



# Coventry Health Plan of Georgia, Inc.

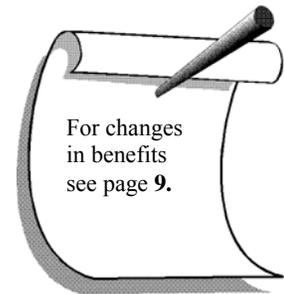
[www.chcga.com](http://www.chcga.com)

2006

## Health Maintenance Organization High Deductible Health Plan

Serving: *The Atlanta Metropolitan Area*

**Enrollment in this plan is limited. You must live or work in our Geographic service area to enroll. See page 8 for requirements.**



**Enrollment code for this Plan:**

- L51 High Deductible Health Plan – Self Only**
- L52 High Deductible Health Plan – Self and Family**

**Special Notice:** In 2006 we added a new Out-of-Network benefit.



**ACCREDITED  
HEALTH UTILIZATION  
MANAGEMENT**

This plan has URAC accreditation.  
See the 2005 Guide for more  
information on accreditation

Authorized for distribution by the:



**United States  
Office of Personnel Management**

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

**RI 73-837**

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Privacy Complaints  
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 Georgia About Our Prescription Drug Coverage and Medicare**

OPM has determined that Coventry Health Care of Georgia 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 Georgia 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.

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### **Please be advised**

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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 at a later date, 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](http://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](http://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

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This brochure describes the benefits of Coventry Health Care of Georgia, Inc. (Coventry) under our contract (CS 2898) with the United States Office of Personnel Management, as authorized by the Federal Employees Health Benefits law. The address for administrative offices is:

Coventry Health Care of Georgia, Inc.  
1100 Circle 75 Parkway, Suite 1400  
Atlanta, Georgia 30339

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

If you are enrolled in this Plan, you are entitled to the benefits described in this brochure. If you are enrolled in Self and Family coverage, each eligible family member is also entitled to these benefits.

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

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## Plain Language

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

- Except for necessary technical terms, we use common words. For instance, “you” means the enrollee or family member, “we” means Coventry Health Care of Georgia, 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](http://www.opm.gov/insure) or e-mail OPM at [fehwebcomments@opm.gov](mailto:fehwebcomments@opm.gov). You may also write to OPM at the U.S. Office of Personnel Management, Insurance Services Programs, Program Planning & Evaluation Group, 1900 E Street, NW, Washington, DC 20415-3650.

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## Stop Health Care Fraud!

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

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

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

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

- Carefully review explanations of benefits (EOBs) that you receive from us.
- Do not ask your doctor to make false entries on certificates, bills or records in order to get us to pay for an item or service.
- If you suspect that a provider has charged you for services you did not receive, billed you twice for the same service, or misrepresented any information, do the following:

Call the provider and ask for an explanation. There may be an error.

If the provider does not resolve the matter, call us at 800/418-3300 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.html](http://www.ahrq.gov/consumer/pathqpack.html). The Agency for Healthcare Research and Quality makes available a wide-ranging list of topics not only to inform consumers about patient safety but to help choose quality health care providers and improve the quality of care you receive.
- ▶ [www.npsf.org](http://www.npsf.org). The National Patient Safety Foundation has information on how to ensure safer health care for you and your family.
- ▶ [www.talkaboutrx.org/consumer.html](http://www.talkaboutrx.org/consumer.html). The National Council on Patient Information and Education is dedicated to improving communication about the safe, appropriate use of medicines.
- ▶ [www.leapfroggroup.org](http://www.leapfroggroup.org). The Leapfrog Group is active in promoting safe practices in hospital care.
- ▶ [www.ahqa.org](http://www.ahqa.org). The American Health Quality Association represents organizations and health care professionals working to improve patient safety.
- ▶ [www.quic.gov/report](http://www.quic.gov/report). Find out what federal agencies are doing to identify threats to patient safety and help prevent mistakes in the nation's health care delivery system.

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## Section 1. Facts about this plan

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

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

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

### General features of our High Deductible Health Plan

HDHPs have higher annual deductibles and annual out-of-pocket maximum limits than other types of FEHB plans.

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

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

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

- You may use the money in your HSA to pay all or a portion of the annual deductible, co-payments, coinsurance, or other out-of-pocket costs that meet the IRS definition of a qualified medical expense. Distributions from your HSA are tax-free for qualified medical expenses for you, your spouse, and your dependents, even if they are not covered by a HDHP. You may withdraw money from your HSA for items other than qualified medical expenses, but it will be subject to income tax and, if you are under 65 years old, an additional 10% penalty tax on the amount withdrawn.
- For each month that you are enrolled in an HDHP and eligible for an HSA, the HDHP will pass through (contribute) a portion of the health plan premium to your HSA. In addition, you (the account holder) may contribute your own money to your HSA up to an allowable amount determined by IRS rules. In addition, your HSA dollars earn tax-free interest.
- You may allow the contributions in your HSA to grow over time, like a savings account. The HSA is portable – you may take the HSA with you if you leave the Federal government or switch to another plan.
- If you are not eligible for an HSA, or become ineligible to continue an HSA, you are eligible for a Health Reimbursement Arrangement (HRA). Although an HRA is similar to an HSA, there are major differences.
  - An HRA does not earn interest.
  - An HRA is not portable if you leave the Federal government or switch to another plan.
- We protect you against catastrophic out-of-pocket expenses for covered services. Your annual out-of-pocket expenses for covered services, including deductibles and co-payments, are limited to \$5,000 for Self-Only enrollment, or \$10,000 for family coverage for in-network services and \$10,000 for self and \$20,000 family for out-of-network services.

### We have network providers

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

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

### **How we pay providers**

We pay hospitals, physicians and other health care providers based on contractually negotiated fees for services provided. These Participating Providers accept negotiated payment from Us; You will be responsible for your co-payments, coinsurance and deductibles.

Primary care physicians, specialists, hospitals and other providers in Coventry's network may be paid as follows:

- Per individual service (based on contracted rates)
- Per hospital day or admission (based on contractual arrangements)
- Per event, case rates for certain services

### **Your Rights**

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

- Coventry Health Care of Georgia, Inc. is a for profit company that has been serving the greater Metropolitan Atlanta service area for over ten years. We operate under the licensing requirements of Georgia's Office of Insurance and Safety Fire Commission.

If you want more information about us, call (800) 395-2545, or write to:

Coventry Health Care of Georgia Inc., P.O. Box 7711, London, KY 40742, Attn: Customer Service. You may also visit our Web site at [www.chcga.com](http://www.chcga.com).

### **Service Area**

To enroll in this Plan, you must live or work in our Service Area. This is where our network providers practice. Our Service Area consists of the following counties: Barrow, Bartow, Cherokee, Clayton, Cobb, Coweta, DeKalb, Douglas, Fayette, Forsyth, Fulton, Gwinnett, Hall, Henry, Jackson, Newton, Paulding, Rockdale, Spalding, and Walton.

