the state of location • Services are a substitute or alternative to hospitalization • Services include intravenous therapy and medications Other services include: • Drugs, supplies, and supplements • Home IV and antibiotic therapy	Nothing
Not covered: • *Nursing care requested by, or for the convenience of, the patient or the patient's family* • *Services primarily for hygiene, feeding, exercising, moving the patient, homemaking, companionship or giving oral medication* • *Nursing care that could appropriately be rendered in a Plan medical office, affiliated hospital, or skilled nursing facility* • *Nursing care that can be performed safely and effectively by people whom, in order to provide the care do not require medical licenses or certificates, or the presence of a supervising licensed nurse* • *Home care primarily for personal assistance that does not include a medical component and is not diagnostic, therapeutic, or rehabilitative*	*All charges.*
Alternative treatments	
No benefits	*All charges.*

Educational classes and programs	You pay
When provided or referred by a primary physician or other participating provider. Coverage is available for Health education, services including instructions on achieving and maintaining physical well being; learning how to control and identify warning signs of asthma or diabetes; and how to use medication and treat symptoms. Please call Customer Service at 1-800-969-3343 for assistance. Coverage is limited to: • Asthma education (Telephonic – No charge) • Diabetes self-management	$15 per office visit

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

IMPORTANT

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

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan physicians must provide or arrange your care.
- We have no calendar year deductible.
- Be sure to read Section 4, *Your costs for covered services,* for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- The amounts listed below are for the charges billed by a physician or other health care professional for your surgical care. Look in Section 5(c) for charges associated with the facility (i.e. hospital, surgical center, etc.).
- **YOU MUST GET PRECERTIFICATION OF SOME SURGICAL PROCEDURES.** Please refer to the precertification information shown in Section 3.

IMPORTANT

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 • Treatment of burns • Circumcision of a newborn • Correction of congenital anomalies (see reconstructive surgery) • Surgical treatment of morbid obesity -- a condition in which an individual weighs 100 pounds or 100% over his or her normal weight according to current underwriting standards; eligible members must be age 18 or over • Insertion of internal prosthetic devices. See 5(a) – Orthopedic and prosthetic devices for device coverage information Note: Generally, we pay for internal prostheses (devices) according to where the procedure is done. For example, we pay Hospital benefits for a pacemaker and Surgery benefits for insertion of the pacemaker.	$15 per office visit; Nothing in a hospital.
• Voluntary sterilization (e.g., Tubal ligation, Vasectomy)	$100 per procedure
Not covered: • *Reversal of voluntary sterilization* • *Routine treatment of conditions of the foot; see Foot care.*	*All charges.*

Reconstructive surgery	You pay
• 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 on the other breast; – 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 per office visit
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.*
Oral and maxillofacial surgery	
Oral surgical procedures, when medically necessary, 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 medically necessary surgical procedures that do not involve the teeth or their supporting structures • Treatment of (TMJ) Temporomandibular Joint Dysfunction, including surgical and non-surgical intervention, corrective orthopedic appliances and physical therapy.	$15 per office visit; Nothing in a hospital.

Oral and maxillofacial surgery *(continued)*	**You pay**
Not covered: • *Oral implants and transplants* • *Procedures that involve the teeth or their supporting structure (such as the periodontal membrane, gingiva, and alveolar bone). Other procedures that involve the teeth or intra-oral areas surrounding the teeth, including shortening of the mandible or maxillae for cosmetic purposes*	*All charges.*
Organ/tissue transplants	
Limited to: • Cornea • Heart • Heart/lung • Kidney • Kidney/Pancreas • Liver • Lung: Single – Double • Pancreas • Allogeneic (donor) bone marrow transplants • Autologous bone marrow transplants (autologous stem cell and peripheral stem cell support) for the following conditions: acute lymphocytic or non-lymphocytic leukemia; advanced Hodgkin's lymphoma; advanced non-Hodgkin's lymphoma; advanced neuroblastoma; breast cancer; multiple myeloma; epithelial ovarian cancer; and testicular, mediastinal, retroperitoneal and ovarian germ cell tumors • Intestinal transplants (small intestine) and the small intestine with the liver or small intestine with multiple organs such as the liver, stomach, and pancreas Note: We cover related medical and hospital expenses of the donor when we cover the recipient provided the recipient is a plan member. After referral to a transplant facility, the following will apply: • If our Medical Director or the referral facility decides you do not satisfy criteria for a transplant, we only pay for covered services you receive before that decision is made • We, and the plan providers are not responsible for finding, furnishing, or ensuring the availability of a bone marrow or organ donor • We cover reasonable medical and hospital expenses as long as the expenses are directly related to a covered transplant of the donor or an individual identified as a potential donor, even if a member • Unless otherwise authorized by our Medical Director, we provide transplants only at approved Transplant Network facilities	Nothing

