

Coventry Health Care of Louisiana

<http://www.chclouisiana.com>

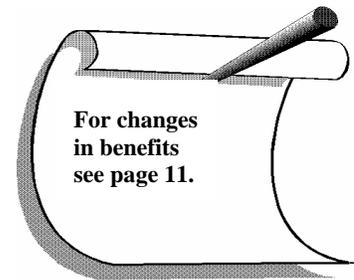


2006

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

Serving: The New Orleans, Baton Rouge and Shreveport areas.

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



Enrollment code for this Plan:

Baton Rouge area

- JA1 High Option – Self Only**
- JA2 High Option – Self and Family**
- JA4 Standard Option – Self Only**
- JA5 Standard Option - Self and Family**
- LT1 High Deductible Health Plan (HDHP) – Self Only**
- LT2 High Deductible Health Plan (HDHP) – Self and Family**

New Orleans area

- BJ1 High Option – Self Only**
- BJ2 High Option – Self and Family**
- BJ4 Standard Option – Self Only**
- BJ5 Standard Option - Self and Family**
- HB1 High Deductible Health Plan (HDHP) – Self Only**
- HB2 High Deductible Health Plan (HDHP) – Self and Family**

Shreveport area

- HS1 High Option – Self Only**
- HS2 High Option – Self and Family**
- HS4 Standard Option – Self Only**
- HS5 Standard Option - Self and Family**
- L31 High Deductible Health Plan (HDHP) – Self Only**
- L32 High Deductible Health Plan (HDHP) – Self and Family**



Authorized for distribution by the:



**United States
Office of Personnel Management**

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

RI 73-244

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

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

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

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

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

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

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

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

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

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

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

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

- Ask OPM to limit how your personal medical information is used or given out. However, OPM may not be able to agree to your request if the information is used to conduct operations in the manner described above.
- Get a separate paper copy of this notice.

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

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

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

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

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

Important Notice from Coventry Health Care of Louisiana About Our Prescription Drug Coverage and Medicare

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

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

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

Please be advised

If you lose or drop your FEHB coverage, you will have to pay a higher Part D premium if you go without equivalent prescription drug coverage for a period of 63 days or longer. If you enroll in Medicare Part D, your premium will increase 1 percent per month for each month you did not have equivalent prescription drug coverage. For example, if you go 19 months without Medicare Part D prescription drug coverage, your premium will always be at least 19 percent higher than what most other people pay. You may also have to wait until the next open enrollment period to enroll in Medicare Part D.

Medicare's Low Income Benefits

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

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

Visit www.medicare.gov for personalized help,

Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

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Introduction

This brochure describes the benefits of Coventry Health Care of Louisiana under our contract (CS 2050) with the United States Office of Personnel Management, as authorized by the Federal Employees Health Benefits law. The address for Coventry Health Care of Louisiana administrative offices is:

Coventry Health Care of Louisiana
3838 North Causeway Blvd., Suite 3350
Metairie, LA 70002

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, 2006, unless those benefits are also shown in this brochure.

OPM negotiates benefits and rates with each plan annually. Benefit changes are effective January 1, 2006, and changes are summarized on page 11. Rates are shown at the end of this brochure.

Plain Language

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

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

If you have comments or suggestions about how to improve the structure of this brochure, let OPM know. Visit OPM’s “Rate Us” feedback area at www.opm.gov/insure or e-mail OPM at fehwebcomments@opm.gov. You may also write to OPM at the U.S. Office of Personnel Management, Insurance Services Programs, Program Planning & Evaluation Group, 1900 E Street, NW, Washington, DC 20415-3650.

Stop Health Care Fraud!

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

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

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

- 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 800/314-6613 and explain the situation.

If we do not resolve the issue:

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

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

- Do not maintain as a family member on your policy:

Your former spouse after a divorce decree or annulment is final (even if a court order stipulates otherwise); or

Your child over age 22 (unless he/she is disabled and incapable of self support).

- If you have any questions about the eligibility of a dependent, check with your personnel office if you are employed, with your retirement office (such as OPM) if you are retired, or with the National Finance Center if you are enrolled under Temporary Continuation of Coverage.
- You can be prosecuted for fraud and your agency may take action against you if you falsify a claim to obtain FEHB benefits or try to obtain services for someone who is not an eligible family member or who is no longer enrolled in the Plan.

Preventing medical mistakes

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

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

Ask questions and make sure you understand the answers.

Choose a doctor with whom you feel comfortable talking.

Take a relative or friend with you to help you ask questions and understand answers.

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

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

Tell them about any drug allergies you have.

Ask about any risks or side effects of the medication and what to avoid while taking it. Be sure to write down what your doctor or pharmacist says.

Make sure your medicine is what the doctor ordered. Ask the pharmacist about your medicine if it looks different than you expected.

Read the label and patient package insert when you get your medicine, including all warnings and instructions.

Know how to use your medicine. Especially note the times and conditions when your medicine should and should not be taken.

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

Ask when and how you will get the results of tests or procedures.

Don't assume the results are fine if you do not get them when expected, be it in person, by phone, or by mail.

Call your doctor and ask for your results.

Ask what the results mean for your care.

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

Ask your doctor about which hospital has the best care and results for your condition if you have more than one hospital to choose from to get the health care you need.

Be sure you understand the instructions you get about follow-up care when you leave the hospital.

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

Make sure you, your doctor, and your surgeon all agree on exactly what will be done during the operation.

Ask your doctor, “Who will manage my care when I am in the hospital?”

Ask your surgeon:

Exactly what will you be doing?

About how long will it take?

What will happen after surgery?

How can I expect to feel during recovery?

Tell the surgeon, anesthesiologist, and nurses about any allergies, bad reaction to anesthesia, and any medications you are taking.

Want more information on patient safety?

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

Section 1. Facts about this plan

General features of our High and Standard Option Plans- HMO Plan:

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

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

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

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

General features of our High Deductible Health Plan (HDHP):

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

- Using the most cost effective provider

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

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

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

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

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

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

You may use the money in your I to pay all or a portion of the annual deductible, copayments, coinsurance, or other out-of-pocket costs that meet the IRS definition of a qualified medical expense. Distributions from your I are tax-free for qualified medical expenses for you, your spouse, and your dependents, even if they are not covered by a HDHP. You may withdraw money from your I for items other than qualified medical expenses, but it will be subject to income tax and, if you are under 65 years old, an additional 10% penalty tax on the amount withdrawn.

For each month that you are enrolled in an HDHP and eligible for an I, the HDHP will pass through (contribute) a portion of the health plan premium to your I. In addition, you (the account holder) may contribute your own money to your I up to an allowable amount determined by IRS rules. In addition, your I dollars earn tax-free interest.

You may allow the contributions in your I to grow over time, like a savings account. The I is portable – you may take the I with you if you leave the Federal government or switch to another plan.

- If you are not eligible for an I, or become ineligible to continue an I, you are eligible for a Health Reimbursement Arrangement (HRA). Although an HRA is similar to an I, there are major differences. An HRA does not earn interest.
 - An HRA is not portable if you leave the Federal government or switch to another plan.
 - An HRA does not earn interest.
- We protect you against catastrophic out-of-pocket expenses for covered services. Your annual out-of-pocket expenses for covered services, including deductibles and copayments, are limited to \$4,000 for Self-Only enrollment, or \$8,000 for family coverage.

We have network providers

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

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

How we pay providers

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

If you have any questions regarding choosing a doctor, please call our Member Services Department at 800/341-6613.

The Plan's provider directory lists primary care doctors (generally family practitioners, pediatricians, and internists) with their locations and phone numbers, and notes whether or not the doctor is accepting new patients. Directories are updated on a regular basis and are available at the time of enrollment or upon request by calling the Member Services Department at 800/341-6613; you can also find out if your doctor participates with this Plan by calling this number. If you are interested in receiving care from a specific provider who is listed in the directory, call the provider to verify that he or she still participates with the Plan and is accepting new patients. Important note: When you enroll in this Plan, services (except for emergency benefits) are provided through the Plan's delivery system; the continued availability and/or participation of any one doctor, hospital, or other provider, cannot be guaranteed.

If you are receiving services from a doctor who leaves the Plan, the Plan will pay for covered services until the Plan can arrange with you for you to be seen by another participating doctor.

Your Rights

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

- Coventry Health Care is a Federally qualified health maintenance organization (HMO)
- Profit status – For profit

If you want more information about us, call 800/341-6613, or write to Coventry Health Care of Louisiana, Inc., 3838 North Causeway Blvd., Suite 3350, Metairie, LA 70002. You may also contact us by fax at 504/834-2694 or visit our website at www.chclouisiana.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 the following parishes:

New Orleans service area: Jefferson, Orleans, Plaquemines, St. Bernard, St. Charles and St. Tammany.

Baton Rouge service area: Ascension, Livingston, St. John the Baptist, East Baton Rouge, West Baton Rouge, Assumption, East Feliciana, Iberville, Lafayette, Pointe Coupee, St. Helena, St. James, Tangipahoa, Vermillion, West Feliciana and Washington.

Shreveport service area: Bossier, Caddo, DeSoto, Red River and Webster.

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

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

Section 2. How we change for 2006

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.

Changes to this Plan

- We added a new standard option for 2006.
- We added Bossier, Cado, DeSoto, Red River and Webster parishes to our service area for 2006.

Changes to High Option only

- Baton Rouge Area – Your share of the non-Postal premium will increase by 131.8% for Self-Only or 139.4% for Self and Family.
- New Orleans Area – Your share of the non-Postal premium will increase by 11.7% for Self-Only or 11.7% for Self and Family.
- The inpatient hospital admission copayment is now \$150 per day up to \$450 maximum per admission. Previously, the copayment was \$100 per day up to a \$300 maximum per admission.
- The outpatient hospital copayment is now \$100 per facility use. Previously, the copayment was \$50 for facility use.
- The hospital emergency room copayment is now \$100 per visit. Previously, the copayment was \$50 per visit.
- The ambulance copayment is now \$100 per trip. Previously, the copayment was \$50 per trip.
- The retail prescription drug copayments are now \$10 per generic formulary, \$25 per formulary drugs, and \$50 per non-formulary drugs. Previously, the copayments were \$10 per generic formulary, \$20 per formulary drugs, and \$45 per non-formulary drugs.
- The mail-order prescription drug copayments are now \$20 per generic formulary, \$50 per formulary drugs, and \$100 per non-formulary drugs. Previously, the copayments were \$20 per generic formulary, \$40 per formulary drugs, and \$90 per non-formulary drugs.

Changes to High Deductible Health Plan only

- Baton Rouge Area – Your share of the non-Postal premium will increase by 105.6% for Self-Only or 115% per Self and Family.
- New Orleans Area – Your share of the non-Postal premium will increase by 23.6% for Self-Only or 23.6% for Self and Family.

In-network

- The individual deductible is \$1,100 instead of \$1,050.
- The family deductible is \$2,200 instead of \$2,100.

Section 3. How you get care

Identification cards	<p>We will send you an identification (ID) card when you enroll. You should carry your ID card with you at all times. You must show it whenever you receive services from a Plan provider, or fill a prescription at a Plan pharmacy. Until you receive your ID card, use your copy of the Health Benefits Election Form, SF-2809, your health benefits enrollment confirmation letter (for annuitants), or your electronic enrollment system (such as Employee Express) confirmation letter.</p> <p>If you do not receive your ID card within 30 days after the effective date of your enrollment, or if you need replacement cards, call us at 800-341-6613. You may also request replacement cards through our Web site at www.chclouisiana.com</p>
Where you get covered care	<p>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.</p>
Plan providers	<p>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.</p> <p>We list Plan providers in the provider directory, which we update periodically. The list is also on our Web site.</p>
Plan facilities	<p>Plan facilities are hospitals and other facilities in our service area that we contract with to provide covered services to our members. We list these in the provider directory, which we update periodically. The list is also on our Web site.</p>
What you must do to get covered care	<p>It depends on the type of care you need.</p>
Primary care	<p>Coventry does not require you to select a primary care physician.</p>

Specialty care

You may see a Specialist in the network without a referral.

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

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

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

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

Reduce our service area and you enroll in another FEHB Plan,

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

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

Hospital care

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

If you are in the hospital when your enrollment in our Plan begins, call our customer service department immediately at 800-341-6613. 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. If your plan terminates participation in the FEHB Program in whole or in part, or if OPM orders an enrollment change, this continuation of coverage provision does not apply. In such case, the hospitalized family member's benefits under the new plan begin on the effective date of enrollment.

Circumstances beyond our control

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

Services requiring our prior approval

For certain services 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. Your physician must obtain prior authorization.

Your physician must get the Plan's approval before sending you to a hospital or recommended follow-up care. Before giving approval, we consider if the service is medically necessary, and if it follows generally accepted medical practice.

If you obtain services from a specialist, hospital or other health care provider, the services will be covered only if medically necessary and authorized, except in the case of emergency medical services and urgent care. Certain services, such as, but limited to inpatient hospital services, outpatient surgeries/treatments, skilled nursing facilities, home health services, durable medical equipment, certain diagnostic tests and subacute care also require approval of the utilization review department before the services are initiated.

Section 4. Your costs for covered services

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

Copayments

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

High Option: Example: when you see your physician you pay a \$15 copayment per office visit.

Deductible

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

High Option: We have no deductible.

Standard Option: The calendar year deductible amount is \$500 for individual and \$1,000 for family coverage.

High Deductible Health Plan:

In-network: The calendar year deductible amount is \$1,100 for individual coverage (subscribers covering no spouse or dependents) and \$2,200 for family coverage (subscribers covering spouse and/or family).

Out of Network: The calendar year deductible amount is \$2,000 for individual coverage (subscribers covering no spouse or dependents) and \$4,000 for family coverage (subscribers covering spouse and/or family).

No benefit is payable for Covered Services subject to a Deductible, until the Deductible is met. You are responsible for paying Your Deductible. The individual Deductible is a limit on the amount You must pay before you receive benefits. The family Deductible is the limit on the total amount Members of the same family covered under this Agreement must pay before receiving benefits.

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

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

Coinsurance

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

High Option: Example: you pay 50% of our allowance for infertility and allergy testing.

Standard Option: Example: you pay 20% of our allowance for outpatient surgery.

High Deductible Health Plan: Example: In network – you pay 20% of our allowance for durable medical equipment after you have met the deductible. Out of network – you pay 30% of our allowance for durable medical equipment after you have met the deductible.

Note: If your provider routinely waives (does not require you to pay) your copayments, deductibles, or coinsurance, the provider is misstating the fee and may be violating the law. In

this case, when we calculate our share, we will reduce the provider's fee by the amount waived.

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

Your catastrophic protection out-of-pocket maximum

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

- Certain Outpatient Facility Services
- Infertility treatment

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

Standard Option: After your total \$2,500 per person or \$5,000 per family enrollment in any calendar year, you do not have to pay any more for covered services. However, copayments for the following services do not count toward your catastrophic protection out-of-pocket maximum, and you must continue to pay copayments for these services

High Deductible Health Plan:

In network – Your out-of pocket maximum for this plan is \$4,000 per individual and \$8,000 per family.

Out of network – Your out-of pocket maximum for this plan is \$6,000 per individual and \$12,000 per family

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

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

Differences between our allowance and the bill

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

High and Standard Option Benefits

See page 11 for how our benefits changed this year. Page 107 and page 108 are a benefits summary of each option. Make sure that you review the benefits that are available under the option in which you are enrolled.