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

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## Section 2 How we changed for 2006

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- Your share of the non-Postal premium will increase by 21.9% for Self Only or 22.7% for Self and Family
- We have increased our HSA/HRA contributions to \$1,250 for individuals and \$2,500 for families. Previously the contributions were, respectively, \$500 and \$1,000.

### **In-network**

- We have changed our current HDHP benefit to an in-network benefit with the following changes:
- The individual deductible is \$2,250 instead of \$1,500.
- The family deductible is \$4,500 instead of \$3,000.
- The retail prescription drug co-payments are \$10 per generic formulary, \$25 per formulary drugs and \$40 per non-formulary drugs. Previously, the co-payments were \$10 per generic formulary, \$25 per formulary drugs and \$50 per non-formulary drugs.
- The mail order prescription drug co-payments are \$20 per generic formulary, \$50 per formulary drugs and \$80 per non-formulary drugs. Previously, the co-payments were \$20 per generic formulary, \$50 per formulary drugs and \$100 per non-formulary drugs.
- Coinsurance is now 20% instead of 15% for all other covered benefits except:
  - Emergency room - \$150 per visit
  - Ambulance - \$150 co-payment per trip

### **Out-of-network**

- We have added an out-of-network HDHP benefit in 2006.

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## Section 3. How you get care

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### Identification cards

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

If you do not receive your ID card within 30 days after the effective date of your enrollment, or if you need replacement cards, call us at (800) 395-2545 or write to us at **Coventry Health Care of Georgia, Inc., P.O. Box 7711, London, KY 40742**. You may also request replacement cards through our Web site: [www.chcga.com](http://www.chcga.com).

### Where you get covered care

You get care from Our network of Participating Providers.

- **Plan providers**

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

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

- **Plan facilities**

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

### What you must do to get covered care

It depends on the type of care you need. This plan does not require you or members of your family to select a Primary Care Physician (PCP). However, we encourage you and each member of your family to select a PCP so that he or she can coordinate care for you and your family.

- **Primary care**

Health Plan Members may choose their PCP from the Directory of Health Care Providers, a list of Family and General Practitioners, Internists and Pediatricians which is updated monthly. This list may be obtained by calling the Customer Services Department at (800) 395-2545 Monday through Friday, 7:00 a.m. to 6:00 p.m. or via our web site, [www.chcga.com](http://www.chcga.com).

- **Specialty care**

In the event that you require a Specialist's services, you may seek care directly from the specialist or your PCP may coordinate your care. All care must be obtained from a Participating Provider unless specifically authorized by Us, in accordance with Our policies and procedures.

- **Hospital care**

Your PCP or the Participation Physician who admits You to an inpatient or outpatient facility is responsible for obtaining Authorization from Us. If you are in the hospital when your enrollment in our Plan begins, call our Customer Service Department immediately at (800) 395-2545. 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 92<sup>nd</sup> day after you become a member of this Plan, whichever happens first.

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

### **How to get approval for...**

- **HMO Network Coverage Option**

In the event You require a Specialist's services or Hospitalization, Your PCP (if you have one) may be required to coordinate Your care. All care must be obtained from a Participating Provider unless specifically authorized by Us, in accordance with Our policies and procedures.

Your PCP or the Participating Physician who admits You to an inpatient or outpatient facility is responsible for obtaining Authorization from Us. For all other care, You may make an appointment directly with the designated Participating Provider to obtain the Covered Services unless an Authorization is otherwise required in the Schedule of Benefits (see Section 5). Notification letters for approvals and denials will be sent to both Members and Providers for all services that require Authorization.

- **Your hospital stay**

The Participating Physician who coordinates your care or admits you to an inpatient or outpatient facility is responsible for obtaining Authorization from us. Notification letters for approvals and denials will be sent to both Members and Providers for all services that require Authorization.

- **Self Referral**

You may receive Medically Necessary care from Participating Providers without referral from the your Primary Care Physician of record or authorization from us or you may receive Medically Necessary care from Providers who are not affiliated with us in any way. Such services may be delivered in or out of the Service Area.

If You self-refer to a Participating Provider, the Participating Physician who admits You to an inpatient or outpatient facility is responsible for obtaining Authorization from Us. For all other care, You may make an appointment directly with the designated Participating Provider to obtain the Covered Services unless an Authorization is otherwise required in the schedule of Benefits (see Section 5). Notification letters for approvals and denials will be sent to both Members and Providers for all services that require Authorization.

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

You may receive Covered Services from Non-Participating Providers. If you self-refer to a Non-Participating Provider, You are responsible for ensuring that the Non-Participating Provider complies with Our Utilization Management Policies. You must in certain situations receive Pre-Authorization from Us prior to receiving a Covered Service (call Our Customer Service Department to determine when Covered Services require Pre-Authorization). Under the Out-of-Network Option, the Covered Services may be delivered in or out of the Service Area. Not all services may be obtained from an Out-of-Network provider, including but not limited to transplants and vision services. Except for Emergency Services, coverage for Covered Services provided by Non-Participating Providers is limited to the Out-of-Network Rate less applicable Co-payments, Coinsurance and Deductibles.

**Out-of-Network Rate**

We reimburse non-Participating Providers at the Out-of-Network Rate which is based on Medicare's Atlanta region fee schedule or, if Medicare does not have a comparable procedure code, then the rate is based on St. Anthony's Atlanta region fee schedule. If neither Medicare nor St. Anthony's values a procedure code, then reimbursement is based on a percentage of billed charge for that procedure code.

If the amount You are charged for a Covered Service is equal to or less than the Out-of-Network Rate, the charges should be completely Covered by Your Out of Network Benefit, except for any Co-payment, Deductible and Coinsurance payments You must make. However, if the amount You are charged is in excess of the Out-of-Network Rate for a particular Covered Service, you must pay the excess, in addition to any applicable Co-payment, Deductible and Coinsurance payments.

**Circumstances beyond our control**

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

**Services requiring our prior approval**

For In-Network benefits, the Participating Physician who coordinates Your care or admits You to an inpatient or outpatient facility is responsible for obtaining Authorization from Us. Notification letters for approvals and denials will be sent to both Members and Providers for all services that require Authorization. We call this review and approval process precertification or preauthorization. For Out-of-Network benefits, you are responsible for obtaining Authorization from us.

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## Section 4. Your cost for covered services

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This is what you will pay out-of-pocket for covered care.

### **Co-payments**

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

Example: When you receive a prescription from the pharmacy, you pay \$10 for generic formulary drugs after the deductible.

### **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. Coinsurance for preventive care do not count toward any deductible.

The calendar year In-Network deductible is \$2,250 for self-only and \$4,500 for self and family. The calendar year Out-of-Network deductible is \$5,000 for self-only and \$10,000 for self and family.

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. Most services unless otherwise stated in this brochure are subject to 20% coinsurance.

Example: You pay 20% of our allowance for physician services and durable medical equipment.

Note: If your provider routinely waives (does not require you to pay) your co-payments, 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 20% coinsurance, the actual charge is \$80. We will pay \$64.00 (80% of the actual charge of \$80).