Organ/tissue transplants *(continued)*	**You pay**
Not covered: • *Donor screening tests and donor search expenses, except those performed for the actual donor* • *Any related conditions or complications for a member who is donating an organ or tissue when the recipient is not a member* • *Outpatient immunosuppressive agents* • *Any transplant procedure that is performed in a facility that has not been designated by the Medical Director as a approved transplant facility* • *Implants of non-human or artificial organs* • *Transplants not listed as covered*	*All charges.*
Anesthesia	
Professional services provided in: • Hospital (inpatient)	Nothing
Professional services provided in – • Hospital outpatient department • Skilled nursing facility • Ambulatory surgical center • Office	$15 per office visit

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

IMPORTANT

Here are some important things to remember 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.
- We have no calendar year deductible.
- Be sure to read Section 4, *Your costs for covered services,* for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- The amounts listed below are for the charges billed by the facility (i.e., hospital or surgical center) or ambulance service for your surgery or care. Any costs associated with the professional charge (i.e., physicians, etc.) are covered in Sections 5(a) or (b).
- **YOUR PHYSICIAN MUST GET PRECERTIFICATION OF HOSPITAL STAYS.** Please refer to Section 3 to be sure which services require precertification. If hospitalization is required, your primary physician will arrange admission to one of our participating hospitals. Either your primary care physician will admit you or you will be referred to a participating provider who will manage your inpatient coordination with your primary care physician. Your admitting physician will give you instructions about which hospital to go to, including the date and time you should arrive. Before the arrangements are made, please remind your primary care physician or participating physician that you need to go to a participating hospital.

IMPORTANT

Benefit Description	You pay
Inpatient hospital	
Room and board, such as • ward, semiprivate, or intensive care accommodations; • general nursing care; and • meals and special diets. • special duty nursing care when medically necessary NOTE: When it is medically necessary, a plan physician may prescribe private accommodations. If you want a private room when it is not medically necessary, you pay the additional charge above the semiprivate room rate.	$100 per day up to a maximum of $300 per admission

Inpatient hospital continued on next page.

Inpatient hospital *(continued)*	**You pay**
Other hospital services and supplies, such as: • Operating, recovery, maternity, and other treatment rooms • Prescribed drugs and medicines • Diagnostic laboratory tests and X-rays • Administration of blood and blood products • Blood or blood plasma, if not donated or replaced • Dressings, splints, casts, and sterile tray services • Medical supplies and equipment, including oxygen • Anesthetics, including nurse anesthetist services • Medical supplies, appliances, medical equipment, and any covered items billed by a hospital for use at home	Nothing
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 not medically necessary*	*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 • 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.	$50 per surgery
Not covered: blood and blood derivatives not replaced by the member	*All charges.*

Extended care benefits/skilled nursing care facility benefits	You pay
Up to 60 days per member per calendar year when: • Full-time skilled nursing care is necessary • Confinement in a skilled nursing facility is medically necessary Services include: • Bed, board, and general nursing • Prescribed drugs and their administration • Biologicals • Supplies • Durable medical equipment ordinarily furnished by the facility	Nothing
Not covered: custodial care or care in an intermediate care facility	*All charges.*
Hospice care	
Hospice care is a program for caring for the terminally ill that emphasizes supportive and palliative services, such as home care and pain control, rather than curative care of the terminal illness. A person who is terminally ill may elect to receive hospice benefits. Services are provided under the direction of a Plan doctor who certifies that the patient is in the terminal stages of illness, with a life expectancy of six months or less. • You must reside in the service area Services will be provided in the home or • in a Plan approved hospice facility • Services include inpatient care, outpatient care, and family counseling (except financial, legal or spiritual counseling provided by a volunteer). • These palliative and supportive services include nursing care, medical social services, physician services, and short-term inpatient care for pain control and acute chronic symptom management. We also provide services for symptom control to enable the person to continue life with as little disruption as possible.	Nothing
Not covered: • *Services in the member's home outside of the service area* • *Any service for which the hospice does not customarily charge the member, or his or her family* • *Independent nursing, homemaker services*	*All charges.*

Ambulance	You pay
• Local professional ambulance service to the nearest hospital equipped to handle your medical condition when medically appropriate. We limit coverage to $400 per transport.	30% coinsurance per transport up to our $400 coverage limit
• Air ambulance when medically appropriate.	30% of covered charges
Not covered: Non-emergent transport due to absence of other transportation, non-emergent transport regardless of who requested the ambulance service	*All charges*

Section 5 (d). Emergency services/accidents

IMPORTANT

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

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- We have no calendar year deductible
- Be sure to read Section 4, *Your costs for covered services,* for valuable information about how cost sharing works.
- Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

IMPORTANT

What is a medical emergency?