To obtain more information about our benefits, contact us at 800-341-6613 or at our Web site at www.chclouisiana.com

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

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan physicians must provide or arrange your care.
- High Option – We have no deductible.
- Standard Option – The calendar year deductible is \$500 per person and \$1,000 per family.
- 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.

Diagnostic and treatment services	You pay	After the calendar year deductible, you pay
	High Option	Standard Option
Professional services of physicians <ul style="list-style-type: none"> • In physician’s office 	\$15 per office visit	\$20 per visit to a primary care physician \$30 per visit to a specialist
Professional services of physicians <ul style="list-style-type: none"> • In an urgent care center • Office medical consultations • Second surgical opinion 	\$15 per office visit	\$20 per visit to a primary care physician \$30 per visit to a specialist
<ul style="list-style-type: none"> • At home 	\$25 per visit	\$25 per visit

Lab, X-ray and other diagnostic tests	You pay	After the calendar year deductible, you pay
	High Option	Standard Option
Tests, such as: Blood tests Urinalysis Non-routine pap tests Pathology X-rays Non-routine Mammograms Ultrasound Electrocardiogram and EEG	Nothing	Nothing
<ul style="list-style-type: none"> • CAT Scans/MRI 	Nothing	20% after deductible
Preventive care, adult		
Routine screenings, such as: Total Blood Cholesterol Colorectal Cancer Screening, including Fecal occult blood test Sigmoidoscopy, screening – every five years starting at age 50 Double contrast barium enema – every five years starting at age 50 Colonoscopy screening – every ten years starting at age 50	\$15 per office visit	\$20 per visit to a primary care physician \$30 per visit to a specialist
Routine Prostate Specific Antigen (PSA) test – one annually for men age 40 and older	\$15 per office visit	\$20 per visit to a primary care physician \$30 per visit to a specialist

Preventive care, adult – continued on next page

Preventive care, adult <i>(continued)</i>	You pay	After the calendar year deductible, you pay
	High Option	Standard Option
Routine Pap test Note: You do not pay a separate copay for a pap test performed during your routine annual physical, see <i>Diagnosis and Treatment</i> , above.	\$15 per office visit	\$20 per visit to a primary care physician \$30 per visit to a specialist
Routine mammogram – covered for women age 35 and older, as follows: From age 35 through 39, one baseline during this five year period From age 40 through 49, one every 24 months or more frequently if recommended by a Participating Physician At age 50 and older, one every 12 months	Nothing	Nothing
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 older	\$15 per office visit	\$20 per visit to a primary care physician \$30 per visit to a specialist
<i>Not covered: Physical exams required for obtaining or continuing employment or insurance, attending schools or camp, or travel.</i>	<i>All charges.</i>	<i>All charges.</i>
Preventive care, children		
Childhood immunizations recommended by the American Academy of Pediatrics	\$15 per office visit	\$20 per visit to a primary care physician \$30 per visit to a specialist
Well-child care charges for routine examinations, immunizations and care (up to age 22) Examinations, such as: Eye exams through age 17 to determine the need for vision correction Ear exams through age 17 to determine the need for hearing correction Examinations done on the day of immunizations (up to age 22)	\$15 per office visit	\$20 per visit to a primary care physician \$30 per visit to a specialist

Maternity care	You pay	After the calendar year deductible, you pay
	High Option	Standard Option
<p>Complete maternity (obstetrical) care, such as:</p> <p>Prenatal care</p> <p>Delivery</p> <p>Postnatal care</p> <p>Note: Here are some things to keep in mind:</p> <p>You do not need to precertify your normal delivery; see page 13 for other circumstances, such as extended stays for you or your baby.</p> <p>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.</p> <p>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</p> <p>We pay hospitalization and surgeon services (delivery) the same as for illness and injury. See Hospital benefits (Section 5c) and Surgery benefits (Section 5b).</p>	<p>\$15 copayment for initial visit only</p>	<p>\$30 copayment for initial visit only</p>
<p><i>Not covered: Routine sonograms to determine fetal age, size or sex.</i></p>	<p><i>All charges.</i></p>	<p><i>All charges.</i></p>
Family planning		
<p>A range of voluntary family planning services, limited to:</p> <ul style="list-style-type: none"> • Surgically implanted contraceptives (such as Norplant) • Injectable contraceptive drugs (such as Depo provera) • Diaphragm (fitting only) <p>Note: We cover oral contraceptives under the prescription drug benefit.</p>	<p>\$15 per office visit</p>	<p>20% coinsurance</p>
<p>Voluntary sterilization (vasectomy or tubal ligation)</p>	<p>\$100 per procedure</p>	<p>20% coinsurance</p>
<p><i>Not covered:</i></p> <p><i>Reversal of voluntary surgical sterilization</i></p> <p><i>Genetic counseling.</i></p> <p><i>Intrauterine Devices (IUDs).</i></p>	<p><i>All charges.</i></p>	<p><i>All charges.</i></p>

Infertility services	You pay	After the calendar year deductible, you pay
	High Option	Standard Option
Diagnosis and treatment of infertility such as: Artificial insemination: intravaginal insemination (IVI) intracervical insemination (ICI) intrauterine insemination (IUI)	50% of charges	20% coinsurance
<i>Not covered:</i> <i>Assisted reproductive technology (ART) procedures, such as:</i> <i>in vitro fertilization</i> <i>embryo transfer, gamete intra-fallopian transfer (GIFT) and zygote intra-fallopian transfer (ZIFT)</i> <i>Services and supplies related to ART procedures</i> <i>Cost of donor sperm</i> <i>Cost of donor egg</i> <i>Fertility Drugs</i>	<i>All charges.</i>	<i>All charges.</i>
Allergy care		
Testing Allergy injections and treatments	50% of charges \$15 per office visit	20% coinsurance \$20 per visit to a primary care physician \$30 per visit to a specialist
Allergy serum	Nothing	Nothing
<i>Not covered: Provocative food testing and sublingual allergy desensitization</i>	<i>All charges.</i>	<i>All charges.</i>

Treatment therapies	You pay	After the calendar year deductible, you pay
	High Option	Standard Option
<p>Chemotherapy and radiation therapy</p> <p>Note: High dose chemotherapy in association with autologous bone marrow transplants is limited to those transplants listed under Organ/Tissue Transplants on page 30.</p> <p>Respiratory and inhalation therapy</p> <p>Dialysis – hemodialysis and peritoneal dialysis</p> <p>Intravenous (IV)/Infusion Therapy – Home IV and antibiotic therapy</p> <p>Oxygen for home use and equipment</p> <p>Growth hormone therapy (GHT)</p> <p>Note: Growth hormone is covered under the prescription drug benefit.</p>	\$15 per office visit	20% coinsurance
Physical and occupational therapies		
<p>60 consecutive days per condition for the services of each of the following:</p> <p>qualified physical therapists and</p> <p>occupational therapists</p> <p>Note: We only cover therapy to restore bodily function when there has been a total or partial loss of bodily function due to illness or injury.</p> <p>Cardiac rehabilitation following a heart transplant, bypass surgery or a myocardial infarction is provided for up to 60 days for physical therapy.</p>	20% of charges	20% coinsurance
<p><i>Not covered:</i></p> <p><i>Long-term rehabilitative therapy</i></p> <p><i>Exercise programs</i></p>	<i>All charges.</i>	<i>All charges.</i>
Speech therapy		
60 consecutive days per condition	20% of charges.	20% coinsurance

Hearing services (testing, treatment, and supplies)	You pay	After the calendar year deductible, you pay
	High Option	Standard Option
Hearing testing for children through age 17 (see <i>Preventive care, children</i>)	\$15 per office visit	\$20 per visit to a primary care physician \$30 per visit to a specialist
<i>Not covered:</i> <i>All other hearing testing</i> <i>Hearing aids, testing and examinations for them</i>	<i>All charges.</i>	<i>All charges.</i>
Vision services (testing, treatment, and supplies)		
Diagnosis and treatment of diseases of the eye	\$15 per office visit	\$30 per office visit
Prosthetic devices, such as lenses following cataract removal	50% of charges	\$30 per office visit
<i>Not covered:</i> <i>Eyeglasses or contact lenses and after age 17, examinations for them</i> <i>Eye exercises and orthoptics</i> <i>Radial keratotomy and other refractive surgery</i> <i>Annual eye refractions</i>	<i>All charges.</i>	<i>All charges.</i>
Foot care		
Routine foot care when you are under active treatment for a metabolic or peripheral vascular disease, such as diabetes. Note: See Orthopedic and prosthetic devices for information on podiatric shoe inserts.	\$15 per office visit	\$20 per visit to a primary care physician \$30 per visit to a specialist.
<i>Not covered:</i> <i>Cutting, trimming or removal of corns, calluses, or the free edge of toenails, and similar routine treatment of conditions of the foot, except as stated above</i> <i>Treatment of weak, strained or flat feet or bunions or spurs; and of any instability, imbalance or subluxation of the foot (unless the treatment is by open cutting surgery)</i>	<i>All charges.</i>	<i>All charges.</i>

Orthopedic and prosthetic devices	You pay	After the calendar year deductible, you pay
	High Option	Standard Option
<p>High Option – Our maximum allowance for this benefit is \$1,000 per calendar year.</p> <p>Standard Option – Our maximum allowance for this benefit is \$5,000 per calendar year.</p> <p>Artificial limbs and eyes; stump hose</p> <p>Externally worn breast prostheses and surgical bras, including necessary replacements following a mastectomy</p> <p>Internal prosthetic devices, such as artificial joints, pacemakers, cochlear implants, and surgically implanted breast implant following mastectomy. Note: See 5(b) for coverage of the surgery to insert the device.</p> <p>Orthopedic devices, such as braces</p> <p>Foot orthotics</p> <p>Corrective orthopedic appliances for non-dental treatment of temporomandibular joint (TMJ) pain dysfunction syndrome.</p>	<p>Nothing up to our maximum allowance.</p> <p>All charges over the maximum.</p>	<p>20% coinsurance up to the maximum allowance of \$5,000 per calendar year.</p> <p>All charges over the maximum.</p>
<p><i>Not covered:</i></p> <p><i>Heel pads and heel cups</i></p> <p><i>Lumbosacral supports</i></p> <p><i>Corsets, trusses, elastic stockings, support hose, and other supportive devices</i></p>	<p><i>All charges.</i></p>	<p><i>All charges.</i></p>

Durable medical equipment (DME)	You pay	After the calendar year deductible, you pay
	High Option	Standard Option
<p>High Option – Our maximum allowance for this benefit is \$1,000 per calendar year.</p> <p>Standard Option – Our maximum allowance for this benefit is \$5,000 per calendar year.</p> <p>Rental or purchase, at our option, including repair and adjustment, of durable medical equipment prescribed by your Plan physician, such as oxygen and dialysis equipment. Under this benefit, we also cover:</p> <ul style="list-style-type: none"> • Hospital beds; • Wheelchairs; • Crutches; • Walkers; • Blood glucose monitors; and • Insulin pumps. <p>Note: Call us at 800-341-6613 as soon as your Plan physician prescribes this equipment.</p>	<p>Nothing up to our maximum allowance.</p> <p>All charges over the maximum.</p>	<p>20% coinsurance up to the maximum allowance of \$5,000 per calendar year.</p> <p>All charges over the maximum.</p>
<p><i>Not covered: Motorized wheelchairs.</i></p>	<p><i>All charges.</i></p>	<p><i>All charges.</i></p>
Home health services		
<p>Home health care ordered by a Plan physician and provided by a registered nurse (R.N.), licensed practical nurse (L.P.N.), licensed vocational nurse (L.V.N.), or home health aide.</p> <p>Services include oxygen therapy, intravenous therapy and medications.</p>	<p>Nothing</p>	<p>20% coinsurance</p>
<p><i>Not covered:</i></p> <p><i>Nursing care requested by, or for the convenience of, the patient or the patient's family;</i></p> <p><i>Home care primarily for personal assistance that does not include a medical component and is not diagnostic, therapeutic, or rehabilitative.</i></p> <p><i>Nursing aides</i></p>	<p><i>All charges.</i></p>	<p><i>All charges.</i></p>

Chiropractic	You pay	After the calendar year deductible, you pay
	High Option	Standard Option
Manipulation of the spine and extremities After initial evaluation, treatment plan must be submitted to Coventry Health Care to authorize additional visits.	\$15 per office visit	\$30 per office visit
Alternative treatments		
<i>No benefit</i>	<i>All charges.</i>	<i>All charges.</i>

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

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan physicians must provide or arrange your care.
- High Option – We have no deductible.
- Standard Option - The calendar year deductible is \$500 per person and \$1,000 per family.
- Be sure to read Section 4, Your costs for covered services, for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- The amounts listed below are for the charges billed by a physician or other health care professional for your surgical care. Look in Section 5(c) for charges associated with the facility (i.e. hospital, surgical center, etc.).
- **YOUR PHYSICIAN MUST GET PRECERTIFICATION OF SOME SURGICAL PROCEDURES.** Please refer to the precertification information shown in Section 3 to be sure which services require precertification and identify which surgeries require precertification.