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

The In-Network out-of-pocket maximum is \$5,000 for self only and \$10,000 for self and family. The Out-of-Network out-of-pocket maximum is \$10,000 for self only and \$20,000 for self and family.

Be sure to keep accurate records of your co-payments since you are responsible for informing us when you reach the maximum.

### **Carryover**

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

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## Section 5. Benefits

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Note: This benefits section is divided into subsections. Please read the important things you should keep in mind at the beginning of each subsection. Also read the General Exclusions in Section 6; they apply to the benefits in the following subsections. To obtain claim forms, claims filing advice, or more information about HDHP benefits, contact us at (800) 395-2545 or at our Web site at [www.chcga.com](http://www.chcga.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. If we establish an HRA for you we will credit 1/12th per month of eligibility.

With this Plan, preventive care, after applicable co-payments, is covered in full. As you receive other non-preventive medical care, you must meet the Plan's deductible before we pay benefits. 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), and well-child care, child and adult immunizations, disease management and wellness programs. These services are covered at 100% after any applicable coinsurance, when 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 5.1(b). The Plan typically pays 80% for in-network care. This plan provides no out-of-network benefits.

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 5.1(c) for more details).

## **HSA**

By law, HSAs are available to members who are not eligible for Medicare or do not have other health insurance coverage. In 2006, for each month you are eligible for an HSA premium pass through, we will contribute to your HSA \$104.17 per month for a Self-Only enrollment or \$208.33 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, which in this case is \$2,250 for self only and \$4,500 for self and family. See maximum contribution information in Section 5.1(c). You can use funds in your HSA to help pay your health plan deductible.

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

HSA features include:

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

## **HRA**

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

In 2006, we will give you an HRA credit of \$104.17 per month for a Self-Only enrollment or \$208.33 per month 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, Inc.
- 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 co-payments) for covered services is limited to \$5,000 per person or \$10,000 per family enrollment for in-network services (\$10,000 per person or \$20,000 per family for Out-of-Network Services). 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 5.1(b)

Traditional medical coverage subject to the deductible, and Section 5.1(d) Catastrophic protection for out-of-pocket expenses for more details.

## **Health education resources and account management tools**

Section 5.1(e) describes the health education resources and account management tools available to you to help you manage your health care and your health care dollars.

These resources include health assessment tools, information on maintaining health, details on disease management, cost of care information and other useful information. You can find this information on our web site, [www.chcga.com](http://www.chcga.com)

## Section 5.1 (a) Preventive care

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

- The Plan pays 100% for the preventive care services listed in this section (after any applicable co-payments or coinsurance) as long as you use a network provider.
- For all other covered expenses, please see Section 5.1(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
<b>Preventive care, adult</b>	
Professional services, such as: <ul style="list-style-type: none"> <li>• Routine physicals</li> <li>• Routine screenings</li> <li>• Routine immunizations</li> </ul>	In Network: 20% Coinsurance Out-of-Network: 40% Coinsurance
Not covered: <ul style="list-style-type: none"> <li>• <i>Physical exams required for obtaining or continuing employment or insurance, or travel.</i></li> <li>• <i>Immunizations, boosters, and medications for travel.</i></li> </ul>	All charges.
<b>Preventive care, children</b>	
<ul style="list-style-type: none"> <li>• Professional services, such as:</li> <li>• Well-child visits for routine examinations, immunizations and care (up to age 22)</li> <li>• Childhood immunizations recommended by the American Academy of Pediatrics</li> <li>• 1 routine eye exam every 12 months</li> <li>• Hearing testing for children through age 17</li> </ul>	In Network: 20% Coinsurance Out-of-Network: 40% Coinsurance
Not covered: Physical exams required for obtaining or continuing employment or insurance, attending schools or camp, or travel. <ul style="list-style-type: none"> <li>• <i>Immunizations, boosters, and medications for travel.</i></li> </ul>	All charges.

## Section 5.1 (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 preventive care is covered at 100% after applicable co-payments or coinsurance under Section 5.1 and is not subject to the calendar year deductible. Traditional Medical Coverage is subject to the deductible.
- The calendar year In-Network deductible is \$2,250 per person or \$4,500 per family enrollment. The Out-of-Network deductible is \$5,000 for self-only and \$10,000 for self and family. The family deductible can be satisfied by one or more family members. The deductible applies to almost all benefits in Section 5.1. You must pay your deductible before your Traditional Medical Coverage may begin.
- Under Traditional Medical Coverage, you are responsible for your coinsurance and co-payments 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, co-payments and deductibles total \$5,000 per person or \$10,000 per family enrollment for in-network benefits or \$10,000 per person or \$20,000 per family enrolment for out-of-network benefits in any calendar year, you do not have to pay any more for covered services from network providers. However, certain expenses do not count toward your out-of-pocket maximum and you must continue to pay these expenses once you reach your out-of-pocket maximum (such as expenses in excess of the Plan’s benefit maximum, or if you use out-of-network providers, amounts in excess of the Plan allowance).
- In-network benefits apply only when you use a network provider.
- 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	You pay
The deductible applies to almost all benefits in this section. In the You pay column, we say “No deductible” when it does not apply. When you receive covered services from network providers, you are responsible for paying the allowable charges until you meet the deductible.	100% of allowable charges until you meet the deductible of \$2,250 per person or \$4,500 per family enrollment for In-Network Services. 100% of allowable charges until you meet the deductible of \$5,000 per person or \$10,000 per family enrollment for Out-of-Network Services.
After you meet the deductible, we pay the allowable charge (less your coinsurance or co-payment) until you meet the annual catastrophic out-of-pocket maximum.	After you meet the deductible, you pay the indicated coinsurance or co-payments for covered services. You may choose to pay the coinsurance and co-payments from your HSA or HRA, or you can pay for them out-of-pocket.

**Section 5.1(b)(1).Medical services and supplies provided by physicians & other health care professionals**

Benefit Description	After the deductible, you pay
<b>Diagnostic and treatment services</b>	
Professional services of physicians <ul style="list-style-type: none"> <li>• In physician’s office</li> <li>• In an urgent care center for routine services</li> <li>• During a hospital stay</li> <li>• In a skilled nursing facility</li> <li>• Physician Services At home</li> </ul>	In Network: 20% Coinsurance Out-of-Network: 40% Coinsurance
<b>Lab, X-ray and other diagnostic tests</b>	
Tests, such as: <ul style="list-style-type: none"> <li>• Radiology imaging, blood tests, X Rays</li> <li>• MRI, CAT and PET Scans</li> </ul>	In Network: 20% Coinsurance Out-of-Network: 40% Coinsurance
<b>Maternity care</b>	
Complete maternity (obstetrical) care, such as: <ul style="list-style-type: none"> <li>• Prenatal/Postnatal care (one time co-payment, covered under Section 5.1(a) Preventive care)</li> <li>• Delivery</li> <li>• Note: Here are some things to keep in mind:               <ul style="list-style-type: none"> <li>• You do not need to precertify your normal delivery; see below for other circumstances, such as extended stays for you or your baby.</li> <li>• You may remain in the hospital up to 48 hours after a regular delivery and 96 hours after a cesarean delivery. We will cover an extended inpatient stay if medically necessary but you, your representatives, your doctor, or your hospital must recertify the extended stay.</li> <li>• We cover routine nursery care of the newborn child during the covered portion of the mother’s maternity stay. We will cover other care of an infant who requires non-routine treatment only if we cover the infant under a Self and Family enrollment. Surgical benefits, not maternity benefits, apply to circumcision.</li> <li>• We pay hospitalization and surgeon services (delivery) the same as for illness and injury. See Hospital benefits and Surgery benefits.</li> </ul> </li> </ul>	In Network: 20% Coinsurance Out-of-Network: 40% Coinsurance
<i>Not covered: Newborns Home Delivery</i>	All charges.