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

What to do in case of emergency:

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

Emergencies within our service area:

If you are admitted to a non-participating facility, call Customer Service at (800) 969-3343. You must notify us about your medical emergency within a reasonable time period as dictated by the circumstances. If you are hospitalized in a non-participating hospital and plan physicians believe your care can be provided in one of our participating hospitals, we will transfer you when medically feasible. Follow-up services will normally be performed by your primary care physician.

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

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

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

Emergencies outside our service area:

If you are hospitalized, We must be notified about your medical emergency within a reasonable time period as dictated by the circumstances. If a participating physician believes your care can be provided in one of our participating hospitals, we will transfer you when medically feasible.

Benefit Description	You pay
Emergency within our service area	
• Emergency care at a doctor's office • Emergency care at an urgent care center • Emergency care as an outpatient or inpatient at a hospital, including doctor's services Note: We waive the copay if you are admitted to the hospital	$15 per visit $25 per visit $75 per visit
Not covered: Elective care or non-emergency care	*All charges.*
Emergency outside our service area	
• Emergency care at a doctor's office • Emergency care at an urgent care center • Emergency care as an outpatient or inpatient at a hospital, including doctor's services	Nothing
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 (within or outside of service area)	
• Local professional ambulance service to the nearest hospital equipped to handle your medical condition when medically appropriate. We limit coverage to $400 per transport. • Air ambulance when medically appropriate.	30% coinsurance per transport up to our $400 coverage limit 30% of covered charges
Not covered: Transports we determine are not medically necessary	*All charges.*

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

IMPORTANT

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

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

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- We have no calendar year deductible
- Be sure to read Section 4, *Your costs for covered services,* for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- **YOU MUST GET PREAUTHORIZATION OF THESE SERVICES.** See the instructions after the benefits description below.

IMPORTANT

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 illness or conditions.
Diagnostic and treatment of psychiatric conditions, mental illness and mental disorders. Services include: • Diagnostic evaluation • Professional services, including individual or group therapy by providers such as psychiatrists, psychologists, or clinical social workers	$15 per visit
• Crisis intervention and stabilization for acute episodes • Medication evaluation and management • Psychological testing necessary to determine the appropriate treatment	$15 when the test is not performed during your office visit. You only pay the office visit copayment when the test is performed during your office visit.

Mental health and substance abuse benefits - continued on next page

Mental health and substance abuse benefits *(continued)*	You pay
Diagnosis and treatment of alcoholism and drug abuse. Services include: • Detoxification (medical management of withdrawal from the substance) • Treatment and counseling (including individual and group therapy visits) • Rehabilitation Note: Your mental health or substance abuse provider will develop a treatment plan to assist you in improving or maintaining your condition and functional level, or to prevent relapse. Note: You may see an outpatient mental health or substance abuse provider without referral from your primary care physician. However, before you see a mental health provider you must obtain authorization for the visit from APS Healthcare, Inc., at 800-752-7242. They can be reached for routine referrals between 8 a.m. and 6 p.m. CST Monday through Friday, or for emergency services 24 hours a day. Your mental health provider will obtain subsequent authorizations for treatment.	$15 per visit
• Inpatient psychiatric care • Services in approved alternative care settings such as partial hospitalization, half-way house, residential treatment, full-day hospitalization, facility based intensive outpatient treatment • Inpatient substance abuse care • Inpatient detoxification	$100 per day up to a maximum of $300 per admission
Not covered: Services we have not approved. *Note: OPM will base its review of disputes about treatment plans on the treatment plan's clinical appropriateness. OPM will generally not order us to pay or provide one clinically appropriate treatment plan in favor of another.*	*All charges.*

Preauthorization

To be eligible to receive these benefits you must follow your treatment plan and all the following authorization processes:

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

All inpatient and outpatient treatment must be authorized through APS Healthcare, Inc., at 800-752-7242.