Benefit Description	You pay	After the calendar year deductible, you pay
Surgical procedures	High Option	Standard Option
A comprehensive range of services, such as:	\$15 per office visit	\$20 per visit to a primary care physician
Operative procedures		
Treatment of fractures, including casting		\$30 per visit to a specialist
Normal pre- and post-operative care by the surgeon		
Endoscopy procedures		
Biopsy procedures		
Removal of tumors and cysts		
Correction of congenital anomalies (see Reconstructive surgery)		

Surgical procedures - continued on next page

Surgical procedures (<i>continued</i>)	You pay	
	High Option	After the calendar year deductible, you pay Standard Option
Surgical treatment of morbid obesity (biatric surgery) will be covered when <u>all</u> of the following criteria are met:	\$15 per office visit	\$20 per visit to a primary care physician \$30 per visit to a specialist
The patient is an adult (≥ 18 years of age) with morbid obesity that has persisted for at least 3 years, and for which there is no treatable metabolic cause for the obesity;		
There is presence of morbid obesity, defined as a body mass index (BMI) exceeding 40, or greater than 35 with documented co-morbid conditions (cardiopulmonary problems e.g., severe apnea, Pickwickian Syndrome, and obesity-related cardiomyopathy, severe diabetes mellitus, hypertension, or arthritis). (BMI is calculated by dividing a patient's weight (in kilograms) by height (in meters) squared. To convert pounds to kilograms, multiply pounds by 0.45. To convert inches to meters, multiply inches by .0254);		
The patient has failed to lose weight (approximately 10% from baseline) or has regained weight despite participation in a three month physician-supervised multidisciplinary program within the past six months that included dietary therapy, physical activity and behavior therapy and support;		
The patient has been evaluated for restrictive lung disease and received surgical clearance by a pulmonologist, if clinically indicated; has received cardiac clearance by a cardiologist if there is a history of prior phen-fen or redux use, and the patient has agreed, following surgery, to participate in a multidisciplinary program that will provide guidance on diet, physical activity and social support; and,		
The patient has completed a psychological evaluation and has been recommended for bariatric surgery by a licensed mental health professional (this must be documented in the patient's medical record) and the patient's medical record reflects documentation by the treating psychotherapist that all psychosocial issues have been identified and addressed; and the psychotherapist indicates that the patient is likely to be compliant with the post-operative diet restrictions;		
Insertion of internal prosthetic devices. See 5(a) – Orthopedic and prosthetic devices for device coverage information		
Treatment of burns		
Voluntary sterilization (e.g., Tubal ligation, Vasectomy)	\$100 per procedure	20% coinsurance
<i>Not covered:</i>	<i>All charges.</i>	<i>All charges.</i>
<i>Reversal of voluntary sterilization</i>		
<i>Routine treatment of conditions of the foot; see Foot care</i>		

Reconstructive surgery	You pay	After the calendar year deductible, you pay
	High Option	Standard Option
Surgery to correct a functional defect	\$15 per office visit	\$20 per visit to a primary care physician
Surgery to correct a condition caused by injury or illness if: the condition produced a major effect on the member's appearance and can reasonably be expected to be corrected by such surgery		\$30 per visit to a specialist
Surgery to correct a condition that existed at or from birth and is a significant deviation from the common form or norm. Examples of congenital anomalies are: protruding ear deformities; cleft lip; cleft palate; birth marks; webbed fingers; and webbed toes.		
All stages of breast reconstruction surgery following a mastectomy, such as: surgery to produce a symmetrical appearance of breasts; treatment of any physical complications, such as lymphedemas; breast prostheses and surgical bras and replacements (see Prosthetic devices)		
Note: If you need a mastectomy, you may choose to have the procedure performed on an inpatient basis and remain in the hospital up to 48 hours after the procedure.		
<i>Not covered:</i>	<i>All charges.</i>	<i>All charges.</i>
<i>Cosmetic surgery – any surgical procedure (or any portion of a procedure) performed primarily to improve physical appearance through change in bodily form, except repair of accidental injury</i>		
<i>Surgeries related to sex transformation</i>		

Oral and maxillofacial surgery	You pay	After the calendar year deductible, you pay
	High Option	Standard Option
Oral surgical procedures, limited to:	\$15 per office visit	\$20 per visit to a primary care physician
Reduction of fractures of the jaws or facial bones;		\$30 per visit to a specialist
Surgical correction of cleft lip, cleft palate or severe functional malocclusion;		
Removal of stones from salivary ducts;		
Excision of leukoplakia or malignancies;		
Excision of cysts and incision of abscesses when done as independent procedures; and		
Other surgical procedures that do not involve the teeth or their supporting structures.		
TMJ treatment and services (non-dental)		
<hr/>		
<i>Not covered:</i>	<i>All charges.</i>	<i>All charges.</i>
<i>Oral implants and transplants</i>		
<i>Procedures that involve the teeth or their supporting structures (such as the periodontal membrane, gingiva, and alveolar bone)</i>		
<i>Dental care involved in treatment of temporomandibular joint (TMJ) pain dysfunction syndrome</i>		

Organ/tissue transplants	You pay	
	High Option	After the calendar year deductible, you pay Standard Option
Limited to:	\$15 per office visit	\$20 per visit to a primary care physician
Cornea		\$30 per visit to a specialist
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		
Limited Benefits – Treatment for breast cancer, multiple myeloma, and epithelial ovarian cancer may be provided in a National Cancer Institute – or National Institutes of Health-approved clinical trial at a Plan-designated center of excellence and if approved by the Plan’s medical director in accordance with the Plan’s protocols.		
Note: We cover related medical and hospital expenses of the donor when we cover the recipient		

Organ/tissue transplants – continued on next page

Organ/tissue transplants (continued)	You pay	After the calendar year deductible, you pay
	High Option	Standard Option
<p><i>Not covered:</i></p> <p><i>Donor screening tests and donor search expenses, except those performed for the actual donor</i></p> <p><i>Implants of artificial organs</i></p> <p><i>Transplants not listed as covered</i></p>	<i>All charges.</i>	<i>All charges.</i>
Anesthesia		
Professional services provided in – Hospital (inpatient)	Nothing	20% coinsurance
Professional services provided in – Hospital outpatient department Skilled nursing facility Ambulatory surgical center Office	\$15 per office visit	20% coinsurance \$20 per visit to a primary care physician \$30 per visit to a specialist

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

Important things you should keep in mind about these benefits:

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

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

- High Option – We have no deductible.
- Standard Option – The calendar year deductible is \$500 per person and \$1,000 per family.

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

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

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

Benefit Description	You pay	After the calendar year deductible, you pay
Inpatient hospital	High Option	Standard Option
<p>Room and board, such as</p> <p>Ward, semiprivate, or intensive care accommodations;</p> <p>General nursing care; and</p> <p>Meals and special diets.</p> <p>Note: If you want a private room when it is not medically necessary, you pay the additional charge above the semiprivate room rate.</p>	<p>\$150 per day up to a \$450 maximum per admission</p>	<p>\$250 per day up to a \$750 maximum per admission</p>

Inpatient hospital – continued on next page.

Inpatient hospital (<i>continued</i>)	You pay	After the calendar year deductible, you pay
	High Option	Standard Option
<p>Other hospital services and supplies, such as:</p> <p>Operating, recovery, maternity, and other treatment rooms</p> <p>Prescribed drugs and medicines</p> <p>Diagnostic laboratory tests and X-rays</p> <p>Administration of blood, blood plasma, and other biologicals</p> <p>Dressings, splints, casts, and sterile tray services</p> <p>Medical supplies and equipment, including oxygen</p> <p>Anesthetics, including nurse anesthetist services</p> <p>Take-home items</p> <p>Medical supplies, appliances, medical equipment, and any covered items billed by a hospital for use at home (Note: calendar year deductible applies.)</p>	<p>Nothing for other hospital services after you pay the hospital admission copayment.</p>	<p>Nothing for other hospital services after you pay the hospital admission copayment.</p>
<p><i>Not covered:</i></p> <p><i>Custodial care</i></p> <p><i>Non-covered facilities, such as nursing homes, schools</i></p> <p><i>Personal comfort items, such as telephone, television, barber services, guest meals and beds</i></p> <p><i>Private nursing care</i></p>	<p><i>All charges.</i></p>	<p><i>All charges.</i></p>

Outpatient hospital or ambulatory surgical center	You pay	After the calendar year deductible, you pay
	High Option	Standard Option
<p>Operating, recovery, and other treatment rooms</p> <p>Prescribed drugs and medicines</p> <p>Diagnostic laboratory tests, X-rays, and pathology services</p> <p>Administration of blood, blood plasma, and other biologicals</p> <p>Pre-surgical testing</p> <p>Dressings, casts, and sterile tray services</p> <p>Medical supplies, including oxygen</p> <p>Anesthetics and anesthesia service</p> <p>Note: We cover hospital services and supplies related to dental procedures when necessitated by a non-dental physical impairment. We do not cover the dental procedures.</p>	\$100 copayment per facility use	20% coinsurance
<i>Not covered: Blood and blood derivatives not replaced by the member</i>	<i>All charges.</i>	<i>All charges.</i>
Extended care benefits/Skilled nursing care facility benefits		
<p>High Option – we limit our coverage to 100 days per calendar year</p> <p>Standard Option - we limit our coverage to 30 days per calendar year</p> <p>Comprehensive range of benefits will be provided when full-time skilled nursing care is necessary and confinement in a skilled nursing facility is in lieu of hospitalization.</p> <p>Covered services include:</p> <ul style="list-style-type: none"> • Bed, board and general nursing care <p>Drugs, biologicals, supplies, and equipment ordinarily provided or arranged by the skilled nursing facility when prescribed by a Plan doctor</p>	Nothing	\$250 per day up to a \$750 maximum per admission
<i>Not covered: Custodial care</i>	<i>All charges.</i>	<i>All charges.</i>
Hospice care		
<p>Supportive and palliative care for a terminally ill member in the home or hospice facility. Services include inpatient and outpatient care, and family counseling. Services are provided under the direction of a Plan doctor who certifies that the patient is in the terminal stages of illness, with a life expectancy of approximately six months or less.</p>	Nothing	20% coinsurance
<i>Not covered: Independent nursing, homemaker services</i>	<i>All charges.</i>	<i>All charges.</i>

Ambulance	You pay	After the calendar year deductible, you pay
	High Option	Standard Option
Local professional ambulance service when medically appropriate	\$100 per transport	20% coinsurance

Section 5(d) Emergency services/accidents

Important things to keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- 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.
- High Option – We have no deductible.
- Standard Option - The calendar year deductible is \$500 per person and \$1,000 per family.

What is a medical emergency?

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

What to do in case of emergency:

Emergencies within our service area: If you are in an emergency situation, contact the local emergency system (e.g., the 911 telephone system) or go to the nearest hospital emergency room. Be sure to tell the emergency room personnel that you are a Plan member so they can notify the Plan.

If you need to be hospitalized in a non-Plan facility, the Plan must be notified within 24 hours or on the first working day following your admission, unless it was not reasonably possible to notify the Plan within that time. If you are hospitalized in non-Plan facilities and Plan doctors believe care can be better provided in a Plan hospital, you will be transferred when medically feasible with any ambulance charges covered in full.

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

Emergencies outside our service area: Benefits are available for any medically necessary health service that is immediately required because of injury or unforeseen illness.

If you need to be hospitalized, the Plan must be notified within 24 hours or on the first working day following your admission, unless it was not reasonably possible to notify the Plan within that time. If a Plan doctor believes care can be better provided in a Plan hospital, you will be transferred when medically feasible with any ambulance charges covered in full.

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

Benefit Description	You pay	After the calendar year deductible, you pay
Emergency within our service area	High Option	Standard Option
<ul style="list-style-type: none"> • Emergency care at a doctor’s office • Emergency care at an urgent care center • Emergency care as an outpatient at a hospital, including doctors’ services 	\$15 per office visit \$15 per office visit \$100 per visit	\$20 per office visit \$20 per office visit \$150 per visit
<i>Not covered: Elective care or non-emergency care</i>	<i>All charges.</i>	<i>All charges.</i>
Emergency outside our service area		
<ul style="list-style-type: none"> • Emergency care at a doctor’s office • Emergency care at an urgent care center • Emergency care as an outpatient at a hospital, including doctors’ services 	\$15 per office visit \$15 per office visit \$100 per visit	\$20 per office visit \$20 per office visit \$150 per visit
<i>Not covered:</i> <ul style="list-style-type: none"> • <i>Elective care or non-emergency care</i> • <i>Emergency care provided outside the service area if the need for care could have been foreseen before leaving the service area</i> • <i>Medical and hospital costs resulting from a normal full-term delivery of a baby outside the service area</i> 	<i>All charges</i>	<i>All charges</i>
Ambulance		
Professional ambulance service when medically appropriate. Note: See 5(c) for non-emergency service.	\$100 per transport	20% coinsurance

Section 5(e) Mental health and substance abuse benefits

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

Important things to keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- 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.
- High Option – We have no deductible.
- Standard Option - The calendar year deductible is \$500 per person and \$1,000 per family.
- **YOU MUST GET PREAUTHORIZATION OF THESE SERVICES.** See the instructions after the benefits description below.

Benefit Description	You pay	After the calendar year deductible, you pay
Mental health and substance abuse benefits	High Option	Standard Option
<p>All diagnostic and treatment services recommended by a Plan provider and contained in a treatment plan that we approve. The treatment plan may include services, drugs, and supplies described elsewhere in this brochure.</p> <p>Note: Plan benefits are payable only when we determine the care is clinically appropriate to treat your condition and only when you receive the care as part of a treatment plan that we approve.</p>	Your cost sharing responsibilities are no greater than for other illnesses or conditions.	Your cost sharing responsibilities are no greater than for other illnesses or conditions.
<p>Professional services, including individual or group therapy by providers such as psychiatrists, psychologists, or clinical social workers</p> <p>Medication management</p>	\$15 per visit	<p>\$20 per visit to a primary care physician</p> <p>\$30 per visit to a specialist</p>
Diagnostic tests	Nothing	Nothing
Cat Scan, MRI, PET Scan, MRA	Nothing	20% coinsurance

Mental health and substance abuse benefits – continued on next page.

Mental health and substance abuse benefits <i>(continued)</i>	You pay	After the calendar year deductible, you pay
	High Option	Standard Option
<p>Services provided by a hospital or other facility</p> <p>Services in approved alternative care settings such as partial hospitalization, half-way house, residential treatment, full-day hospitalization, facility based intensive outpatient treatment</p> <p>We may allow Members to exchange one inpatient day of treatment for four (4) outpatient visits or exchange four (4) outpatient visits for one inpatient day of treatment. We may also allow a Member to exchange two (2) days of Transitional Partial Hospitalization or two (2) days of residential treatment center hospitalization for each inpatient day of treatment.</p>	<p>\$150 per day up to a \$450 maximum per admission</p>	<p>\$250 per day up to a \$750 maximum per admission</p>
<p><i>Not covered: Services we have not approved.</i></p> <p><i>Note: OPM will base its review of disputes about treatment plans on the treatment plan's clinical appropriateness. OPM will generally not order us to pay or provide one clinically appropriate treatment plan in favor of another.</i></p>	<p><i>All charges.</i></p>	<p><i>All charges.</i></p>

Preauthorization To be eligible to receive these benefits you must obtain a treatment plan and follow all of the following network authorization processes: To receive a mental health referral, please call 1-800-245-8327.

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

Section 5(f) Prescription drug benefits

Important things to keep in mind about these benefits:

- We cover prescribed drugs and medications, as described in the chart beginning on the next page.
- All benefits are subject to the definitions, limitations and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Some prescriptions do require prior authorization from the medical director. Your physician obtains the authorization by completing a form and sending it to Coventry.
- High Option – We have no deductible.
- Standard Option - The calendar year deductible is \$500 per person and \$1,000 per family.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

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

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

Where you can obtain them. You may fill the prescription at a contracted Plan pharmacy or by mail.

We use a formulary. We use a committee of doctors, pharmacists and other health care professionals to develop a formulary that gives you access to quality medications. FDA-approved brand-name and generic medications are reviewed for safety, side effects, effectiveness and overall value. We continually update the formulary based on the latest research. If your doctor prescribes a medication that is not on the list, you can get that medication, but you will share in a greater portion of the cost.

- **These are the dispensing limitations.** The quantity of each prescription is limited to that sufficient to treat the acute phase of illness or a 30-day supply maximum, whichever is less, per copayment. **Members called to active duty in a time of national or other emergency who need to obtain a greater than normal supply of prescribed medications should call 1-866-320-0697.**

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

Mail Order. You can obtain through Mail Order covered "maintenance" prescription drugs use to treat chronic or long-term health conditions such as high blood pressure or diabetes) for a 90-day supply. You pay \$20 copay per prescription unit or refill for formulary generic drugs, \$50 copay for formulary name brand drugs and \$100 for non formulary.