<b>Family planning</b>	<b>After the deductible, you pay</b>
<ul style="list-style-type: none"> <li>• Elective Sterilization</li> <li>• Covered Services include sterilization for both sexes, counseling, treatment and follow-up, information on birth control, insertion and removal of intra-uterine devices and Norplant and measurement for contraceptive diaphragms.</li> </ul>	In Network: 20% Coinsurance Out-of-Network: 40% Coinsurance
Not covered: Reversal of voluntary sterilization	All charges.
<b>Infertility services</b>	<b>After the deductible, you pay</b>
Diagnosis and treatment of infertility such as: <ul style="list-style-type: none"> <li>– Artificial insemination: intravaginal insemination (IVI)</li> <li>– intracervical insemination (ICI)</li> <li>– intrauterine insemination (IUI)</li> </ul> Fertility drugs Note: We cover injectable fertility drugs under medical benefits and oral fertility drugs under the prescription drug benefit.	In Network: 20% Coinsurance Out-of-Network: 40% Coinsurance
<i>Not covered:</i> <i>Assisted Reproductive Technologies (ART), including but not limited to:</i> <i>In vitro fertilization</i> <i>Treatment for infertility when the Follicle Stimulating Hormone (FSH) level is greater than 19 mIU/ml</i> <i>Reversal of voluntary sterilization</i> <i>Embryo transfer including gamete (GIFT) and zygote (ZIFT )</i> <i>Any services performed to induce ovulation or sperm production, such as ultrasounds, laboratory services, physicians services and supplies.</i> <i>All costs associated with surrogate motherhood and supplies relating to conception, pregnancy and delivery</i> <i>Any costs associated with acquiring, or storing donor sperm</i> <i>Any treatments for infertility when the cause is due to voluntary sterilization</i>	All charges.
<b>Allergy care</b>	<b>After the deductible, you pay</b>
Testing and treatment Allergy injections	In Network: 20% Coinsurance Out-of-Network: 40% Coinsurance
Allergy serum	Nothing

<b>Treatment therapies</b>	<b>After the deductible, you pay</b>
Growth Hormone Therapy is a Covered Service based upon Coventry's medical criteria. Radiation Therapy Respiratory and Inhalation Therapy Chemotherapy Cardiac rehabilitation, limited to 30 visits per calendar Pulmonary rehabilitation, limited to 30 visits per calendar	In Network: 20% Coinsurance Out-of-Network: 40% Coinsurance
<b>Physical and occupational therapies</b>	<b>After the deductible, you pay</b>
60 days per condition for the services of each of the following: 1. qualified physical therapists 2. occupational therapists	In Network: 20% Coinsurance Out-of-Network: 40% Coinsurance
<i>Not covered:</i> – Long term rehabilitative therapy – Exercise programs	<i>All charges.</i>
<b>Speech therapy</b>	<b>After the deductible, you pay</b>
60 days per condition	In Network: 20% Coinsurance Out-of-Network: 40% Coinsurance
<b>Hearing services (testing, treatment and supplies)</b>	<b>After the deductible, you pay</b>
See preventive care, children	See preventive care, children
<b>Vision services (testing, treatment, and supplies)</b>	<b>After the deductible, you pay</b>
Treatment of diseases or injury to the eye	In Network: 20% Coinsurance Out-of-Network: 40% Coinsurance
<i>Not covered: Eye exercises and therapy; Eye glasses, contact and corrective lenses unless Covered by a Rider to the Health Plan; An exception is made for the first pair of corrective lenses following cataract surgery or to treat eye conditions such as keratoconus; Radial keratotomy and laser eye surgery to correct refractive errors.</i>	<i>All charges.</i>
<b>Foot care</b>	<b>After the deductible, you pay</b>
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.	In Network: 20% Coinsurance Out-of-Network: 40% Coinsurance
<i>Not covered:</i> <i>Foot care that is routine, such as removal or reduction of corns and calluses, clipping of the nail, treatment of flat feet, fallen arches and chronic foot strain except for patients with diabetes or ischemic vascular disease</i> <i>Foot orthotics, except orthotics for treatment of patients with diabetes and/or ischemic foot disease.</i>	<i>All charges.</i>

Orthopedic and prosthetic devices	After the deductible, you pay
<p>External prosthetic items and devices are generally not covered except for those items specified as Covered such as breast prostheses and lymphedema sleeves prescribed following a mastectomy for breast cancer or breast disease.</p>	<p>In Network: 20% Coinsurance Out-of-Network: 40% Coinsurance</p>
<p><i>Not covered: Examples of prosthetic items and devices which We do not cover include but are not limited to: cosmetic prostheses, orthopedic shoes and other supportive devices for the feet; splints and braces unless they are used instead of casts for fractures; prosthetics specifically intended for sports or occupational purposes; penile prostheses or sexual aids; repair or replacement due to Your inappropriate use or maintenance of the device; replacement required because the device is lost, misplaced or stolen. We do not cover the replacement, repair or maintenance of any prosthetic item or device that is not Covered.</i></p>	<p><i>All charges.</i></p>
Durable medical equipment (DME)	After the deductible, you pay
<p>Rental or purchase, at our option, including repair and adjustment, of durable medical equipment prescribed by your physician, such as oxygen and dialysis equipment. Under this benefit, we also cover.</p> <ul style="list-style-type: none"> <li>– Hospital beds;</li> <li>– Wheelchairs;</li> <li>– Crutches;</li> <li>– Walkers;</li> <li>– Blood glucose monitors; and</li> <li>– Insulin pumps</li> </ul> <p>Note: Call us at 800-395-2545 as soon as your Plan physician prescribes this equipment. We will arrange with a health care provider to rent or sell you durable equipment at discounted rates and will tell you more about this service when you call.</p>	<p>In Network: 20% Coinsurance Out-of-Network: 40% Coinsurance</p>
<p><i>Not covered: including, but not limited to: Comfort or convenience items; bed boards; bath and toilet lifts; chairs and rails, chair lifts; over-bed tables; wheelchair trays and flotation devices; air purifiers; exercise equipment; stethoscopes; blood pressure gauges; breast pumps; orthopedic shoes; shoe inserts and arch supports, abduction bars, heel lifts, cups and pads, elastic support stockings; light box therapy and lymphedema sleeves (unless covered under Section 5); Any item or device commonly available without a prescription; Motorized scooters except when determined to be Medically Necessary by Us for severe debilitating neuromuscular disorders such as late stage multiple sclerosis or amyotrophic lateral sclerosis (ALS or Lou Gehrig's Disease); Cranial molding helmets.</i></p>	<p><i>All charges.</i></p>