Limitation

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

Section 5 (f). Prescription drug benefits

IMPORTANT

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

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

IMPORTANT

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

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

  If your plan physician specifically prescribes a non-formulary drug because it is medically necessary, you will receive the non-formulary drug at the Plan non-formulary copayment. If you request a non-formulary drug when your physician has prescribed a substitution, we will not provide the non-formulary drug. However, you may purchase the non-formulary drug from a Plan pharmacy at our allowance.
- **These are the dispensing limitations.** Prescription Drugs will be dispensed in the quantity determined by the Prescribing Provider. The following also apply:
- One (1) applicable copayment is due each time a prescription is filled or refilled at a retail pharmacy for up to a thirty-one (31) day supply.
- Mail Order Drugs are obtained through Caremark, our mail order prescription drug program, and may be dispensed with two (2) applicable copayment(s), or $20 formulary generic and $40 brand name generic, for a ninety-three (93) day supply. **To order prescriptions or refills please contact Caremark's Customer Service at (800) 378-7040 or visit the website** www.rxrequest.com**. Available 24 hours a day – 7 days a week.**
- If a brand name Prescription Drug is dispensed, and an equivalent generic Prescription Drug is available, you pay an Ancillary Charge in addition to the formulary brand name copayment. The Ancillary Charge will be due regardless of whether or not the Prescribing Provider indicates that the pharmacy is to "Dispense as Written." The Ancillary Charge is the difference between the average wholesale price of the brand name and the maximum allowable cost price of the generic prescription. Copayments and Ancillary Charges do not apply to the Catastrophic Protection Out-of-Pocket Maximum.

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

- **When you have to file a claim.** When you receive drugs from a Plan pharmacy, you do not have to file a claim. For a covered out-of-area emergency, you will need to file a claim when you receive drugs from a no-Plan pharmacy.

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 (per vial) and lancets • Glucose test strips • Oral contraceptive drugs • Injectable contraceptive drugs (such as Depo Provera) • Growth hormone	**Retail Pharmacy** $10 per generic formulary $20 per brand name formulary $50 per non formulary **Mail Order (93-day supply)** $20 per generic formulary $40 per brand name formulary Note: Our mail order benefit is limited to the two tiers listed above Note: If there is no generic equivalent available, you will still have to pay the brand name copay.
• Drugs to treat sexual dysfunction (Note: This drug has dispensing limitations. Contact the Plan for details)	50% of our allowance
• Insulin – Under retail pharmacy benefit, you can obtain up to a 3 month supply of insulin.	$30 generic, $60 brand name formulary, $150 non formulary brand
• Oral Contraceptive drugs – Under retail pharmacy benefit, you can obtain up to a 3 month supply of oral contraceptives drugs	$30 generic, $60 brand name formulary, $150 non formulary brand
• Disposable needles and syringes for the administration of covered medications. • Immunosuppressant drugs required after a covered transplant.	Nothing

Covered medications and supplies *(continued)*	**You pay**
Not covered: • *Drugs and supplies for cosmetic purposes* • *Medical supplies such as dressings and antiseptics* • *Smoking cessation drugs, and devices including nicotine gum* • *Drugs to enhance athletic performance* • *Fertility drugs* • *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* • *Drugs available without a prescription or for which there is a non-prescription equivalent* • *Prescription drugs for a non-covered service* • *Drugs used for hair restoration* • *Dietary supplements, appetite suppressants, and other drugs used to treat obesity or assist in weight reduction*	*All charges.*

Section 5 (g). Special features

Feature	Description
24 hour nurse line	Call FirstHelp anytime you or a family member experience health symptoms that need attention. Nurses are available to you and your family 24 a day, 7 days a week and are trained to handle your questions. Any member who visits an emergency room or urgent care center as a result of advice from FirstHelp will automatically have associated claims approved. With FirstHelp authorization, you will know in advance if medical services will be covered. You may call 1-800-622-9528 or for the hearing impaired call 1-800-735-2966.
Services for deaf and hearing impaired	The Missouri TDD relay number is 1-800-735-2966. The Kansas TDD relay number is 1-800-766-3777.
Transplant Network	In order to provide members requiring a transplant the opportunity for the best outcomes and experiences, We have contracted with United Resource Networks for access to a network of transplant programs with proven expertise. United Resource Networks evaluates transplant programs throughout the United States, and has built a nationally-recognized network of programs called the United Resource Networks Transplant Network.
Flexible Benefits Option	Under the flexible benefits option, we determine the most effective way to provide services. • We may identify medically appropriate alternatives to traditional care and coordinate other benefits as a less costly alternative benefit. • Alternative benefits are subject to our ongoing review. • By approving an alternative benefit, we cannot guarantee you will get it in the future. • The decision to offer an alternative benefit is solely ours, and we may withdraw it at any time and resume regular contract benefits. • Our decision to offer or withdraw alternative benefits is not subject to OPM review under the disputed claims process.