Prescription drug benefits begin on the next page

Benefit Description	You pay	After the calendar year deductible, you pay
Covered medications and supplies	High Option	Standard Option
<p>We cover the following medications and supplies prescribed by a Plan physician and obtained from a Plan pharmacy or through our mail order program:</p> <ul style="list-style-type: none"> • Drugs and medicines that by Federal law of the United States require a physician’s prescription for their purchase, except as excluded below. • Insulin • Insulin syringes and medication • Disposable needles and syringes for the administration of covered medications • Drugs for sexual dysfunction (see Note below) • Contraceptive drugs and devices • Growth hormones <p>Note: Contact the Plan for drug dose limits for sexual dysfunction.</p> <p>Note: If there is no generic equivalent available, you will still have to pay the brand name copay.</p>	<p>Retail Pharmacy</p> <p>\$10 per generic</p> <p>\$25 per formulary name brand</p> <p>\$50 per non-formulary</p> <p>Mail Order (Maintenance medications only)</p> <p>\$20 per generic</p> <p>\$50 per formulary name brand</p> <p>\$100 per non-formulary</p>	<p>Retail Pharmacy</p> <p>\$10 per generic</p> <p>\$25 per formulary name brand</p> <p>\$50 per non-formulary</p> <p>Mail Order (Maintenance medications only)</p> <p>\$20 per generic</p> <p>\$50 per formulary name brand</p> <p>\$100 per non-formulary</p>

Here are some things to keep in mind about our prescription drug program:

A generic equivalent will be dispensed if it is available, unless your physician specifically requires a name brand. If you receive a name brand drug when a Federally-approved generic drug is available, you have to pay the difference in cost between the name brand drug and the generic.

We administer a formulary. If your physician believes a name brand product is necessary or there is no generic available, your physician may prescribe a name brand drug from a formulary list. This list of name brand drugs is a preferred list of drugs that we selected to meet patient needs at a lower cost. You must pay a \$50 copay for a non-formulary drug. To order a prescription drug brochure, call 800/341-6613.

<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Drugs and supplies for cosmetic purposes</i> • <i>Drugs to enhance athletic performance</i> • <i>Fertility drugs</i> • <i>Drugs obtained at a non-Plan pharmacy; except for out-of-area emergencies</i> • <i>Vitamins, nutrients and food supplements even if a physician prescribes or administers them</i> • <i>Nonprescription medicines</i> 	<p><i>All charges.</i></p>	<p><i>All charges.</i></p>
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Section 5(g) Special features

Feature	Description
Flexible benefits option	<p>Under the flexible benefits option, we determine the most effective way to provide services.</p> <ul style="list-style-type: none">• We may identify medically appropriate alternatives to traditional care and coordinate other benefits as a less costly alternative benefit.• 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.
24 hour nurse line	<p>For any of your health concerns, 24 hours a day, 7 days a week, you may call First Help at 1-800-622-9528 and talk with a registered nurse who will discuss treatment options and answer your health questions.</p>

Section 5(h) Dental benefits

Important things to keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary
- Plan dentists must provide or arrange your care.
- High Option – We have no deductible.
- Standard Option - The calendar year deductible is \$500 per person and \$1,000 per family.
- We cover hospitalization for dental procedures only when a non-dental physical impairment exists which makes hospitalization necessary to safeguard the health of the patient. See Section 5(c) for inpatient hospital benefits. We do not cover the dental procedure unless it is described below.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

Accidental injury benefit	You pay	After the calendar year deductible, you pay
	High Option	Standard Option
We cover restorative services and supplies necessary to promptly repair (but not replace) sound natural teeth. The need for these services must result from an accidental injury.	\$15 per office visit	\$20 per visit to a primary care physician \$30 per visit to a specialist
Dental benefits		
<i>We have no other dental benefits.</i>	<i>All charges.</i>	

Section 5(j) Non-FEHB benefits available to Plan members

The benefits on this page are not part of the FEHB contract or premium, **and you cannot file an FEHB disputed claim about them.** Fees you pay for these services do not count toward FEHB deductibles or catastrophic protection out-of-pocket maximums.

Vision care	Routine eye exams are covered once every 12 months for a \$15 copayment through the Avesis providers. Providers may be found at www.avesis.com . You are also eligible to receive substantial discounts on eyeglasses, contact lenses and non-prescription items such as sunglasses and contact lens solutions. Please read the flyer that describes your extra Vision Care benefit.
Dental care	You are eligible to receive substantial discounts on dental care, including diagnostic and preventative, restorative, crowns, endodontics, periodontics, prosthodontics and orthodontics. Please read the accompanying flyer that describes Dental Care benefits available through this program.
Health Club	You are eligible to receive discount memberships from participating health clubs.

Section 6. High Deductible Health Plan Option

Note: This benefits section is divided into subsections. Please read the important things you should keep in mind at the beginning of each subsection. Also read the General exclusions in Section 7; they apply to the benefits in the following subsections. To obtain claim forms, claims filing advice, or more information about our benefits, contact us at 800-341-6613 or at our Web site at www.chclouisiana.com.

Summary

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

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

With this Plan, preventive care is not subject to the deductible. As you receive other non-preventive medical care, you must meet the Plan's deductible before we pay benefits according to the benefit chart on page 50. You can choose to use funds available in your HSA to make payments toward the deductible or you can pay toward your deductible entirely out-of-pocket, allowing your savings to continue to grow.

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

In-network preventive care

The Plan covers preventive care services, such as periodic health evaluations (e.g., annual physicals), screening services (e.g., mammograms), routine prenatal and well-child care, child and adult immunizations. These services are covered at 80% if you use a network provider and are fully described in Section 5.1(a). *You do not have to meet the deductible before using these services.*

Traditional in-network medical care

After you have paid the Plan's deductible, we pay benefits under traditional in-network coverage described in Section 6(a). The Plan typically pays 80% for in-network care.

Covered services include:

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

Savings

Health Savings Accounts or Health Reimbursement Arrangements provide a means to help you pay out-of-pocket expenses (see Section 6k) for more details).

Health Savings Account (HSA)

By law, HSAs are available to members who are not eligible for Medicare or do not have other health insurance coverage. In 2006, for each month you are eligible for an HSA premium pass through, we will contribute to your HSA \$41.67 per month for a Self-Only enrollment or \$83.33 per month for a Self and Family enrollment. In addition to our monthly contribution, you have the option to make additional tax-free contributions to your HSA, so long as total contributions do not exceed the limit established by law. See maximum contribution information in Section 5.1. You can use funds in your HSA to help pay your health plan deductible.

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

HSA features include:

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

Health Reimbursement Arrangement (HRA)

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

In 2006, we will give you an HRA credit of \$500 per year for a Self-Only enrollment and \$1,000 for a Self and Family enrollment. You can use funds in your HRA to help pay your health plan deductible and/or for certain expenses that don't count toward the deductible.

HRA features include:

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

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

When you use network providers, your annual maximum for out-of-pocket expenses (deductibles, coinsurance and copayments) for covered services is limited to \$4,000 per person or \$8,000 per family enrollment. However, certain expenses do not count toward your out-of-pocket maximum and you must continue to pay these expenses once you reach your out-of-pocket maximum (such as expenses in excess of the Plan's allowable amount or benefit maximum). Refer to Section 4 *Your catastrophic protection out-of-pocket maximum*, Section 6.1(b) *Traditional medical coverage subject to the deductible*, and Section 6.1(c) *Catastrophic protection for out-of-pocket expenses* for more details.

Section 6(a) Preventive care

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

- **In Network** – The calendar year deductible is \$1,100 per person or \$2,200 per family enrollment. The family deductible can be satisfied by one or more family members. The deductible applies to almost all benefits in Section 6.2. You must pay your deductible before your Traditional Medical Coverage may begin. Most benefits after the deductible is met are covered at 80%; you are responsible for 20% of allowed charges up to the Out-of-Pocket maximum.
- **Out of Network** – The calendar year deductible is \$2,000 per person or \$4,000 per family enrollment. The family deductible can be satisfied by one or more family members. The deductible applies to almost all benefits in Section 6.2. You must pay your deductible before your Traditional Medical Coverage may begin. Most benefits after the deductible is met are covered at 70%; you are responsible for 30% of allowed charges up to the Out-of-Pocket maximum.
- For all other covered expenses, please see Section 6(b) –Traditional Medical Coverage.
- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.

Benefits Description	You pay
Preventive care, adult	
Routine screenings, such as: <ul style="list-style-type: none"> • Total Blood CholesterolColorectal Cancer Screening, including Fecal occult blood test Sigmoidoscopy, screening – every five years starting at age 50 Double contrast barium enema – every five years starting at age 50 Colonoscopy screening – every ten years starting at age 50 • Annual Chlamydia Screening Test for women who are younger than 20 years old who are sexually active, and at least 20 years old who have multiple risk factors; and men who have multiple risk factors. • Routine Prostate Specific Antigen (PSA) test – one annually for men age 40 and older. 	In-network: 20% of the Plan Allowance, not subject to the Deductible Out-of-network: 30% of the Plan Allowance, not subject to the Deductible
Routine annual pap test Note: The office visit is covered if pap test is received on the same day; see <i>Diagnosis and Treatment</i> , above.	In-network: 20% of the Plan Allowance, not subject to the Deductible Out-of-network: 30% of the Plan Allowance, not subject to the Deductible

<p>Routine mammogram – covered for women age 35 and older, as follows:</p> <p>From age 35 through 39, one during this five year period</p> <p>From age 40 through 64, one every calendar year</p> <p>At age 65 and older, one every two consecutive calendar years</p>	<p>In-network: 20% of the Plan Allowance, not subject to the Deductible</p> <p>Out-of-network: 30% of the Plan Allowance, not subject to the Deductible</p>
<p>Preventive care, adult, continued</p>	<p>You pay</p>
<p>Routine immunizations, limited to:</p> <p>Tetanus-diphtheria (Td) booster – once every 10 years, ages 19 and over (except as provided for under Childhood immunizations)</p> <p>Influenza vaccine, annually</p> <p>Pneumococcal vaccine, age 65 and older</p>	<p>In-network: 20% of the Plan Allowance, not subject to the Deductible</p> <p>Out-of-network: 30% of the Plan Allowance, not subject to the Deductible</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Physical exams required for obtaining or continuing employment or insurance, marriage, sports, licensing, adoption, attending schools or camp, or travel or those ordered by a third party..</i> • <i>Immunizations, boosters, and medications for travel.</i> 	<p><i>All charges</i></p>
<p>Preventive care, child</p>	
<p>Childhood immunizations recommended by the American Academy of Pediatrics</p>	<p>In-network: 20% of the Plan Allowance, not subject to the Deductible</p> <p>Out-of-network: 30% of the Plan Allowance, not subject to the Deductible</p>
<p>Hearing loss screening for newborns provided by the Hospital before discharge</p> <p>Well-child care charges for routine examinations, immunizations and care (up to age 22)</p> <p>Examinations, such as:</p> <ul style="list-style-type: none"> 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 (up to age 22) 	<p>In-network: 20% of the Plan Allowance, not subject to the Deductible</p> <p>Out-of-network: 30% of the Plan Allowance, not subject to the Deductible</p>

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

Important things you should keep in mind about your these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- **In Network** - The calendar year deductible is \$1,100 per person or \$2,200 per family enrollment. The family deductible can be satisfied by one or more family members. The deductible applies to almost all benefits in Section 6.2. You must pay your deductible before your Traditional Medical Coverage may begin. Most benefits after the deductible is met are covered at 80%; you are responsible for 20% of allowed charges up to the Out-of-Pocket maximum.
- **Out of Network** - The calendar year deductible is \$2,000 per person or \$4,000 per family enrollment. The family deductible can be satisfied by one or more family members. The deductible applies to almost all benefits in Section 6.2. You must pay your deductible before your Traditional Medical Coverage may begin. Most benefits after the deductible is met are covered at 70%; you are responsible for 30% of allowed charges up to the Out-of-Pocket maximum.
- Under Traditional Medical Coverage, you are responsible for your coinsurance for covered expenses.
- When you use network providers, you are protected by an annual catastrophic maximum on out-of-pocket expenses for covered services. After your coinsurance, deductibles total \$4,000 per person or \$8,000 per family enrollment in any calendar year, you do not have to pay any more for covered services from network providers. However, certain expenses do not count toward your out-of-pocket maximum and you must continue to pay these expenses once you reach your out-of-pocket maximum (such as expenses in excess of the Plan's benefit maximum, or if you use out-of-network providers, amounts in excess of the Plan allowance).
- 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.

Deductible before Traditional Medical Coverage begins	After the deductible, you pay
<p>The deductible applies to almost all benefits in this Section. In the <i>You pay</i> column, we say "No deductible" when it does not apply. When you receive covered services from network providers, you are responsible for paying the allowable charges until you meet the deductible.</p>	<p>In network - 100% of allowable charges until you meet the deductible of \$1,100 per person or \$2,200 per family enrollment.</p> <p>Out of network - 100% of allowable charges until you meet the deductible of \$2,000 per person or \$4,000 per family enrollment.</p> <p>You may choose to pay deductible expenses from your HSA or HRA, or you can pay for them out-of-pocket.</p>

After you meet the deductible, we pay the allowable charge (less your coinsurance or copayment) until you meet the annual catastrophic out-of-pocket maximum.

In-network: After you meet the deductible, you pay the 20% coinsurance or listed copayments for covered services. You may choose to pay the coinsurance and copayments from your HSA or HRA, or you can pay for them out-of-pocket.

Out-of-network: After you meet the deductible, you pay the 30% coinsurance based on our Plan allowance and any difference between our allowance and the billed amount.

Section 6(c) Medical services and supplies provided by physicians and other health care professionals

Benefit Description	After the deductible, you pay
Diagnostic and treatment services	
Professional services of physicians <ul style="list-style-type: none"> • In physician's office 	In-network: 20% of the Plan allowance Out-of-network: 30% of the Plan allowance and any difference between our allowance and the billed amount.
Professional services of physicians <ul style="list-style-type: none"> • In an urgent care center • Office medical consultations • Second surgical opinion 	In-network: 20% of the Plan allowance Out-of-network: 30% of the Plan allowance and any difference between our allowance and the billed amount.
Lab, X-ray and other diagnostic tests	
Tests, such as: Blood tests Urinalysis Non-routine pap tests Pathology X-rays Non-routine Mammograms CAT Scans/MRI Ultrasound Electrocardiogram and EEG	In-network: 20% of the Plan allowance Out-of-network: 30% of the Plan allowance and any difference between our allowance and the billed amount.