<b>Home health services</b>	<b>After the deductible, you pay</b>
<p>Covered Service when all of the following requirements are met:  the service is ordered by a Physician;  services required are of a type which can only be performed by a licensed nurse, physical therapist, speech therapist, or occupational therapist;  the services are a substitute or alternative to hospitalization;  part-time intermittent services are required;  a treatment plan has been established and periodically reviewed by the ordering Physician;  the services are authorized by Us;  the agency rendering services is Medicare certified and licensed by the State of location; and the Member is home bound.</p>	<p>In Network: 20% Coinsurance  Out-of-Network: 40% Coinsurance</p>
<p><i>Not covered:</i>  Care rendered by a relative; transportation; care delivered primarily for convenience or personal assistance. Custodial and domiciliary care, residential care, protective and supportive care including, but not limited to, educational services, rest cures, and convalescent care; This also includes assistance in the home with activities of daily living such as bathing, dressing, eating and preparing meals, shopping, performing general household services, and taking medication</p>	<p><i>All charges.</i></p>
<b>Chiropractic</b>	<b>After the deductible, you pay</b>
<p>6 visits per calendar year</p>	<p>In Network: 20% Coinsurance  Out-of-Network: 40% Coinsurance</p>
<b>Alternative treatments</b>	<b>After the deductible, you pay</b>
<p><i>No Benefit</i></p>	<p><i>All charges</i></p>
<b>Educational classes and programs</b>	<b>After the deductible, you pay</b>
<p>Diabetic outpatient self-management training and education  Nutritional Counseling provided by a Registered Dietician or Participating Physician in connection with diabetes, coronary artery disease and hyperlipidemia.  Wellness Program directory which contains information about health clubs, child care services, educational programs, vision care discounts and other innovative wellness services.</p>	<p>Nothing</p>
<p><i>Not covered: Classes and programs not expressly listed as Covered Services</i></p>	<p><i>All charges.</i></p>

**Section 5.1 (b) (2) Surgical and anesthesia services provided by physicians & other health care professionals**

Benefit Description	After the deductible, you pay
<b>Surgical procedures</b>	
YOUR PARTICIPATING PROVIDER IS RESPONSIBLE FOR OBTAINING PRECERTIFICATION FOR SURGICAL PROCEDURES. Please refer to the precertification information in Section 3.	
<p>A comprehensive range of services, such as:</p> <ul style="list-style-type: none"> <li>Operative procedures</li> <li>Treatment of fractures, including casting</li> <li>Normal pre- and post-operative care by the surgeon</li> <li>Correction of amblyopia and strabismus</li> <li>Endoscopy procedures</li> <li>Biopsy procedures</li> <li>Removal of tumors and cysts</li> </ul> <ul style="list-style-type: none"> <li>• Correction of congenital anomalies (see Reconstructive surgery)</li> <li>• Surgical treatment of morbid obesity (Bariatric surgery)               <ul style="list-style-type: none"> <li>- A condition in which an individual weighs 100 pounds or 100% over his or her normal weight according to current underwriting standards eligible members must be age 18 or over.</li> <li>- When we approve coverage, we provide treatment of morbid obesity through gastric bypass surgery or another surgical method that is recognized by the National Institutes of Health as effective for the long-term reversal of morbid obesity and consistent with criteria approved by the National Institutes of Health.</li> <li>- We provide benefits like any other medically necessary surgical procedures for Members whose body mass index is greater than 40 kilograms per meter squared, or equal to or greater than 35 kilograms per meter squared with a co-morbid medical condition including hypertension, cardiopulmonary condition, sleep apnea or diabetes.</li> <li>- Body mass index is calculated by dividing the Member’s weight in kilograms by the Member’s height in meters squared.</li> </ul> </li> <li>• Insertion of internal prosthetic devices. See 5.1(b)(1) – <i>Orthopedic and prosthetic devices</i> for device coverage information</li> <li>• Voluntary sterilization (e.g., Tubal ligation, Vasectomy)</li> <li>• Treatment of burns.</li> <li>• Note: Generally, we pay for internal prostheses (devices) according to where the procedure is done. For example, we pay Hospital benefits for a pacemaker and Surgery benefits for insertion of the pacemaker.</li> </ul>	<p>In Network: 20% Coinsurance Out-of-Network: 40% Coinsurance</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li><i>Surgeries primarily performed for cosmetic purposes</i></li> <li><i>Surgery to reverse voluntary sterilization</i></li> <li><i>Surgery to correct refractive conditions for vision</i></li> </ul>	<p><i>All charges.</i></p>

<b>Reconstructive surgery</b>	<b>After the deductible, you pay</b>
<p>Surgery to correct a functional defect</p> <p>Surgery to correct a condition caused by injury or illness if:</p> <ul style="list-style-type: none"> <li>– the condition produced a major effect on the member’s appearance and</li> <li>– the condition can reasonably be expected to be corrected by such surgery</li> </ul> <p>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.</p> <p>All stages of breast reconstruction surgery following a mastectomy, such as:</p> <ul style="list-style-type: none"> <li>– surgery to produce a symmetrical appearance of breasts;</li> <li>– treatment of any physical complications, such as lymphedemas;</li> <li>– breast prostheses and surgical bras and replacements (see Prosthetic devices)</li> </ul> <p>Note: If you need a mastectomy, you may choose to have the procedure performed on an inpatient basis and remain in the hospital up to 48 hours after the procedure.</p>	<p>In Network: 20% Coinsurance Out-of-Network: 40% Coinsurance</p>
<p><i>Not covered:</i></p> <p><i>Surgeries primarily performed for cosmetic purposes</i></p> <p><i>Surgery to reverse voluntary sterilization</i></p> <p><i>Surgeries for sexual transformation</i></p>	<p><i>All charges.</i></p>
<b>Oral and maxillofacial surgery</b>	<b>After the deductible, you pay</b>
<p>Covered Service for the removal of tumors and cysts of the jaws, lips, cheeks, tongue, roof and floor of the mouth, and removal of bony growths of the jaw, soft and hard palate when the member’s health is affected.</p> <p>Coverage benefit limited to the functional restoration of structures and treatment as a result of trauma resulting in fracture of jaw or laceration of mouth, tongue, or gums when:</p> <ul style="list-style-type: none"> <li>• Both the injury and the treatment occur while Your Coverage under this Health Plan is in effect; and you seek treatment within twenty-four (24) hours of the accidental injury.</li> <li>• TMJ related services (non-dental)</li> </ul> <p>General anesthesia and associated charges related to dental services may be Covered Services, as set forth in Section 5.1(b).</p>	<p>In Network: 20% Coinsurance Out-of-Network: 40% Coinsurance</p>
<p><i>Not covered:</i></p> <p><i>Oral implants or transplants</i></p> <p><i>Procedures that involve the teeth or their supporting structures (such as the periodontal membrane, gingiva, and alveolar bone).</i></p>	<p><i>All charges.</i></p>