Section 5 (h). Dental benefits

IMPORTANT

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

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are dentally necessary.
- We have no calendar year deductible. There are no out-of-network benefits.
- You must pay the dentist the listed copay at the time of service. You are not limited to a specific number of visits per year. You do not have to be assigned to a certain provider office. You may visit any dentist in the plan. A plan dentist must provide or arrange your care.
- We cover hospitalization for dental procedures only when a non-dental physical impairment exist which makes hospitalization necessary to safeguard the health of the patient. See section 5(c) for inpatient benefits.
- Be sure to read Section 4, *Your costs for covered* services, for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare**.**
- This is not a complete list of our Dental benefits. For a complete list of our Dental benefits, contact National Dental Plans (NDP) a CompDent company toll free at (800) 456-5500 or visit NDP's website at www.compdent.com.
- Important Note: Prior to treatment, always discuss all fees with the dentist. Some of our benefits list the amount you pay for the service. For other covered benefits, you pay a percentage of the dentist's usual and customary fee. **IT IS YOUR RESPONSIBILITY TO BE INFORMED ABOUT YOUR DENTAL COVERAGE**.

IMPORTANT

Accidental injury benefit	You pay
We cover emergency restorative services and supplies necessary to promptly repair (but not replace) sound natural teeth. The need for these services must result from an accidental injury.	The remaining cost after a 20% reduction of participating specialist fees

Dental Benefits	
Service	**You pay**
General dentist (you pay restorative services)	
Amalgam (fillings silver, plastic or composite)	$33 – 55
Crowns (Stainless steel, cast or porcelain/metal)	$431 – 458
Periodontic services	
Root planning (per quadrant)	$44 – 114
Orthodontic services	The remaining cost after a 20% reduction of the participating specialist usual & customary fees for services provided
Standard fully banded case (available to members age 19 and under)	
Endodontic services	The remaining cost after a 20% reduction of the participating specialist usual & customary fees for services provided
Root canals	

Dental benefits continued on next page

Dental benefits *(continued)*	**You pay**
Oral surgery	
Simple extraction	$45
Extractions (each additional tooth)	$39
Surgical removal of erupted tooth	$85
Prosthetic services	
Dentures (complete upper or lower)	$540
Partial dentures	$455
• Any treatment provided by a participating specialist (advanced degree) will be charged at a 20% reduction of participating specialist fees for that particular case. Note: Some specialists may require a consultation visit before treatment is initiated.	The remaining cost after a 20% reduction of the participating specialist usual & customary fees for services provided
Not covered: • *Services for injuries or conditions that are covered under Workman's Compensation or Employer Liability Laws.* • *Services which are provided without cost to the member by any municipality, county, or other political subdivision.* • *Cost of dental care that is covered under automobile medical, no fault, or similar type insurance.* • *General anesthesia, IV sedation, nitrous oxide, hospitalization or hospital medical charges of any kind.* • *Osseointegrated implants* • *Member's dental fees apply only when treatment is performed at a participating dental office. If the services of a non-participating specialist or non-participating general dentist are required, these dental fees do not apply, and the patient will be responsible for the non-participating dentist's usual, customary and reasonable fee.* • *Reduced fees will not be honored if the dental treatment is already in progress or if the patient's membership is no longer valid.* • *Any member accepted for orthodontics must remain a member of the dental plan for the full duration of their treatment or risk additional charges from their participating Orthodontist.* • *A patient's existing dental or medical condition may necessitate extra precautionary procedures and require additional charges.* **Please discuss all fees with the dentist prior to treatment.**	*All charges.*

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

The exclusions in this section apply to all benefits. **Although we may list a specific service as a benefit, we will not cover it unless your Plan doctor determines it is medically necessary to prevent, diagnose, or treat your illness, disease, injury, or condition.**

We do not cover the following:

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

Section 7. Filing a claim for covered services

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

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

Medical, hospital, and drug benefits

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

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

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

Submit your claims to:

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

Deadline for filing your claim

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

When we need more information

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

Section 8. The disputed claims process

Follow this Federal Employees Health Benefits Program disputed claims process if you disagree with our decision on your claim or request for services, drugs, or supplies – including a request for preauthorization:

Step	Description
1	Ask us in writing to reconsider our initial decision. You must: (a) Write to us within 90 days from the date of our decision; and (b) Send your request to us at: Coventry Health Care of Kansas, Inc., Attn: Member Appeals, 1001 East 101st Terrace, Suite 300, Kansas City, MO 64131; 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.
2	We have 30 days from the date we receive your request to: (a) Pay the claim (or, if applicable, arrange for the health care provider to give you the care); or (b) Write to you and maintain our denial -- go to step 4; or (c) Ask you or your provider for more information. If we ask your provider, we will send you a copy of our request—go to step 3.
3	You or your provider must send the information so that we receive it within 60 days of our request. We will then decide within 30 more days. If we do not receive the information within 60 days, we will decide within 30 days of the date the information was due. We will base our decision on the information we already have. We will write to you with our decision.
4	If you do not agree with our decision, you may ask OPM to review it. You must write to OPM within: • 90 days after the date of our letter upholding our initial decision; or • 120 days after you first wrote to us -- if we did not answer that request in some way within 30 days; or • 120 days after we asked for additional information. Write to OPM at: Office of Personnel Management, Office of Insurance Programs, Health Benefits Contracts Division 3, 1900 E Street, NW, Washington, DC 20415-3630.

The Disputed Claims process *(continued)*

Send OPM the following information:

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

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

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

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

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

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

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

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

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

(a) We haven't responded yet to your initial request for care or preauthorization/prior approval, then call us at 1-800-969-3343 and we will expedite our review; or

(b) We denied your initial request for care or preauthorization/prior approval, then:

- If we expedite our review and maintain our denial, we will inform OPM so that they can give your claim expedited treatment too, or
- You may call OPM's Health Benefits Contracts Division 3 at 202/606-0755 between 8 a.m. and 5 p.m. eastern time.

Section 9. Coordinating benefits with other coverage

When you have other health coverage

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

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

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

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

•What is Medicare?

Medicare is a Health Insurance Program for:

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

Medicare has two parts:

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

If you are eligible for Medicare, you may have choices in how you get your health care. Medicare + Choice is the term used to describe the various health plan choices available to Medicare beneficiaries. The information on the next few pages shows how we coordinate benefits with Medicare, depending on the type of Medicare managed care plan you have.

•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, like prescription drugs.

When you are enrolled in Original Medicare along with this Plan, you still need to follow the rules in this brochure for us to cover your care. Your care must continue to be authorized by your Plan PCP, or precertified as required. We will not waive any of our copayments, coinsurance.

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

- When we are the primary payer, we process the claim first.

- When Original Medicare is the primary payer, Medicare processes your claim first. In most cases, your claims will be coordinated automatically and we will then provide secondary benefits for covered charges. You will not need to do anything. To find out if you need to do something to file your claims, call us at 1-800-969-3343 or visit our website at www.chckansas.com.

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

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

Primary Payer Chart		
A. When either you -- or your covered spouse -- are age 65 or over and …	**Then the primary payer is…**	
	Original Medicare	**This Plan**
1) Are an active employee with the Federal government (including when you or a family member are eligible for Medicare solely because of a disability),		✓
2) Are an annuitant,	✓	
3) Are a reemployed annuitant with the Federal government when… a) The position is excluded from FEHB, or	✓	
b) The position is not excluded from FEHB (Ask your employing office which of these applies to you)		✓
4) 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),	✓	
5) Are enrolled in Part B only, regardless of your employment status,	✓ (for Part B services)	✓ (for other services)
6) Are a former Federal employee receiving Workers' Compensation and the Office of Workers' Compensation Programs has determined that you are unable to return to duty,	✓ (except for claims related to Workers' Compensation.)	
B. When you -- or a covered family member -- have Medicare based on end stage renal disease (ESRD) and…		
1) Are within the first 30 months of eligibility to receive Part A benefits solely because of ESRD,		✓
2) Have completed the 30-month ESRD coordination period and are still eligible for Medicare due to ESRD,	✓	
3) Become eligible for Medicare due to ESRD after Medicare became primary for you under another provision,	✓	
C. When you or a covered family member have FEHB and…		
1) Are eligible for Medicare based on disability, and a) Are an annuitant, or	✓	
b) Are an active employee, or		✓
c) Are a former spouse of an annuitant, or	✓	
d) Are a former spouse of an active employee		✓

- **Medicare managed care plan**

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

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

There is not a group Medicare managed care plan available.