Maternity care	After the deductible, you pay
<p>Complete maternity (obstetrical) care, such as:</p> <p>Prenatal care</p> <p>Delivery</p> <p>Postnatal care</p> <p>Note: Here are some things to keep in mind:</p> <p>You do not need to precertify your normal delivery; see below for other circumstances, such as extended stays for you or your baby.</p> <p>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.</p> <p>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</p> <p>We pay hospitalization and surgeon services (delivery) the same as for illness and injury. See Hospital benefits and Surgery benefits.</p>	<p>In-network: 20% of the Plan allowance</p> <p>Out-of-network: 30% of the Plan allowance and any difference between our allowance and the billed amount.</p>
<p><i>Not covered: Routine sonograms to determine fetal age, size or sex.</i></p>	<p><i>All charges.</i></p>
Family planning	
<p>A range of voluntary family planning services, limited to:</p> <ul style="list-style-type: none"> • Surgically implanted contraceptives (such as Norplant) • Injectable contraceptive drugs (such as Depo provera) • Diaphragm (fitting only) • Voluntary sterilization (vasectomy or tubal ligation) <p>Note: We cover oral contraceptives under the prescription drug benefit.</p>	<p>In-network: 20% of the Plan allowance</p> <p>Out-of-network: 30% of the Plan allowance and any difference between our allowance and the billed amount.</p>
<p><i>Not covered:</i></p> <p><i>Reversal of voluntary surgical sterilization</i></p> <p><i>Genetic counseling.</i></p> <p><i>Intrauterine Devices (IUDs).</i></p>	<p><i>All charges.</i></p>

Infertility services	After the deductible, you pay
<p>In-network – We limit coverage to a maximum plan benefit of \$1,500.</p> <p>Out of network – Not covered.</p> <p>Diagnosis and treatment of infertility such as:</p> <p>Artificial insemination:</p> <p style="padding-left: 40px;"><i>intravaginal insemination (IVI)</i></p> <p style="padding-left: 40px;"><i>intracervical insemination (ICI)</i></p> <p style="padding-left: 40px;"><i>intrauterine insemination (IUI)</i></p>	<p>In-network: 20% of the Plan allowance</p> <p>Out-of-network: Not covered</p>
<p><i>Not covered:</i></p> <p><i>Assisted reproductive technology (ART) procedures, such as:</i></p> <p style="padding-left: 40px;"><i>in vitro fertilization</i></p> <p style="padding-left: 40px;"><i>embryo transfer, gamete intra-fallopian transfer (GIFT) and zygote intra-fallopian transfer (ZIFT)</i></p> <p><i>Services and supplies related to ART procedures</i></p> <p><i>Cost of donor sperm</i></p> <p><i>Cost of donor egg</i></p> <p><i>Fertility Drugs</i></p>	<p><i>All charges.</i></p>
Allergy care	
<p>Testing</p> <p>Allergy injections and treatments</p> <p>Allergy serum</p>	<p>In-network: 20% of the Plan allowance</p> <p>Out-of-network: 30% of the Plan allowance and any difference between our allowance and the billed amount.</p>
<p><i>Not covered: Provocative food testing and sublingual allergy desensitization</i></p>	<p><i>All charges.</i></p>

Treatment therapies	After the deductible, you pay
<p>Chemotherapy and radiation therapy</p> <p>Note: High dose chemotherapy in association with autologous bone marrow transplants is limited to those transplants listed under Organ/Tissue Transplants on page 66.</p> <p>Respiratory and inhalation therapy</p> <p>Dialysis – hemodialysis and peritoneal dialysis</p> <p>Intravenous (IV)/Infusion Therapy – Home IV and antibiotic therapy</p> <p>Oxygen for home use and equipment</p> <p>Growth hormone therapy (GHT)</p> <p>Note: Growth hormone is covered under the prescription drug benefit.</p>	<p>In-network: 20% of the Plan allowance</p> <p>Out-of-network: 30% of the Plan allowance and any difference between our allowance and the billed amount.</p>
Physical and occupational therapies	
<p>60 consecutive days per condition for the services of each of the following:</p> <p>qualified physical therapists and</p> <p>occupational therapists</p> <p>Note: We only cover therapy to restore bodily function when there has been a total or partial loss of bodily function due to illness or injury.</p> <p>Cardiac rehabilitation following a heart transplant, bypass surgery or a myocardial infarction is provided for up to 60 days for physical therapy.</p>	<p>In-network: 20% of the Plan allowance</p> <p>Out-of-network: 30% of the Plan allowance and any difference between our allowance and the billed amount.</p>
<p><i>Not covered:</i></p> <p><i>Long-term rehabilitative therapy</i></p> <p><i>Exercise programs</i></p>	<p><i>All charges.</i></p>
Speech therapy	
<p>60 consecutive days per condition</p>	<p>In-network: 20% of the Plan allowance</p> <p>Out-of-network: 30% of the Plan allowance and any difference between our allowance and the billed amount.</p>

Hearing services (testing, treatment, and supplies)	After the deductible, you pay
<p>Hearing testing for children through age 17 (see <i>Preventive care, children</i>)</p>	<p>In-network: 20% of the Plan allowance</p> <p>Out-of-network: 30% of the Plan allowance and any difference between our allowance and the billed amount.</p>
<p><i>Not covered:</i></p> <p><i>All other hearing testing</i></p> <p><i>Hearing aids, testing and examinations for them</i></p>	<p><i>All charges.</i></p>
Vision services (testing, treatment, and supplies)	
<p>Diagnosis and treatment of diseases of the eye</p> <p>Prosthetic devices, such as lenses following cataract removal</p>	<p>In-network: 20% of the Plan allowance</p> <p>Out-of-network: 30% of the Plan allowance and any difference between our allowance and the billed amount.</p>
<p><i>Not covered:</i></p> <p><i>Eyeglasses or contact lenses and after age 17, examinations for them</i></p> <p><i>Eye exercises and orthoptics</i></p> <p><i>Radial keratotomy and other refractive surgery</i></p> <p><i>Annual eye refractions</i></p>	<p><i>All charges.</i></p>
Foot care	
<p>Routine foot care when you are under active treatment for a metabolic or peripheral vascular disease, such as diabetes.</p> <p>Note: See Orthopedic and prosthetic devices for information on podiatric shoe inserts.</p>	<p>In-network: 20% of the Plan allowance</p> <p>Out-of-network: 30% of the Plan allowance and any difference between our allowance and the billed amount.</p>
<p><i>Not covered:</i></p> <p><i>Cutting, trimming or removal of corns, calluses, or the free edge of toenails, and similar routine treatment of conditions of the foot, except as stated above</i></p> <p><i>Treatment of weak, strained or flat feet or bunions or spurs; and of any instability, imbalance or subluxation of the foot (unless the treatment is by open cutting surgery)</i></p>	<p><i>All charges.</i></p>

Orthopedic and prosthetic devices	After the deductible, you pay
<p>Our maximum allowance for this benefit is \$5,000 per calendar year</p> <p>Artificial limbs and eyes; stump hose</p> <p>Externally worn breast prostheses and surgical bras, including necessary replacements following a mastectomy</p> <p>Internal prosthetic devices, such as artificial joints, pacemakers, cochlear implants, and surgically implanted breast implant following mastectomy. Note: See 5(b) for coverage of the surgery to insert the device.</p> <p>Orthopedic devices, such as braces</p> <p>Foot orthotics</p> <p>Corrective orthopedic appliances for non-dental treatment of temporomandibular joint (TMJ) pain dysfunction syndrome.</p>	<p>In-network: 20% of the Plan allowance</p> <p>Out-of-network: 30% of the Plan allowance and any difference between our allowance and the billed amount.</p>
<p><i>Not covered:</i></p> <p><i>Heel pads and heel cups</i></p> <p><i>Lumbosacral supports</i></p> <p><i>Corsets, trusses, elastic stockings, support hose, and other supportive devices</i></p>	<p><i>All charges.</i></p>
Durable medical equipment (DME)	
<p>Our maximum allowance for this benefit is \$5,000 per calendar year</p> <p>Rental or purchase, at our option, including repair and adjustment, of durable medical equipment prescribed by your Plan physician, such as oxygen and dialysis equipment. Under this benefit, we also cover:</p> <ul style="list-style-type: none"> • Hospital beds; • Wheelchairs; • Crutches; • Walkers; • Blood glucose monitors; and • Insulin pumps. <p>Note: Call us at 800-341-6613 as soon as your Plan physician prescribes this equipment.</p>	<p>In-network: 20% of the Plan allowance</p> <p>Out-of-network: 30% of the Plan allowance and any difference between our allowance and the billed amount.</p>
<p><i>Not covered: Motorized wheelchairs.</i></p>	<p><i>All charges.</i></p>

Home health services	After the deductible, you pay
<p>Home health care ordered by a Plan physician and provided by a registered nurse (R.N.), licensed practical nurse (L.P.N.), licensed vocational nurse (L.V.N.), or home health aide.</p> <p>Services include oxygen therapy, intravenous therapy and medications.</p>	<p>In-network: 20% of the Plan allowance</p> <p>Out-of-network: 30% of the Plan allowance and any difference between our allowance and the billed amount.</p>
<p><i>Not covered:</i></p> <p><i>Nursing care requested by, or for the convenience of, the patient or the patient's family;</i></p> <p><i>Home care primarily for personal assistance that does not include a medical component and is not diagnostic, therapeutic, or rehabilitative.</i></p> <p><i>Nursing aides</i></p>	<p><i>All charges.</i></p>
Chiropractic	
<p>Manipulation of the spine and extremities</p> <p>After initial evaluation, treatment plan must be submitted to Coventry Health Care to authorize additional visits.</p>	<p>In-network: 20% of the Plan allowance</p> <p>Out-of-network: 30% of the Plan allowance and any difference between our allowance and the billed amount.</p>
Alternative treatments	
<p><i>No benefit</i></p>	<p><i>All charges</i></p>

Section 6(d) Surgical and anesthesia services provided by physicians and other health care professionals

Benefit Description	After the deductible, you pay
Surgical procedures	
YOUR PHYSICIAN MUST GET PRECERTIFICATION OF SOME SURGICAL PROCEDURES. Please refer to the precertification information shown in Section 3 to be sure which services require precertification and identify which surgeries require precertification.	In-network: 20% of the Plan allowance Out-of-network: 30% of the Plan allowance and any difference between our allowance and the billed amount.
A comprehensive range of services, such as:	
Operative procedures	
Treatment of fractures, including casting	
Normal pre- and post-operative care by the surgeon	
Endoscopy procedures	
Biopsy procedures	
Removal of tumors and cysts	
Correction of congenital anomalies (see Reconstructive surgery)	

Surgical treatment, vertical-banded gastroplasty (gastric stapling) and roux-en-y gastric bypass (Roux-en-Y), of morbid obesity will be covered by the health plans of Coventry Health Care, Inc. (Coventry) when all of the following criteria are met:

In-network: 20% of the Plan allowance

Out-of-network: 30% of the Plan allowance and any difference between our allowance and the billed amount.

The patient is an adult (≥ 18 years of age) with morbid obesity that has persisted for at least 3 years, and for which there is no treatable metabolic cause for the obesity;

There is presence of morbid obesity, defined as a body mass index (BMI) exceeding 40, or greater than 35 with documented co-morbid conditions (cardiopulmonary problems e.g., severe apnea, Pickwickian Syndrome, and obesity-related cardiomyopathy, severe diabetes mellitus, hypertension, or arthritis). (BMI is calculated by dividing a patient's weight (in kilograms) by height (in meters) squared. To convert pounds to kilograms, multiply pounds by 0.45. To convert inches to meters, multiply inches by .0254);

The patient has failed to lose weight (approximately 10% from baseline) or has regained weight despite participation in a three month physician-supervised multidisciplinary program within the past six months that included dietary therapy, physical activity and behavior therapy and support;

The patient has been evaluated for restrictive lung disease and received surgical clearance by a pulmonologist, if clinically indicated; has received cardiac clearance by a cardiologist if there is a history of prior phen-fen or redux use, and the patient has agreed, following surgery, to participate in a multidisciplinary program that will provide guidance on diet, physical activity and social support; and,

The patient has completed a psychological evaluation and has been recommended for bariatric surgery by a licensed mental health professional (this must be documented in the patient's medical record) and the patient's medical record reflects documentation by the treating psychotherapist that all psychosocial issues have been identified and addressed; and the psychotherapist indicates that the patient is likely to be compliant with the post-operative diet restrictions;

Insertion of internal prosthetic devices. See 6(c) – Orthopedic and prosthetic devices for device coverage information

Treatment of burns

Voluntary sterilization (e.g., Tubal ligation, Vasectomy)

Not covered:

All charges.

Reversal of voluntary sterilization

Routine treatment of conditions of the foot; see Foot care

Reconstructive surgery**After the deductible, you pay**

Surgery to correct a functional defect

In-network: 20% of the Plan allowance

Surgery to correct a condition caused by injury or illness if:

Out-of-network: 30% of the Plan allowance and any difference between our allowance and the billed amount.

the condition produced a major effect on the member's appearance and

the condition can reasonably be expected to be corrected by such surgery

Surgery to correct a condition that existed at or from birth and is a significant deviation from the common form or norm. Examples of congenital anomalies are: protruding ear deformities; cleft lip; cleft palate; birth marks; webbed fingers; and webbed toes.

All stages of breast reconstruction surgery following a mastectomy, such as:

surgery to produce a symmetrical appearance of breasts;

treatment of any physical complications, such as lymphedemas;

breast prostheses and surgical bras and replacements (see Prosthetic devices)

Note: If you need a mastectomy, you may choose to have the procedure performed on an inpatient basis and remain in the hospital up to 48 hours after the procedure.

Not covered:

All charges.

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

Oral and maxillofacial surgery**After the deductible, you pay**

Oral surgical procedures, limited to:

In-network: 20% of the Plan allowance

Reduction of fractures of the jaws or facial bones;

Out-of-network: 30% of the Plan allowance and any difference between our allowance and the billed amount.

Surgical correction of cleft lip, cleft palate or severe functional malocclusion;

Removal of stones from salivary ducts;

Excision of leukoplakia or malignancies;

Excision of cysts and incision of abscesses when done as independent procedures; and

Other surgical procedures that do not involve the teeth or their supporting structures.

TMJ treatment and services (non-dental)

Not covered:

All charges.

Oral implants and transplants

Procedures that involve the teeth or their supporting structures (such as the periodontal membrane, gingiva, and alveolar bone)

Dental care involved in treatment of temporomandibular joint (TMJ) pain dysfunction syndrome

Organ/tissue transplants	After the deductible, you pay
Limited to:	In-network: 20% of the Plan allowance
Cornea	Out-of-network: 30% of the Plan allowance and any difference between our allowance and the billed amount.
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	
Limited Benefits – Treatment for breast cancer, multiple myeloma, and epithelial ovarian cancer may be provided in a National Cancer Institute – or National Institutes of Health-approved clinical trial at a Plan-designated center of excellence and if approved by the Plan’s medical director in accordance with the Plan’s protocols.	
Note: We cover related medical and hospital expenses of the donor when we cover the recipient	

Organ/tissue transplants – continued on next page

Organ/tissue transplants (continued)	After the deductible, you pay
<i>Not covered:</i>	<i>All charges.</i>
<i>Donor screening tests and donor search expenses, except those performed for the actual donor</i>	
<i>Implants of artificial organs</i>	
<i>Transplants not listed as covered</i>	

Anesthesia

Professional services provided in –	In-network: 20% of the Plan allowance
Hospital (inpatient)	Out-of-network: 30% of the Plan allowance and any difference between our allowance and the billed amount.
Professional services provided in –	In-network: 20% of the Plan allowance
Hospital outpatient department	Out-of-network: 30% of the Plan allowance and any difference between our allowance and the billed amount.
Skilled nursing facility	
Ambulatory surgical center	
Office	

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

Important things you should keep in mind about these benefits:

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

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

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

The amounts listed below are for the charges billed by the facility (i.e., hospital or surgical center) or ambulance service for your surgery or care. Any costs associated with the professional charge (i.e., physicians, etc.) are in Sections 6(c) or (d).

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

Benefit Description	After the deductible, you pay
Inpatient hospital	
<p>Room and board, such as</p> <p>Ward, semiprivate, or intensive care accommodations;</p> <p>General nursing care; and</p> <p>Meals and special diets.</p> <p>Note: If you want a private room when it is not medically necessary, you pay the additional charge above the semiprivate room rate.</p>	<p>In-network: 20% of the Plan allowance</p> <p>Out-of-network: 30% of the Plan allowance and any difference between our allowance and the billed amount.</p>

Inpatient hospital - continued on next page.