Organ/tissue transplants	After the deductible, you pay
<p>Limited to:</p> <ul style="list-style-type: none"> <li>• Cornea</li> <li>• Heart</li> <li>• Heart/lung</li> <li>• Kidney</li> <li>• Kidney/Pancreas</li> <li>• Liver</li> <li>• Lung: Single – Double</li> <li>• Pancreas</li> <li>• Allogeneic (donor) bone marrow transplants</li> <li>• Autologous bone marrow transplants (autologous stem cell and peripheral stem cell support) for the following conditions: acute lymphocytic or non-lymphocytic leukemia; advanced Hodgkin’s lymphoma; advanced non-Hodgkin’s lymphoma; advanced neuroblastoma; breast cancer; multiple myeloma; epithelial ovarian cancer; and testicular, mediastinal, retroperitoneal and ovarian germ cell tumors</li> <li>• Intestinal transplants (small intestine) and the small intestine with the liver or small intestine with multiple organs such as the liver, stomach, and pancreas</li> <li>• Coventry Transplant Network</li> </ul> <p>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.</p> <p>Donor screening tests are Covered and are subject to a lifetime benefit maximum of ten thousand dollars (\$10,000) when performed at a facility approved by Us.</p> <p>If not Covered by any other source, the cost of any care, including complications, arising from an organ donation by a Non-Covered individual when the recipient is a Covered individual will be Covered for the duration of the contract of the Covered individual when approved by Us.</p> <p>The cost of any care, including complications, arising from an organ donation by a Covered individual when the recipient is not a covered individual is Excluded. Travel expenses for members and living donors are covered according to Our transplant travel benefit. Members are covered when CHC is the primary insurer and a Coventry Transplant Network Facility is used.</p>	<p>In Network: 20% Coinsurance Out-of-Network: 40% Coinsurance</p>
<p><i>Not covered:</i></p> <p><i>Transplant services not authorized and obtained at a Coventry Transplant Network Facility determined by Us; donor screening tests; Experimental or Investigational procedures; travel and lodging expenses incurred by a Member who resides less than one hundred fifty (150) miles from the Coventry Transplant Network Facility; and any related conditions or complications related to organ donation when a Member is donating organ or tissue to a non-Covered individual.</i></p>	<p><i>All charges.</i></p>

<b>Anesthesia</b>	<b>After the deductible, you pay</b>
Professional services provided in – Hospital (inpatient)	In Network: 20% Coinsurance Out-of-Network: 40% Coinsurance
Professional services provided in – Hospital outpatient department Skilled nursing facility Ambulatory surgical center Office  Anesthesia and Hospital or facility charges for dental services performed in a Hospital or ambulatory surgical facility in connection with dental procedures for children seven (7) years of age or younger, persons with serious mental or physical conditions and persons with significant behavioral problems, where the Provider treating the patient certifies that because of the patient's age or condition or problem, hospitalization or general anesthesia is required in order to safely and effectively perform the dental procedure(s) will be Covered. Prior Authorization of the facility will be required in accordance to the Health Plan's utilization review process.	In Network: 20% Coinsurance Out-of-Network: 40% Coinsurance
<i>Not Covered: Professional fees for oral surgeons and dental providers associated with such treatment are not Covered.</i>	<i>All charges</i>

### Section 5.1 (b) (3) Services provided by a hospital or facility, and ambulance services

Benefit Description	After the deductible, you pay
<p><b>Inpatient hospital</b></p> <p>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 5.1(b)(1) or (b)(2).  <b>YOUR PHYSICIAN MUST GET PRECERTIFICATION OF HOSPITAL STAYS.</b></p>	
<p>Room and board, such as:            Ward, semiprivate, or intensive care accommodations;            General nursing care; and            Meals and special diets.            Note: If you want a private room when it is not medically necessary, you pay the additional charge above the semiprivate room rate.</p>	<p>In Network: 20% Coinsurance            Out-of-Network: 40% Coinsurance</p>
<p><i>Not covered:</i>  <i>Personal comfort and convenience items, including but not limited to, televisions and telephones.</i></p>	<p><i>All charges.</i></p>

<b>Outpatient hospital or ambulatory surgical center</b>	<b>After the deductible, you pay</b>
<ul style="list-style-type: none"> <li>• Other hospital services and supplies, such as:</li> <li>• Operating, recovery, and other treatment rooms</li> <li>• Prescribed drugs and medicines</li> <li>• Diagnostic laboratory tests, X-rays, and pathology services</li> <li>• Administration of blood, blood plasma, and other biologicals</li> <li>• Blood and blood plasma, if not donated or replaced</li> <li>• Pre-surgical testing</li> <li>• Dressings, casts, and sterile tray services</li> <li>• Medical supplies, including oxygen</li> <li>• Anesthetics and anesthesia service</li> </ul> <p>Note: – We cover hospital services and supplies related to dental procedures when necessitated by a non-dental physical impairment. We do not cover the dental procedures.</p>	<p>In Network: 20% Coinsurance Out-of-Network: 40% Coinsurance</p>
<p><i>Not covered: blood and blood derivatives not replaced by the member</i></p>	<p><i>All charges.</i></p>
<b>Skilled nursing facility (SNF) benefits</b>	<b>After the deductible, you pay</b>
<p>60 days per benefit year</p>	<p>In Network: 20% Coinsurance Out-of-Network: 40% Coinsurance</p>
<p><i>Not covered: Custodial and domiciliary care, residential care, protective and supportive care including, but not limited to, educational services, rest cures, and convalescent care.</i></p>	<p><i>All charges.</i></p>
<b>Hospice care</b>	<b>After the deductible, you pay</b>
<ul style="list-style-type: none"> <li>• Covered Service. If You are terminally ill, the Health Plan covers hospice services, if all of these conditions are met:</li> </ul> <p>You elect to receive care in or by a hospice provider;</p> <p>Your Provider certifies that You have a life expectancy of six (6) months or less; and</p> <p>Before the services are provided, Your Provider prepares a written treatment plan authorizing the services.</p> <ul style="list-style-type: none"> <li>• Medically Necessary services, provided by a state licensed hospice within the Service Area, are Covered.</li> </ul>	<p>In Network: 20% Coinsurance Out-of-Network: 40% Coinsurance</p>
<p><i>Not covered: Independent nursing, homemaker services</i></p>	<p><i>All charges.</i></p>

<b>Ambulance</b>	<b>After the deductible, you pay</b>
<ul style="list-style-type: none"> <li>Local professional Ambulance services to the nearest facility are included as Covered emergency health services when emergency visit meets Emergency Services criteria in 5.1(b)4.</li> </ul>	\$150 per trip

## Section 5.1 (b) (4) 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:

You may be liable for all Emergency Services costs if the procedures listed below are not followed.