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

Suspended FEHB coverage to enroll in a Medicare managed care plan: If you are an annuitant or former spouse, you can suspend your FEHB coverage to enroll in a Medicare managed care plan, eliminating your FEHB premium. (OPM does not contribute to your Medicare managed care 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 managed care plan's service area.

- **If you do not enroll in Medicare Part A or Part B**

If you do not have one or both Parts of Medicare, you can still be covered under the the FEHB Program. We will not require you to enroll in Medicare Part B and, if you can't get premium-free Part A, we will not ask you to enroll in it.

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 a one of these programs, eliminating your FEHB premium. (OPM does not contribute to any applicable plan premiums.) For information on suspending your FEHB enrollment, contact your retirement office. If you later want to re-enroll in the FEHB Program, generally you may do so only at the next Open Season unless you involuntarily lose coverage under the program.

Workers' Compensation

We do not cover services that:

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

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

Medicaid

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

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

When other Government agencies are responsible for your care

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

When others are responsible for injuries

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

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

Section 10. Definitions of terms we use in this brochure

Calendar year

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

Coinsurance

Coinsurance is the percentage of our allowance that you must pay for your care. See page 11.

Copayment

A copayment is a fixed amount of money you pay when you receive covered services. See page 11.

Covered services

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

Custodial care

Care that is primarily for meeting personal needs: such as walking, getting in and out of bed, bathing, dressing, shopping, eating and preparing meals, performing general household services, or taking medicine. Custodial care that lasts 90 days or more is sometimes know as Long term care.

Deductible

A deductible is a fixed amount of covered expenses you must incur for certain covered services and supplies before we start paying benefits for those services. See page 11.

Experimental or investigational services

A health product or service is deemed Experimental, Investigational or Unproven if one of the following criteria are met: (1) Any drug not approved for use by the FDA; any drug that is classified as IND (investigational new drug) by the FDA; any drug requiring pre-authorization that is proposed for off-label prescribing; (2) Any health service or product that is subject to Investigational Review Board (IRB) review or approval; (3) Any health service or product that is the subject of a clinical trial that meets criteria for Phase I, Phase II or Phase III as set forth by FDA regulations; (4) Any health product or service that is not considered standard treatment by the medical community, based on clinical evidence reported by peer review medical literature and by generally recognized academic experts.

Group health coverage

Health care benefits that are available as a result of your employment, or the employment of your spouse, and that are offered by an employer or through membership in an employee organization. Health care coverage may be insured or indemnity coverage, self-insured or self-funded coverage, or coverage through health maintenance organizations or other managed care plans. Health care coverage purchased through membership in an organization is also "group health coverage."

Medical necessity

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

Our allowance Is the amount we use to determine our payment and your coinsurance for covered services. When you receive services or supplies from Plan providers, it is the amount that we set for the services or supplies if we were to charge for them. When you receive services from non-Plan providers, we determine the amount that we believe is usual and customary for the service or supply, and compare it to the charges. Our allowance is based upon the reasonableness of the charges. If the charges exceed what we believe is reasonable, you may be responsible for the excess over our allowance in addition to your coinsurance.

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

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

Section 11. FEHB facts

No pre-existing condition limitation

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

Where you can get information about enrolling in the FEHB Program

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

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

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

Types of coverage available for you and your family

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

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

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

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

Children's Equity Act

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

If this law applies to you, you must enroll for Self and Family coverage in a health plan that provides full benefits in the area where your children live or provide documentation to your employing office that you have obtained other health benefits coverage for your

children. If you do not do so, your employing office will enroll you involuntarily as follows:

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

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

When benefits and premiums start

The benefits in this brochure are effective on 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. Annuitants' coverage and premiums begin on January 1. If you joined at any other time during the year, your employing office will tell you the effective date of coverage.

When you retire

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

When you lose benefits

•When FEHB coverage ends

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

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

You may be eligible for spouse equity coverage or Temporary Continuation of Coverage.

• Spouse equity coverage

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

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

Enrolling in TCC. Get the RI 79-27, which describes TCC, and the RI 70-5, the *Guide to Federal Employees Health Benefits Plans for Temporary Continuation of Coverage and Former Spouse Enrollees*, from your employing or retirement office or from www.opm.gov/insure. It explains what you have to do to enroll.