Inpatient hospital <i>(continued)</i>	After the deductible, you pay
<p>Other hospital services and supplies, such as:</p> <p>Operating, recovery, maternity, and other treatment rooms</p> <p>Prescribed drugs and medicines</p> <p>Diagnostic laboratory tests and X-rays</p> <p>Blood or blood plasma, if not donated or replaced</p> <p>Dressings, splints, casts, and sterile tray services</p> <p>Medical supplies and equipment, including oxygen</p> <p>Anesthetics, including nurse anesthetist services</p> <p>Take-home items</p> <p>Medical supplies, appliances, medical equipment, and any covered items billed by a hospital for use at home (Note: calendar year deductible applies.)</p>	<p>In-network: 20% of the Plan allowance</p> <p>Out-of-network: 30% of the Plan allowance and any difference between our allowance and the billed amount.</p>
<p><i>Not covered:</i></p> <p><i>Custodial care</i></p> <p><i>Non-covered facilities, such as nursing homes, schools</i></p> <p><i>Personal comfort items, such as telephone, television, barber services, guest meals and beds</i></p> <p><i>Private nursing care</i></p>	<p><i>All charges.</i></p>

Outpatient hospital or ambulatory surgical center	After the deductible, you pay
<p>Operating, recovery, and other treatment rooms</p> <p>Prescribed drugs and medicines</p> <p>Diagnostic laboratory tests, X-rays, and pathology services</p> <p>Administration of blood, blood plasma, and other biologicals</p> <p>Blood and blood plasma, if not donated or replaced</p> <p>Pre-surgical testing</p> <p>Dressings, casts, and sterile tray services</p> <p>Medical supplies, including oxygen</p> <p>Anesthetics and anesthesia service</p> <p>Note: We cover hospital services and supplies related to dental procedures when necessitated by a non-dental physical impairment. We do not cover the dental procedures.</p>	<p>In-network: 20% of the Plan allowance</p> <p>Out-of-network: 30% of the Plan allowance and any difference between our allowance and the billed amount.</p>
<p><i>Not covered: Blood and blood derivatives not replaced by the member</i></p>	<p><i>All charges.</i></p>
Extended care benefits/Skilled nursing care facility benefits	
<p>Comprehensive range of benefits will be provided for up to 30 days per calendar year when full-time skilled nursing care is necessary and confinement in a skilled nursing facility is in lieu of hospitalization.</p> <p>Covered services include:</p> <ul style="list-style-type: none"> • Bed, board and general nursing care • Drugs, biologicals, supplies, and equipment ordinarily provided or arranged by the skilled nursing facility when prescribed by a Plan doctor 	<p>In-network: 20% of the Plan allowance</p> <p>Out-of-network: 30% of the Plan allowance and any difference between our allowance and the billed amount.</p>
<p><i>Not covered: Custodial care</i></p>	<p><i>All charges.</i></p>
Hospice care	
<p>Supportive and palliative care for a terminally ill member in the home or hospice facility. Services include inpatient and outpatient care, and family counseling. Services are provided under the direction of a Plan doctor who certifies that the patient is in the terminal stages of illness, with a life expectancy of approximately six months or less.</p>	<p>In-network: 20% of the Plan allowance</p> <p>Out-of-network: 30% of the Plan allowance and any difference between our allowance and the billed amount.</p>
<p><i>Not covered: Independent nursing, homemaker services</i></p>	<p><i>All charges.</i></p>

Ambulance	After the deductible, you pay
Local professional ambulance service when medically appropriate	<p>In-network: 20% of the Plan allowance</p> <p>Out-of-network: 30% of the Plan allowance and any difference between our allowance and the billed amount.</p>

Section 6(f) Emergency services/accidents

What is a medical emergency?

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

What to do in case of emergency:

Emergencies within our service area: If you are in an emergency situation, contact the local emergency system (e.g., the 911 telephone system) or go to the nearest hospital emergency room. Be sure to tell the emergency room personnel that you are a Plan member so they can notify the Plan.

If you need to be hospitalized in a non-Plan facility, the Plan must be notified within 24 hours or on the first working day following your admission, unless it was not reasonably possible to notify the Plan within that time. If you are hospitalized in non-Plan facilities and Plan doctors believe care can be better provided in a Plan hospital, you will be transferred when medically feasible with any ambulance charges covered in full.

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

Emergencies outside our service area: Benefits are available for any medically necessary health service that is immediately required because of injury or unforeseen illness.

If you need to be hospitalized, the Plan must be notified within 24 hours or on the first working day following your admission, unless it was not reasonably possible to notify the Plan within that time. If a Plan doctor believes care can be better provided in a Plan hospital, you will be transferred when medically feasible with any ambulance charges covered in full.

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

Benefit Description	After the deductible, you pay
Emergency within our service area	
<ul style="list-style-type: none"> • Emergency care at a doctor’s office • Emergency care at an urgent care center • Emergency care as an outpatient at a hospital, including doctors’ services 	<p>In-network: 20% of the Plan allowance</p> <p>Out-of-network: 30% of the Plan allowance and any difference between our allowance and the billed amount.</p>
<i>Not covered: Elective care or non-emergency care</i>	<i>All charges.</i>

Emergency outside our service area	After the deductible, you pay
<ul style="list-style-type: none"> • Emergency care at a doctor’s office • Emergency care at an urgent care center • Emergency care as an outpatient at a hospital, including doctors’ services 	<p>In-network: 20% of the Plan allowance</p> <p>Out-of-network: 30% of the Plan allowance and any difference between our allowance and the billed amount.</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Elective care or non-emergency care</i> • <i>Emergency care provided outside the service area if the need for care could have been foreseen before leaving the service area</i> • <i>Medical and hospital costs resulting from a normal full-term delivery of a baby outside the service area</i> 	<p><i>All charges</i></p>
Ambulance	
<p>Professional ambulance service when medically appropriate.</p> <p>Note: See 5(c) for non-emergency service.</p>	<p>In-network: 20% of the Plan allowance</p> <p>Out-of-network: 30% of the Plan allowance and any difference between our allowance and the billed amount.</p>

Section 6(g) Mental health and substance abuse benefits

Benefit Description	After the deductible, you pay
Mental health and substance abuse benefits	
<p>All diagnostic and treatment services recommended by a Plan provider and contained in a treatment plan that we approve. The treatment plan may include services, drugs, and supplies described elsewhere in this brochure.</p> <p>Note: Plan benefits are payable only when we determine the care is clinically appropriate to treat your condition and only when you receive the care as part of a treatment plan that we approve.</p>	<p>In Network – Your cost sharing responsibilities are no greater than for other illnesses or conditions...</p> <p>Out of Network – No benefit</p>
<p>Professional services, including individual or group therapy by providers such as psychiatrists, psychologists, or clinical social workers</p> <p>Medication management</p> <p>Diagnostic tests</p>	<p>In-network: 20% of the Plan allowance</p> <p>Out of Network – No benefit</p>
<p>Services provided by a hospital or other facility</p> <p>Services in approved alternative care settings such as partial hospitalization, half-way house, residential treatment, full-day hospitalization, facility based intensive outpatient treatment</p> <p>We may allow Members to exchange one inpatient day of treatment for four (4) outpatient visits or exchange four (4) outpatient visits for one inpatient day of treatment. We may also allow a Member to exchange two (2) of Transitional Partial Hospitalization or two (2) days of residential treatment center hospitalization for each inpatient day of treatment.</p>	<p>In-network: 20% of the Plan allowance</p> <p>Out-of-network – No benefit</p>
<p><i>Not covered: Services we have not approved.</i></p> <p><i>Note: OPM will base its review of disputes about treatment plans on the treatment plan's clinical appropriateness. OPM will generally not order us to pay or provide one clinically appropriate treatment plan in favor of another.</i></p>	<p><i>All charges.</i></p>

Preauthorization To be eligible to receive these benefits you must obtain a treatment plan and follow all of the following network authorization processes: To receive a mental health referral, please call 1-800-245-8327.

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

Section 6(h) Prescription drug benefits

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

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

Where you can obtain them. You may fill the prescription at a contracted Plan pharmacy or by mail.

We use a formulary. We use a committee of doctors, pharmacists and other health care professionals to develop a formulary that gives you access to quality medications. FDA-approved brand-name and generic medications are reviewed for safety, side effects, effectiveness and overall value. We continually update the formulary based on the latest research. If your doctor prescribes a medication that is not on the list, you can get that medication, but you will share in a greater portion of the cost.

- **These are the dispensing limitations.** The quantity of each prescription is limited to that sufficient to treat the acute phase of illness or a 30-day supply maximum, whichever is less, per copayment. **Members called to active duty in a time of national or other emergency who need to obtain a greater than normal supply of prescribed medications should call 1-866-320-0697.**

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

Mail Order. You can obtain through Mail Order covered "maintenance" prescription drugs use to treat chronic or long-term health conditions such as high blood pressure or diabetes) for a 90-day supply. You pay \$20 copay per prescription unit or refill for formulary generic drugs, \$40 copay for formulary name brand drugs and \$90 for non formulary.

Benefit Description	After the deductible, you pay
Covered medications and supplies	
<p>We cover the following medications and supplies prescribed by a Plan physician and obtained from a Plan pharmacy or through our mail order program:</p> <ul style="list-style-type: none"> • Drugs and medicines that by Federal law of the United States require a physician's prescription for their purchase, except as excluded below. • Insulin • Insulin syringes and medication • Disposable needles and syringes for the administration of covered medications • Drugs for sexual dysfunction (see Note below) • Contraceptive drugs and devices • Growth hormones <p>Note: Contact the Plan for drug dose limits for sexual dysfunction.</p>	<p>In - Network</p> <p>Retail Pharmacy</p> <p>\$10 per generic</p> <p>\$35 per formulary name brand</p> <p>\$60 per non-formulary</p> <p>Mail Order (Maintenance medications only)</p> <p>\$20 per generic</p> <p>\$70 per formulary name brand</p> <p>\$120 per non-formulary</p> <p>Note: If there is no generic equivalent available, you will still have to pay the brand name copay.</p> <p>Out of Network: No benefit</p>

Covered medications and supplies <i>(continued)</i>	After the deductible, you pay
<p>Here are some things to keep in mind about our prescription drug program:</p> <p>A generic equivalent will be dispensed if it is available, unless your physician specifically requires a name brand. If you receive a name brand drug when a Federally-approved generic drug is available, you have to pay the difference in cost between the name brand drug and the generic.</p> <p>We administer a formulary. If your physician believes a name brand product is necessary or there is no generic available, your physician may prescribe a name brand drug from a formulary list. This list of name brand drugs is a preferred list of drugs that we selected to meet patient needs at a lower cost. You must pay a \$45 copay for a non-formulary drug. To order a prescription drug brochure, call 800/341-6613.</p>	
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Drugs and supplies for cosmetic purposes</i> • <i>Drugs to enhance athletic performance</i> • <i>Fertility drugs</i> • <i>Drugs obtained at a non-Plan pharmacy; except for out-of-area emergencies</i> • <i>Vitamins, nutrients and food supplements even if a physician prescribes or administers them</i> • <i>Nonprescription medicines</i> 	<p><i>All charges.</i></p>

Section 6(i) Special features

Feature	Description
Flexible benefits option	<p>Under the flexible benefits option, we determine the most effective way to provide services.</p> <ul style="list-style-type: none">• We may identify medically appropriate alternatives to traditional care and coordinate other benefits as a less costly alternative benefit.• 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.
24 hour nurse line	<p>For any of your health concerns, 24 hours a day, 7 days a week, you may call First Help at 1-800-622-9528 and talk with a registered nurse who will discuss treatment options and answer your health questions.</p>

Section 6(j) Dental benefits

Accidental injury benefit	After the deductible, you pay
We cover restorative services and supplies necessary to promptly repair (but not replace) sound natural teeth. The need for these services must result from an accidental injury.	In-network: 20% of the Plan allowance Out-of-network: 30% of the Plan allowance and any difference between our allowance and the billed amount.
Dental benefits	
<i>We have no other dental benefits.</i>	<i>All charges.</i>

Section 6(k) Savings – HSAs and HRAs

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

<p>Funding</p> <p>Self Only coverage</p> <p>Self and Family coverage</p>	<p><i>\$500 annual</i> premium pass through by HDHP directly into account, prorated on a monthly basis.</p> <p><i>\$1,000 annual</i> premium pass through by HDHP directly into account, prorated on a monthly basis.</p> <p>Eligibility for contributions will be determined on the first day of the month and will be prorated for length of enrollment.</p>	<p><i>\$500</i> annual credit (prorated monthly and credited to the account) provided by the HDHP upon effective date</p> <p><i>\$1,000</i> annual credit (prorated monthly and credited to the account) provided by the HDHP upon effective date</p> <p>Eligibility for annual credit will be determined on the first day of the month and will be prorated for length of enrollment.</p>
<p>Contributions/credits</p> <p>Self Only coverage</p> <p>Self and Family coverage</p>	<p>The maximum that can be contributed to your HRA is an annual combination of HDHP premium pass through and enrollee contribution funds, which when combined, do not exceed the amount of the deductible, which is \$1,050 self/\$2,100 family</p> <p>For each month you are eligible for HAS contributions, if you choose to contribute to your HAS.</p> <p>The HDHP will make a premium pass through of \$41.67 per month. You may make a maximum annual contribution of \$550.</p> <p>The HDHP will make a premium pass through of \$83.33 per month. Your annual maximum contribution cannot exceed \$1,100</p> <p>If you choose to contribute to your HAS,</p> <ul style="list-style-type: none"> -You must deduct 1/12 of total annual maximum contribution for every month you are not eligible for the HDHP the whole month. For instance, if your enrollment in this Plan was not effective on January 1, 2006, you cannot receive a credit for January and you would need to deduct 1/12 of the annual maximum contribution. -You may rollover funds you have in other HSAs to this HDHP HAS (rollover funds do not affect your annual maximum contribution under this HDHP). - HSAs earn tax-free interest (does not affect your annual maximum contribution). 	<p>The full HRA credit will be available, subject to proration, on the effective date of enrollment. The HRA does not earn interest. You cannot contribute to the HRA.</p> <p>The HDHP will make a premium pass through of \$41.67 per month. You may make a maximum annual contribution of \$550.</p> <p>The HDHP will make a premium pass through of \$83.33 per month. Your annual maximum contribution cannot exceed \$1,100</p>

<p>Access funds</p>	<p>You can access your HAS by the following methods:</p> <ul style="list-style-type: none"> • Debit card • Withdrawal form 	<ul style="list-style-type: none"> • For qualified medical expenses under your HDHP, you will be automatically reimbursed when claims are submitted through your Coventry Health Care Flex Choice HDHP. <p>For expenses not covered by the HDHP, such as orthodontia, a reimbursement form will be sent to you.</p>
<p>Distributions/withdrawals</p> <p>Medical</p>	<p>After meeting the deductible, pay the out-of-pocket expenses for yourself, your spouse or your dependents even if they are not covered by the HDHP from the funds available in your HAS.</p> <p>Medical expenses are not allowable if they occur before the first full month your enrollment is effective, and they are not reimbursable from your HAS until the first of the month following the effective date of your enrollment in this HDHP and the date your HAS account is established.</p> <p>For most Federal enrollees (those not paid on a monthly basis), the earliest date medical expenses will be allowable is February 1, 2006.</p> <p>See IRS Publication 502 for a complete list of eligible expenses.</p>	<p>After meeting the deductible, pay the out-of-pocket expenses for qualified medical expenses for individuals covered under the HDHP.</p> <p>Non-reimbursed qualified medical expenses are allowable if they occur after the effective date of your enrollment in this Plan.</p> <p>See <i>Availability of funds</i> below for information on when funds are available in the HRA.</p> <p>See IRS Publication 502 for a complete list of eligible expenses.</p>
<p>Non-medical</p>	<p>If you are under age 65, withdrawal of funds for non-medical expenses will create a 10% income tax penalty in addition to any other income taxes you may owe on the accumulated funds.</p> <p>When you turn age 65, distributions can be used for any reason without being subject to the 10% penalty</p>	<p>Not applicable – distributions will not be made for anything other than non-reimbursed qualified medical expenses</p>
<p>Availability of funds</p>	<p>Funds are not available until:</p> <ul style="list-style-type: none"> • Your enrollment in this HDHP is effective (effective date is determined by your agency in accord with the event permitting the enrollment change) <p>The HDHP receives record of your enrollment and initially establishes your HAS account with the fiduciary by providing information it must furnish and by contributing the minimum amount required to establish an HAS</p>	<p>Funds are not available until:</p> <ul style="list-style-type: none"> • Your enrollment in this HDHP is effective (effective date is determined by your agency in accord with the event permitting the enrollment change) <p>The HDHP receives record of your enrollment and initially establishes your HRA account with the fiduciary by providing information it must furnish and by contributing the minimum amount required to establish an HRA</p>
<p>Account owner</p>	<p>FEHB enrollee</p>	<p>HDHP</p>

Portable	Yes, you can take this account with you when you separate or retire.	If you retire and remain in this HDHP, you may continue to use and accumulate credits in your HRA. If you terminate employment or change health plans, only eligible expenses incurred while covered under the HDHP will be eligible for reimbursement subject to timely filing requirements. Unused funds are forfeited.
Annual rollover	Yes, accumulates without a maximum cap.	Yes, accumulates without a maximum cap.