When an Emergency occurs, whether in or out of the Service Area, seek medical attention immediately. You or a family member must notify Us within forty-eight (48) hours or the next business day, unless it is not reasonably possible to do so, at (800) 395-2545. The determination of Covered Services is based on Our review of the medical records and symptoms. Services provided in a Hospital Emergency room for non-Emergencies are Excluded.

In the event a Member seeks Emergency Services and, if deemed necessary in the opinion of the emergency health care Provider responsible for the Member's emergency care and treatment and, if warranted by his/her evaluation, the emergency Provider may initiate necessary intervention to stabilize the condition of the Member without seeking or receiving prospective Authorization by the Health Plan.

If, in the opinion of the emergency health care Provider, a Member's condition has stabilized and the emergency health care Provider certifies that the Member can be transported to another facility without suffering detrimental consequences or aggravating the patient's condition, the Member may be relocated to another facility for continued care and treatment, as necessary.

Ground ambulance transportation to return to a Participating Provider within the Service Area is Covered when Authorized by Us. Refusals to be transferred may result in loss of Covered Services for that specific emergency.

Benefit Description	After deductible, you pay
<b>Emergency within our service area</b>	
<ul style="list-style-type: none"> <li>• Emergency care at a doctor's office</li> <li>• Emergency care at an urgent care center</li> <li>• Emergency care as an outpatient at a hospital</li> </ul>	In Network: 20% Coinsurance Out-of-Network: 40% Coinsurance \$150 for hospital emergency room (waived if admitted)
<i>Not covered</i> <i>Non-Emergency Services provided at an emergency facility</i>	<i>All charges.</i>
<b>Emergency outside our service area</b>	<b>After the deductible, you pay</b>
<ul style="list-style-type: none"> <li>• Emergency care at a doctor's office</li> <li>• Emergency care at an urgent care center</li> <li>• Emergency care as an outpatient at a hospital</li> </ul>	In Network: 20% Coinsurance Out-of-Network: 40% Coinsurance \$150 for hospital emergency room (waived if admitted)
<i>Not covered: Non-Emergency Services provided at an emergency facility</i>	<i>All charges.</i>
<b>Ambulance</b>	<b>After the deductible, you pay</b>
Professional ambulance service Air Ambulance, when determined to be a Medical Emergency by Us Note: See 5.1(b)(3) for non-emergency service.	\$150 per trip

## Section 5.1 (b) (5) Mental health and substance abuse benefits

Benefit Description	After the deductible, you pay
<p><b>In-network benefits</b></p> <p>When you get our approval for services and follow a treatment plan we approve, cost-sharing and limitations for in-network mental health and substance abuse benefits will be no greater than for similar benefits for other illnesses and conditions.</p> <p>We provide all diagnostic and treatment services recommended by a network 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: In-network benefits are payable only when we determine the care is clinically appropriate to treat your condition and only when you receive the care as part of a treatment plan that we approve.</p>	<p>Your cost sharing responsibilities are no greater than for other illnesses or conditions.</p>
<ul style="list-style-type: none"> <li>• Professional services, including individual or group therapy by providers such as psychiatrists, psychologists, or clinical social workers</li> <li>• Medication management</li> </ul>	<p>In Network: 20% Coinsurance Out-of-Network: 40% Coinsurance</p>
<ul style="list-style-type: none"> <li>• Diagnostic tests</li> </ul>	<p>In Network: 20% Coinsurance Out-of-Network: 40% Coinsurance</p>
<ul style="list-style-type: none"> <li>• Services provided by a hospital or other facility</li> <li>• Services in approved alternative care settings such as partial hospitalization, half-way house, residential treatment, full-day hospitalization, facility based intensive outpatient treatment</li> </ul>	<p>In Network: 20% Coinsurance Out-of-Network: 40% Coinsurance</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><b>Preauthorization</b></p> <p>To be eligible to receive these benefits you must obtain a treatment plan and your physician must get precertification of hospital stays.</p> <p>If You have any questions about Your Mental Health and Substance Abuse Coverage or the appropriate way to access such Coverage, please contact the mental health vendor at the number located on the back of Your ID card.</p>	
<p><b>In-network limitation</b></p> <p>If you do not obtain an approved treatment plan, we will not provide In-network benefits.</p>	
<p><i>Not covered out-of-network:</i></p>	<p><i>All charges.</i></p>
<p><b>Lifetime maximum</b></p> <p>None</p>	
<p><b>Precertification</b></p> <p>The medical necessity of your admission to a hospital or other covered facility must be precertified for you to receive these In-network benefits. Emergency admissions must be reported within two business days following the day of admission even if you have been discharged. Otherwise, you may not be liable for the costs of the admission.</p>	

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See these sections of the brochure for more valuable information about these benefits:

- Section 3, *How you get care*, for information about catastrophic protection for these benefits.
  - Section 7, *Filing a claim for covered services*, for information about submitting out-of-network claims.
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## Section 5.1(b) (6) Prescription drug benefits

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

Who can write your prescription. A doctor of medicine or other health care professional who is duly licensed under the laws of the jurisdiction in which Prescription Drugs are received; and may, in the usual course of business, legally prescribe Prescription Drugs.

- Where you can obtain them. You may fill the prescription at a pharmacy, including a mail order pharmacy, designated by Us (except for Emergency or Urgent Care Services, out of the service area).

We use a formulary. A Formulary is a list of specific generic and brand name Prescription Drugs Authorized by the Health Plan, and subject to periodic review and modification. Since there may be more than one brand name of a Prescription Drug, not all brands of the same Prescription Drug (e.g., different manufacturers) may be included in the Formulary.

We cover non-formulary drugs prescribed by a Plan doctor. If a brand name non-Formulary Prescription Drug is dispensed, and an equivalent generic Prescription Drug is not available, the Member shall pay the non-Formulary brand name Co-payment. If a brand name non-Formulary Prescription Drug is dispensed, and an equivalent generic Prescription Drug is available, the Member shall pay an Ancillary Charge in addition to the non-Formulary brand name Co-payment.

An Ancillary charge is the difference between the average wholesale price (AWP) of the brand name prescription and maximum allowable cost (MAC) price of the generic prescription which you must pay, in addition to the brand co-payment (if you are dispensed a brand name prescription when a generic is available).

- These are the dispensing limitations. Please read this section in its entirety.

Why use generic drugs? A generic drug is a drug which is identical or equivalent to a brand name drug in dosage, safety, strength, route of administration, quality, performance characteristics and intended use but is usually less expensive than the branded version.

- When you do have to file a claim. To file a pharmacy claim, call our pharmacy benefits manager at Caremark at 800-389-7040.