- **Converting to individual coverage**

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

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

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

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

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

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is a Federal law that offers limited Federal protections for health coverage availability and continuity to people who lose employer group coverage. If you leave the FEHB Program, we will give you a Certificate of Group Health Plan Coverage that indicates how long you have been enrolled with us. You can use this certificate when getting health insurance or other health care coverage. Your new plan must reduce or eliminate waiting periods, limitations, or exclusions for health related conditions based on the information in the certificate, as long as you enroll within 63 days of losing coverage under this Plan. If you have been enrolled with us for less than 12 months, but were previously enrolled in other FEHB plans, you may also request a certificate from those plans. For more information, get OPM pamphlet RI 79-27, Temporary Continuation of Coverage (TCC) under the FEHB Program. See also the FEHB web site (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 have information about Federal and State agencies you can contact for more information.

Long Term Care Insurance Is Still Available!

Open Season for Long Term Care Insurance

- You can protect yourself against the high cost of long term care by applying for insurance in the Federal Long Term Care Insurance Program.
- Open Season to apply for long term care insurance through LTC Partners ends on December 31, 2002.
- If you're a Federal employee, you and your spouse need only answer a few questions about your health during Open Season.
- If you apply during the Open Season, your premiums are based on your age as of July 1, 2002. After Open Season, your premiums are based on your age at the time LTC Partners receives your application.

FEHB Doesn't Cover It

- Neither FEHB plans nor Medicare cover the cost of long term care. Also called "custodial care", long term care helps you perform the activities of daily living such as bathing or dressing yourself. It can also provide help you may need due to a severe cognitive impairment such as Alzheimer's disease.

You Can Also Apply Later, But…

- Employees and their spouses can still apply for coverage after the Federal Long Term Care Insurance Program Open Season ends, but they will have to answer more health-related questions.
- For annuitants and other qualified relatives, the number of health-related questions that you need to answer is the same during and after the Open Season.

You Must Act to Receive an Application

- Unlike other benefit programs, YOU have to take action – you won't receive an application automatically. You must request one through the toll-free number or website listed below.
- Open Season ends December 31, 2002 – act NOW so you won't miss the abbreviated underwriting available to employees and their spouses, and the July 1 "age freeze"!

Find Out More – Contact LTC Partners by calling **1-800-LTC-FEDS (1-800-582-3337) (TDD for the hearing impaired: 1-800-843-3557)** or visiting www.ltcfeds.com to get more information and to request an application.

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

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Summary of benefits for the Coventry Health Care of Kansas, Inc. –2003

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

Benefits	You Pay	Page
Medical services provided by physicians: • Diagnostic and treatment services provided in the office	Office visit copay: $15 primary care or specialist	13
Services provided by a hospital: • Inpatient ..... • Outpatient.....	$100 per day up to a $300 maximum per admission. $50 copay for ambulatory surgery	28 29
Emergency benefits: • In-area ..... • Out-of-area.....	$75 per Emergency room visit Nothing	32 32
Mental health and substance abuse treatment	Regular cost sharing.	34
Prescription drugs.....	$10 per generic formulary; $20 per brand name formulary; $50 per generic or brand name non-formulary **Mail Order:** $20 per generic formulary; $40 per brand name formulary Note: Our mail order benefit is only a 2 tier benefit as listed	36
Dental Care.....	Comprehensive benefit	40
Vision Care.....	Refraction: $15 per office visit	19
Special features: 24 hour nurse line; Services for deaf and hearing impaired, Transplant Network, Flexible Benefits Option		39
Protection against catastrophic costs (your catastrophic protection out-of-pocket maximum).....	Nothing after $2,000/Self Only or $4,000/Family enrollment per year Some costs do not count toward this protection (see page 11)	11

2003 Rate Information for
Coventry Health Care of Kansas, Inc.

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

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

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

		Non-Postal Premium				***Postal Premium***	
		Biweekly		**Monthly**		**Biweekly**	
Type of **Enrollment**	Code	Gov't Share	Your Share	Gov't Share	Your Share	**USPS** Share	**Your** Share
High Option **Self Only**	**HA1**	**$85.49**	**$28.49**	**$185.22**	**$61.74**	**$101.16**	**$12.82**
High Option Self & Family	**HA2**	**$220.56**	**$73.52**	**$477.88**	**$159.29**	**$261.00**	**$33.08**