Health Savings Account

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

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

Can I contribute to my HSA?

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

IRS contribution rules reduce the total annual maximum contribution if you are not eligible for the HDHP during the whole month. For instance, if your enrollment in this Plan was not effective on January 1, 2006, you cannot receive a credit for January and you would need to deduct 1/12 of the annual maximum contribution. Contact CBSA for more details.

Catch-up contributions

If you are age 55 or older, the IRS permits you to make additional catch-up contributions to your HSA. In 2006, you may contribute up to \$500 in “catch-up” contributions. Catch-up contributions in later years increase up to a maximum of \$1,000 in 2009 and beyond. Contributions must stop once an individual is eligible for Medicare. Additional details are available on the IRS Web site at www.irs.gov.

Rate of interest earned

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

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

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

What happens to my HSA if I die?

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

Non-qualified health expenses

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

Tracking your HSA balance

You will receive a periodic statement that shows the “premium pass through” and withdrawals,

and interest earned on your account. In addition, you will receive an Explanation of Payment statement when you withdraw money from your HSA.

Minimum reimbursements from your HSA

You can request reimbursement in any amount.

Health Reimbursement Arrangements

How do I know if I qualify for an HRA?

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

HRA and HSA differences

Please review the chart at the beginning of this Section, which details the differences. The major differences are:

you cannot make contributions to an HRA

funds are forfeited if you leave the HDHP

an HRA does not earn interest, and

HRAs can only pay for qualified medical expenses, such as deductibles, copayments, and coinsurance expenses, for individuals covered by the HDHP.

Section 6(l) Catastrophic protection for out-of-pocket expenses

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

Section 6(m) Health education resources and account management tools

Special features	Description
Health education resources	<p>Visit the Health Information section of our website at www.chclouisiana.com for information to help you take command of your health. This section is organized in simple, user-friendly, sections:</p> <ul style="list-style-type: none"> - Assess Your Health – where you will find a simple, free, online health risk assessment tool to benchmark your wellness, and better understand your overall health status and risks. - About Your Health – for information about a specific condition or general preventive guidelines. - Patient Safety - WebMD – our link to this health site also provides wellness and disease information to help improve health. • Prescription Drug educational materials are also accessible through our website, through a link to our pharmacy benefit manager, Caremark. There, you will find: <ul style="list-style-type: none"> - Detailed information about a wide range of prescription drugs; - A drug interaction tool to help easily determine if a specific drug can have any adverse interactions with each other, with over-the-counter drugs, or with herbals and vitamins; - Facts about why FDA-approved generic drugs should be a first choice for effective, economical treatment. <p>Another key health information tool that we make available to you is our online quality tools, powered by HealthShare®. You can review the frequency of procedures performed by a provider, knowing the correlation between frequency of service and quality of outcomes. We post additional quality outcome information, such as re-admission rates within 30 days, post operative complications, and even death rates.</p> <p>We also publish an e-newsletter to keep you informed on a variety of issues related to your good health. Visit our Web site at www.chclouisiana.com for back editions of this publication, <i>Living Well</i>.</p> <ul style="list-style-type: none"> • In addition, we augment our health education tools with access to our Nurse Advisor Services. Experienced RNs are available through an inbound call center 24x7x365 to assist you and help you to maximize your benefits, by providing clinical and economic information to make an informed decision on how to proceed with care.
Account management tools	<p>For each HSA and HRA account holder, we maintain a complete claims payment history online through Coventry’s password-protected, self-service functionality, My Online Services, at www.chclouisiana.com.</p> <ul style="list-style-type: none"> • You will receive an EOB after every claim. • <u>If you have an HSA,</u> • You will receive a quarterly statement by mail outlining your account balance and activity. <p style="margin-left: 40px;">You may also access your account and review your activity on a daily basis online, via My Online Services, at www.chclouisiana.com.</p> • <u>If you have an HRA,</u> <p style="margin-left: 40px;">You will receive a quarterly statement by mail outlining your account balance and activity.</p>

<p>Consumer choice information</p>	<ul style="list-style-type: none"> • As a member of this HDHP, you may choose any provider. However, you will receive discounts when you see a network provider. Directories are available online at www.chclouisiana.com. • As a member of this HDHP, you may choose any provider. However, you will receive discounts when you see a network provider. Our provider search function on our website www.chclouisiana.com is updated every week. It lets you easily search for a participating physician based on the criteria <i>you</i> choose, such as provider specialty, gender, secondary languages spoken, or hospital affiliation. You can even specify the maximum distance you're willing to travel and, in most instances, get driving directions and a map to the offices of identified providers. • Pricing information for medical care is available at www.chclouisiana.com. There, you will find our Health Services Pricing Tools, which provide average cost information for some the most common categories of service. The easy-to-understand information is sorted by categories of service, including physician office visits, diagnostic tests, surgical procedures, and hospitalization. • Pricing information for prescription drugs is available through our link to the website of our pharmacy benefit manager, Caremark (which you can access via www.chclouisiana.com). Through a password-protected account, you will have the ability to estimate prescription costs before ordering. • Link to online pharmacy through to the wesbite of our pharmacy benefit manager, Caremark (which you can access via www.chclouisiana.com.) • Educational materials on the topics of HSAs, HRAs and HDHPs are available at www.chclouisiana.com.
<p>Care support</p>	<ul style="list-style-type: none"> • Our complex case management programs offer special assistance to members with intricate, long-term medical needs. Our disease management program fosters a proactive approach to managing care from prevention through treatment and management. Your physician can help arranged for participation in these programs, or you can simply contact our member service department. • Patient safety information is available online at www.chclouisiana.com. • Care support is also available to you, in the form of a relationship that we have established with the <i>College of American Pathologists</i> for e-mail reminder notifications. We'll send a message to the e-mail address you provide on a scheduled basis, reminding you to arrange for screening tests.

Section 7. 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 services/accidents);
- Services, drugs, or supplies you receive while you are not enrolled in this Plan;
- Services, drugs, or supplies not medically necessary;
- Services, drugs, or supplies not required according to accepted standards of medical, dental, or psychiatric practice;
- Experimental or investigational procedures, treatments, drugs or devices;
- 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 8. 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, or deductible.

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

Medical and hospital benefits

In most cases, providers and facilities file claims for you. Physicians must file on the form HCFA-1500, Health Insurance Claim Form. Your facility will file on the UB-92 form. For claims questions and assistance, call us at 800-341-6613.

When you must file a claim – such as for services you receive outside 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:

CHC Louisiana/Claims
P.O. Box 7707
London, KY 40742

Prescription drugs

Submit your claims to:

Caremark Claims Department
P.O. Box 686005
San Antonio, Texas 78268-6005

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 9. The disputed claims process

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

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

Step	Description
1	<p>Ask us in writing to reconsider our initial decision. You must:</p> <ol style="list-style-type: none">a) Write to us within 6 months from the date of our decision; andb) Send your request to us at: CHC Louisiana, Inc., 3838 North Causeway Blvd., Suite 3350, Metairie, LA 70002; andc) Include a statement about why you believe our initial decision was wrong, based on specific benefit provisions in this brochure; andd) Include copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms.
2	<p>We have 30 days from the date we receive your request to:</p> <ol style="list-style-type: none">a) Pay the claim (or, if applicable, arrange for the health care provider to give you the care); orb) Write to you and maintain our denial – go to step 4; orc) Ask you or your provider for more information. If we ask your provider, we will send you a copy of our request—go to step 3.
3	<p>You or your provider must send the information so that we receive it within 60 days of our request. We will then decide within 30 more days.</p> <p>If we do not receive the information within 60 days, we will decide within 30 days of the date the information was due. We will base our decision on the information we already have.</p> <p>We will write to you with our decision.</p>
4	<p>If you do not agree with our decision, you may ask OPM to review it.</p> <p>You must write to OPM within:</p> <ul style="list-style-type: none">• 90 days after the date of our letter upholding our initial decision; or• 120 days after you first wrote to us – if we did not answer that request in some way within 30 days; or• 120 days after we asked for additional information. <p>Write to OPM at: United States Office of Personnel Management, Insurance Services Programs, Health Insurance Group 3, 1900 E Street, NW, Washington, DC 20415-3630.</p>

The disputed claims process *(continued)*

Send OPM the following information:

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

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

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

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

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

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

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

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

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

- a) We haven't responded yet to your initial request for care or preauthorization/prior approval, then call us at 800-341-6613 and we will expedite our review; or
- b) We denied your initial request for care or preauthorization/prior approval, then:

If we expedite our review and maintain our denial, we will inform OPM so that they can give your claim expedited treatment too,
or

You may call OPM's Health Insurance Group 3 at 202/606-0737 between 8 a.m. and 5 p.m. eastern time.

Section 10. 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 or older.

Some people with disabilities under 65 years of age.

People with End-Stage Renal Disease (permanent kidney failure requiring dialysis or a transplant).

Medicare has four parts:

Part A (Hospital Insurance). Most people do not have to pay for Part A. If you or your spouse worked for at least 10 years in Medicare-covered employment, you should be able to qualify for premium-free Part A insurance. (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.

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

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

Should I enroll in Medicare?

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

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

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

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

The Original Medicare Plan (Part A or Part B)

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

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

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

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

When Original Medicare is the primary payer, Medicare processes your claim first. In most cases, your claim will be coordinated automatically and we will then provide secondary benefits for covered charges. You will not need to do anything. To find out if you need to do something to file your claim, call us at 800-341-6613 or see our Web site at www.chclouisiana.com.

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

Office visit copayments if you have Medicare Part B

Medicare Advantage (Part C)

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

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

This Plan and another plan's Medicare Advantage plan: You may enroll in another plan's Medicare Advantage plan and also remain enrolled in our FEHB plan. We will still provide benefits when your Medicare Advantage plan is primary, even out of the Medicare Advantage plan's network and/or service area (if you use our Plan providers), but we will not waive any of

our copayments, coinsurance, or deductibles. If you enroll in a Medicare Advantage plan, tell us. We will need to know whether you are in the Original Medicare Plan or in a Medicare Advantage plan so we can correctly coordinate benefits with Medicare.

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

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

This health plan coordinates its prescription drug benefits with Medicare Part D. If you enroll in Medicare Part D, we will review claims for your prescription drug costs that are not covered by Medicare Part D.

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

Primary Payer Chart

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

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

TRICARE and CHAMPVA

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

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

Workers' Compensation

We do not cover services that:

You need because of a workplace-related illness or injury that the Office of Workers' Compensation Programs (OWCP) or a similar Federal or State agency determines they must provide; or

OWCP or a similar agency pays for through a third-party injury settlement or other similar proceeding that is based on a claim you filed under OWCP or similar laws.

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

Medicaid

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

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

When other Government agencies are responsible for your care

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

When others are responsible for injuries

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

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

Section 11. 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. You may also be responsible for additional amounts. See page 15.
Copayment	A copayment is a fixed amount of money you pay when you receive covered services. See page 15.
Covered services	Care we provide benefits for, as described in this brochure.
Deductible	A deductible is a fixed amount of covered expenses you must incur for certain covered services and supplies before we start paying benefits for those services. See page 15.
Experimental or investigational services	A health product or service is deemed experimental or investigational and excluded from coverage under this Agreement if one or more of the following conditions are met: (i) any drug not approved for use by the FDA; any drug that is classified as IND (investigational new drug) by the FDA; (ii) any drug requiring pre-authorization that is proposed for off-label prescribing; (iii) any health product or service that is subject to Investigational Review Board (IRB) review or approval; (iv) any health product or service that is subject of a clinical trial that meets criteria for Phase I, II or III as set forth by FDA regulations; or (v) any health product or service that does not have a demonstrated value based on clinical evidence reported by peer-review medical literature and by generally recognized academic experts
Group health coverage	<p>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. You must arrange for the other coverage within 63 days of leaving this Plan. Your new plan must reduce or eliminate waiting periods, limitations or exclusions for health related conditions based on the information in the certificate.</p> <p>If you have been enrolled with us for less than 12 months, but were previously enrolled in other FEHB plans, you may request a certificate from them, as well.</p>
Us/We	Us and We refer to Coventry Health Care of Louisiana, Inc.
You	You refers to the enrollee and each covered family member.

Section 12. FEHB Facts

Coverage information

No pre-existing condition limitation

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

Where you can get information about enrolling in the FEHB Program

- See www.opm.gov/insure/health for enrollment as well as:
- Information on the FEHB Program and plans available to you
- A health plan comparison tool
- A list of agencies who participate in Employee Express
- A link to Employee Express
- Information on and links to other electronic enrollment systems

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

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

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

Types of coverage available for you and your family

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

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

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

If you or one of your family members is enrolled in one FEHB plan, that person may not be

enrolled in or covered as a family member by another FEHB plan.

Children's Equity Act

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

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

If you have no FEHB coverage, your employing office will enroll you for Self and Family coverage in the Blue Cross and Blue Shield Service Benefit Plan's Basic Option;

If you have a Self Only enrollment in a fee-for-service plan or in an HMO that serves the area where your children live, your employing office will change your enrollment to Self and Family in the same option of the same plan; or

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

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

When benefits and premiums start

The benefits in this brochure are effective January 1. If you joined this Plan during Open Season, your coverage begins on the first day of your first pay period that starts on or after January 1. If you changed plans or plan options during Open Season and you receive care between January 1 and the effective date of coverage under your new plan or option, your claims will be paid according to the 2006 benefits of your old plan or option. However, if your old plan left the FEHB Program at the end of the year, you are covered under that plan's 2005 benefits until the effective date of your coverage with your new plan. Annuitants' coverage and premiums begin on January 1. If you joined at any other time during the year, your employing office will tell you the effective date of coverage.

When you retire

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

When you lose benefits

When FEHB coverage ends

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

Your enrollment ends, unless you cancel your enrollment, or

You are a family member no longer eligible for coverage.

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

Spouse equity coverage

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

Temporary Continuation of Coverage (TCC)

If you leave Federal service, or if you lose coverage because you no longer qualify as a family member, you may be eligible for Temporary Continuation of Coverage (TCC). For example, you can receive TCC if you are not able to continue your FEHB enrollment after you retire, if you lose your Federal job, if you are a covered dependent child and you turn 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 at www.opm.gov/insure/health; refer to the “TCC and HIPAA” frequently asked questions. These highlight HIPAA rules, such as the requirement that Federal employees must exhaust any TCC eligibility as one condition for guaranteed access to individual health coverage under HIPAA, and information about Federal and State agencies you can contact for more information.

Section 13. Two Federal Programs complement FEHB benefits

Important information

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

The Federal Flexible Spending Account Program – *FSAFEDS*

What is an FSA?

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

There are two types of FSAs offered by FSAFEDS:

Health Care Flexible Spending Account (HCFSA)

Covers eligible health care expenses not reimbursed by this Plan, or any other medical, dental, or vision care plan you or your dependents may have.

Eligible dependents for this account include anyone you claim on your Federal Income Tax return as a qualified dependent under the U.S. Internal Revenue Service (IRS) definition and/or with whom you jointly file your Federal Income Tax return, even if you don't have self and family health benefits coverage. *Note:* The IRS has a broader definition of a "family member" than is used under the FEHB Program to provide benefits by your FEHB Plan.

The maximum annual amount that can be allotted for the HCFSA is \$5,000. *Note:* The Federal workforce includes a number of employees married to each other. If each spouse/employee is eligible for FEHB coverage, both may enroll for a HCFSA up to the maximum of \$5,000 each (\$10,000 total). Both are covered under each other's HCFSA. The minimum annual amount is \$250.

Dependent Care Flexible Spending Account (DCFSA)

Covers eligible dependent care expenses incurred so you and your spouse, if married, can work, look for work, or attend school full-time.

Qualifying dependents for this account include your dependent children under age 13, or any person of any age whom you claim as a dependent on your Federal Income Tax return (and who is mentally or physically incapable of self care).

The maximum annual amount that can be allotted for the DCFSA is \$5,000. The minimum annual amount is \$250. *Note:* The IRS limits contributions to a DCFSA. For single taxpayers and taxpayers filing a joint return, the maximum is \$5,000 per year. For taxpayers who file their taxes separately with a spouse, the maximum is \$2,500 per year.

Enroll during Open Season

You **must make an election** to enroll in an FSA during the 2006 FEHB Open Season. Even if you enrolled during 2005, you must make a new election to continue participating in 2006. Enrollment is easy!

Online: visit www.FSAFEDS.com and click on **Enroll**.

Telephone: call an FSAFEDS Benefits Counselor toll-free at 1-877-FSAFEDS (1-877-372-3337), Monday through Friday, from 9 a.m. until 9 p.m., Eastern Time. TTY: 1-800-952-0450.

What is SHPS?

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

Who is eligible to enroll?

If you are a Federal employee eligible for FEHB – even if you’re not enrolled in FEHB – you can choose to participate in either, or both, of the FSAs. *However, if you enroll in an FSA and enroll in a High Deductible Health Plan (HDHP), you are not eligible for a Health Savings Account (HSA) under your HDHP and will be enrolled in a Health Reimbursement Arrangement (HRA) instead.*

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

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

How much should I contribute to my FSA?

Plan carefully when deciding how much to contribute to an FSA. Because of the tax benefits an FSA provides, the IRS requires that you forfeit any money for which you did not incur an eligible expense under your FSA account(s) during the Plan Year. This is known as the “Use-it-or-Lose-it” rule. FSAFEDS has adopted the “grace period” permitted by the IRS. You now have an additional 2 ½ months to incur eligible expenses and reduce any potential forfeitures. In addition, you will have until May 31, following the end of the Plan Year to submit claims for your eligible expenses incurred from January 1 through March 15 of the following year. For example if you enrolled in FSAFEDS for the 2005 Plan Year, you will have from January 1, 2005 until March 15, 2006 to incur eligible expenses and, you may submit claims for those expenses through May 31, 2006.

The FSAFEDS Calculator at www.FSAFEDS.com will help you plan your FSA allocations and provide an estimate of your tax savings based on your individual situation.

What can my HCFSA pay for?

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

Under the High Option of this plan, typical out-of-pocket expenses include: infertility testing and allergy testing.

Under the Standard Option of this plan, typical out-of-pocket expenses include: office visits, inpatient and outpatient hospital.

The IRS governs expenses reimbursable by a HCFSA. See Publication 502 for a comprehensive list of tax-deductible medical expenses. Since Publication 502 is primarily meant to help on preparing your Federal income tax return, there are two important differences to note. **Note: While you will see insurance premiums listed in Publication 502, they are NOT a reimbursable expense for FSA purposes. In addition, over-the-counter medicines and products ARE an eligible expense under your HCFSA, and this is not included in Publication 502.** Publication 502 can be found on the IRS Web site at <http://www.irs.gov/pub/irs-pdf/p502.pdf>. The FSAFEDS Web site also has a comprehensive list of eligible expenses at <https://www.FSAFEDS.com/fsafeds/eligibleexpenses.asp>. If you do not see your service or expense listed, please call an FSAFEDS Benefits Counselor at 1-877-FSAFEDS (372-3337), who will be able to answer your specific questions.

Tax savings with an FSA

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

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

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

Tax credits and deductions

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

Health care expenses

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

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

Paperless Reimbursement – This plan participates in the FSAFEDS paperless reimbursement program. When you enroll for your HCFSA, you will have the opportunity to enroll for paperless reimbursement. If you do, we will send FSAFEDS the information they need to reimburse you for your out-of-pocket costs so you can avoid filing paper claims.

Dependent care expenses

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

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

Does it cost me anything to participate in FSAFEDS?

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

Contact us

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

E-mail: FSAFEDS@shps.net

Telephone: 1-877-FSAFEDS (1-877-372-3337)

TTY: 1-800-952-0450

The Federal Long Term Care Insurance Program

It's important protection

Why should you consider applying for coverage under the **Federal Long Term Care Insurance Program (FLTCIP)**?

FEHB plans do not cover the cost of long term care. Also called "custodial care," long term care is help you receive to perform activities of daily living – such as bathing or dressing yourself - or supervision you receive because of a severe cognitive impairment. The need for long term care can strike anyone at any age and the cost of care can be substantial.

The Federal Long Term Care Insurance Program can help protect you from the potentially high cost of long term care. This coverage gives you options regarding the type of care you receive and where you receive it. With FLTCIP coverage, you won't have to worry about relying on your loved ones to provide or pay for your care.

It's to your advantage to apply sooner rather than later. In order to qualify for coverage under the FLTCIP, you must apply and pass a medical screening (called underwriting). Certain medical conditions, or combinations of conditions, will prevent some people from being approved for coverage. By applying while you're in good health, you could avoid the risk of having a future change in your health disqualify you from obtaining coverage. Also, the younger you are when you apply, the lower your premiums.

You don't have to wait for an open season to apply. The Federal Long Term Care Insurance Program accepts applications from eligible persons at any time. You will have to complete a full underwriting application, which asks a number of questions about your health. However, if you are a new or newly eligible employee, you (and your spouse, if applicable) have a limited opportunity to apply using the abbreviated underwriting application, which asks fewer questions. Newly married spouses of employees also have a limited opportunity to apply using abbreviated underwriting.

Qualified relatives are also eligible to apply. Qualified relatives include spouses and adult children of employees and annuitants, and parents, parents-in-law, and stepparents of

employees.

To request an Information Kit and application Call 1-800-LTC-FEDS (1-800-582-3337) (TTY 1-800-843-3557) or visit www.ltcfeds.com

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

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Summary of benefits for the High Option HMO - 2006

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

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

We only cover services provided or arranged by Plan physicians, except in emergencies.

High Option Benefits	You pay	Page
Medical services provided by physicians: Diagnostic and treatment services provided in the office	Office visit copay: \$15 primary care; \$15 specialist	20
Services provided by a hospital:	\$150 copayment per day, max \$450 per admission	36
Inpatient	\$100 copayment per facility use	38
Outpatient		
Emergency benefits		
In-area	\$100 per Emergency Room visit	41
Out-of-area	\$100 per Emergency Room visit	41
Mental health and substance abuse treatment	Regular cost sharing	42
Prescription drugs:		44
Retail pharmacy	\$10 generic, \$25 brand name, \$50 non-formulary	45
Mail order	\$20 generic, \$50 brand name, \$100 non-formulary	45
Dental care (accidental injury benefit only)	\$15 copayment per office visit	47
Vision care	No benefit.	48
Special features: Flexible benefits option; 24 hour nurse line		46
Protection against catastrophic costs (your catastrophic protection out-of-pocket maximum)	Nothing after \$1,000/Self Only or \$3,000/Family enrollment per year} Some costs do not count toward this protection	16

Summary of benefits for the Standard Option - 2006

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

Standard Option Benefits	After the calendar year deductible, you pay	Page
Medical services provided by physicians:		
Diagnostic and treatment services provided in the office	Office visit copay: \$20 primary care; \$30 specialist	20
Services provided by a hospital:		
Inpatient	\$250 copay per day max of \$750 per admission	36
Outpatient	* 20% coinsurance after the deductible	38
Emergency benefits:		
In-area	\$150 per Emergency Room visit	41
Out-of-area	\$150 per Emergency Room visit	41
Mental health and substance abuse treatment:	Regular cost sharing	42
Prescription drugs:		44
Retail pharmacy	\$10 generic, \$25 brand name, \$50 non-formulary	45
Mail order	\$20 generic, \$50 brand name, \$100 non-formulary	45
Dental care (accidental injury benefit only):	Office visit copay: \$20 primary care; \$30 specialist	47
Vision care:	No benefit.	48
Special features: Flexible benefits option; 24 hour nurse line		46
Protection against catastrophic costs (out-of-pocket maximum):	Nothing after \$2,500 (\$5,000 for family coverage) Some costs do not count toward this protection	16

Summary of benefits for HDHP - 2006

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.

HDHP Benefits	After the deductible, you pay	Page
Medical services provided by physicians:	In-network: 20% of the Plan allowance	55
Diagnostic and treatment services provided in the office	Out-of-network: 30% of the Plan allowance and any difference between our allowance and the billed amount.	
Services provided by a hospital:	In-network: 20% of the Plan allowance	68
Inpatient	Out-of-network: 30% of the Plan allowance and any difference between our allowance and the billed amount.	70
Outpatient		
Emergency benefits	In-network: 20% of the Plan allowance	
In-area	Out-of-network: 30% of the Plan allowance and any difference between our allowance and the billed amount.	72
Out-of-area		73
Mental health and substance abuse treatment	Regular cost sharing	74
Prescription drugs		75
Retail pharmacy	\$10 generic, \$35 brand name, \$60 non-formulary, after the deductible	75
Mail order	\$20 generic, \$70 brand name, \$120 non-formulary, after the deductible	75
Dental care (accidental injury benefit only)	In-network: 20% of the Plan allowance Out-of-network: 30% of the Plan allowance and any difference between	78
Vision care	No benefit.	
Special features: Flexible benefits option; 24 hour nurse line		77
Protection against catastrophic costs (your catastrophic protection out-of-pocket maximum) Some costs do not count toward this protection	In Network - Nothing after \$4,000/Self Only or \$8,000/Family enrollment per year Out-of-Network - Nothing after \$6,000/Self Only or \$12,000/Family enrollment per year	51

2006 Rate Information for Coventry Health Care of Louisiana

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

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

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

Type of Enrollment	Code	<i>Non-Postal Premium</i>	<i>Non-Postal Premium</i>	<i>Non-Postal Premium</i>	<i>Non-Postal Premium</i>	<i>Postal Premium</i>	<i>Postal Premium</i>
		<u>Biweekl</u> ¥	<u>Biweekl</u> ¥	<u>Monthly</u> Gov't Share	<u>Monthly</u> Your Share	<u>Biweekl</u> ¥	<u>Biweekl</u> ¥
Baton Rouge area							
High Option Self Only	JA1	\$139.18	\$94.22	\$301.56	\$204.14	\$164.31	\$69.09
High Option Self and Family	JA2	\$316.08	\$225.99	\$684.84	\$489.65	\$373.15	\$168.92
Standard Option Self-Only	JA4	\$139.18	\$67.08	\$301.56	\$145.34	\$164.31	\$41.95
HDHP Option	JA5	\$316.08	\$162.98	\$684.84	\$353.12	\$373.15	\$105.91
New Orleans area							
High Option Self Only	BJ1	\$129.94	\$43.31	\$281.54	\$93.84	\$153.76	\$19.49
High Option Self & Family	BJ2	\$301.78	\$100.59	\$653.85	\$217.95	\$357.10	\$45.27
Standard Option Self Only	BJ4	\$114.18	\$38.06	\$247.39	\$82.46	\$135.11	\$17.13
Standard Option Self & Family	BJ5	\$265.17	\$88.39	\$574.54	\$191.51	\$313.78	\$39.78
HDHP Option Self Only	HB1	\$93.32	\$31.10	\$202.19	\$67.39	\$110.42	\$14.00
HDHP Option Self & Family	HB2	\$216.73	\$72.24	\$469.58	\$156.52	\$256.46	\$32.51

Type of Enrollment	Code	<i>Non-Postal Premium</i>	<i>Non-Postal Premium</i>	<i>Non-Postal Premium</i>	<i>Non-Postal Premium</i>	<i>Postal Premium</i>	<i>Postal Premium</i>
		<u>Biweekl</u> Y	<u>Biweekl</u> Y	<u>Monthly</u>	<u>Monthly</u>	<u>Biweekl</u> Y	<u>Biweekl</u> Y
		Gov't Share	Your Share	Gov't Share	Your Share	USPS Share	Your Share
Shreveport area							
High Option Self Only	HS1	\$139.18	\$68.60	\$301.56	\$148.63	\$164.31	\$43.47
High Option Self & Family	HS2	\$316.08	\$161.82	\$684.84	\$350.61	373.15	\$104.75
Standard Option Self Only	HS4	\$128.77	\$42.92	\$279.00	\$93.00	\$152.37	\$19.32
Standard Option Self & Family	HS5	\$296.18	\$98.73	\$641.73	\$213.91	\$350.48	\$44.43
HDHP Option Self Only	L31	\$93.32	\$31.10	\$202.19	\$67.39	\$110.42	\$14.00
HDHP Option Self & Family	L32	\$216.73	\$72.24	\$469.58	\$156.52	\$256.46	\$32.51