Subject to the limitations, exclusions, Co-payments and Ancillary Charges described below, outpatient Prescription Drugs will be Covered when written by a Prescribing Provider, and filled at a pharmacy, including a mail order pharmacy, designated by the Health Plan (except for Emergency or Urgent Care Services, out of the service area).

Coverage is subject to drug utilization guidelines including quantity limits and/or Prior Authorization. The following also apply:

- One (1) Co-payment is due each time a prescription is filled or refilled up to a thirty-one (31) days supply or the lesser of:
  - (1) Tablets/capsules: 100 (or as defined by a specific quantity limit); or
  - (2) Oral liquids: 480cc (or as defined by a specific quantity limit); or
  - (3) One (1) commercially prepared container (e.g., inhaler, topicals and vials).
- Generic insulin and diabetic supplies (insulin syringes, with or without needles, needles, blood and urine glucose test strips, lancets and devices, ketone test strips and tabs), up to a thirty-one (31) days supply may be dispensed with one (1) generic level Co-payment for each prescription. Brand name insulin and diabetic supplies up to a thirty-one (31) days supply, may be dispensed with one (1) brand level Co-payment. The Ancillary Charge does not apply to insulin and diabetic supplies.
- Mail order Prescription Drug benefit is available through a mail order pharmacy designated by the Health Plan and/or certain Participating retail pharmacies. Prescription Drugs on the Mail Order Drug List may be dispensed with a Mail Order Co-payment for a ninety-three (93) days supply. Please note that not all Participating pharmacies provide this benefit.

If a brand name Formulary Prescription Drug is dispensed, and an equivalent generic Prescription Drug is not available, the Member shall pay the Formulary brand name Co-payment. If a brand name Formulary Prescription Drug is dispensed, and an equivalent generic Prescription Drug is available, the Member shall pay an Ancillary Charge in addition to the Formulary brand name Co-payment.

If a brand name non-Formulary Prescription Drug is dispensed, and an equivalent generic Prescription Drug is not available, the Member shall pay the non-Formulary brand name Co-payment. If a brand name non-Formulary Prescription Drug is dispensed, and an equivalent generic Prescription Drug is available, the Member shall pay an Ancillary Charge in addition to the non-Formulary brand name Co-payment.

The Ancillary Charge will be due regardless of whether or not the Prescribing Provider indicates that the pharmacy is to "Dispense as Written." Total Member payments shall not exceed the AWP of the Prescription Drug.

Please Note: Co-payments You make for Covered benefits under this rider count toward the Deductible and apply to the Out-of-Pocket Maximum. However, Ancillary Charges *do not* count toward the Deductible and *do not* apply to the Out-of-Pocket Maximum.

The Member has the right to appeal any decision made by the Health Plan. Those appeals should be directed to the Health Plan. There is no coordination of benefits for outpatient Prescription Drugs with other health plans.

Benefit Description	After the deductible, you pay
<p><b>Covered medications and supplies</b></p> <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"> <li>• Drugs and medicines that by Federal law of the United States require a physician’s prescription for their purchase</li> <li>• Insulin</li> <li>• Disposable needles and syringes for the administration of covered medications</li> <li>• Drugs for sexual dysfunction</li> <li>• Contraceptive drugs and devices</li> </ul>	<p><b>In-Network:</b>  <b>Retail (up to a 31-day supply)</b></p> <p>\$10 per generic formulary drug</p> <p>\$25 per brand name formulary drug</p> <p>\$40 per non-formulary drug</p> <p>Mail Order (up to a 93-day supply)</p> <p>\$20 per generic formulary drug</p> <p>\$50 per brand name formulary drug</p> <p>\$80 per non-formulary drug</p> <p>Note: If there is no generic equivalent available, you will still have to pay the brand name co-pay.</p> <p><b>Out-of-Network:</b>  We have no out-of-network prescription drug benefits</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• <i>Compounded prescriptions whose only ingredients do not require a prescription or whose major ingredients are not FDA approved for the treatment of the indication</i></li> <li>• <i>Injectable medications, except those designated by the Health Plan</i></li> <li>• <i>Over-the-counter products</i></li> <li>• <i>Nicorette gum and smoking cessation skin patches</i></li> <li>• <i>Drugs used primarily for hair restoration</i></li> <li>• <i>Dietary supplements, appetite suppressants, and other drugs used to treat obesity or assist in weight reduction</i></li> <li>• <i>Medications used to enhance athletic performance</i></li> </ul>	<p><i>All charges.</i></p>

## Section 5.1(b) (7) Special features

Special feature	Description
<b>Flexible benefits option</b>	<p>Under the flexible benefits option, we determine the most effective way to provide services.</p> <ul style="list-style-type: none"> <li>• We may identify medically appropriate alternatives to traditional care and coordinate other benefits as a less costly alternative benefit.</li> <li>• Alternative benefits are subject to our ongoing review.</li> <li>• By approving an alternative benefit, we cannot guarantee you will get it in the future.</li> <li>• The decision to offer an alternative benefit is solely ours, and we may withdraw it at any time and resume regular contract benefits.</li> </ul> <p>Our decision to offer or withdraw alternative benefits is not subject to OPM review under the disputed claims process.</p>
<b>Complex Case Management Services</b>	<p>Our clinical team includes nurses who specialize in coordinating care and benefits for our Members, if you feel you may benefit from this service call us at (800) 395-2545</p>
<b>Health Assessment and Health Information</b>	<p>Our web site contains health information and tools to assess your health status, we encourage you to check it out at <a href="http://www.chcga.com">www.chcga.com</a></p>
<b>Centers of excellence</b>	<p>Our network of Providers includes the Coventry Transplant Network, these are hospitals and physicians specializing in transplantation services</p>
<b>Travel benefit</b>	<p>Travel expenses for members and living donors are covered according to Our transplant travel benefit. Members are covered when Coventry Health Care of Georgia is the primary insurer and a Coventry Transplant Network Facility is used.</p>

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### Section 5.1(b) (8) Dental benefits

<b>Accidental injury benefit</b>	<b>You pay</b>
We cover restorative services and supplies necessary to promptly repair (but not replace) sound natural teeth. The need for these services must result from an accidental injury.	In Network: 20% Coinsurance Out-of-Network: 40% Coinsurance
<b>Dental benefits</b>	
We have no other dental benefits	

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**Section 5.1(c) Savings – HSAs and HRAs**

<b>Feature Comparison</b>	<b>Health Savings Account (HSA)</b>	<b>Health Reimbursement Arrangement (HRA) Provided when you are ineligible for an HSA</b>
<b>Administrator</b>	<p>The Plan will establish an HSA for you with Corporate Benefit Services of America, Inc. (CBSA) this HDHP’s fiduciary (an administrator, trustee or custodian as defined by Federal tax code and approved by IRS.)                      Corporate Benefit Services of America, Inc                      PO Box 270520                      Golden Valley, MN 55427                      (800) 566 9311                      Or <a href="https://services.cbsainc.com/eehome.asp">https://services.cbsainc.com/eehome.asp</a></p>	<p>Corporate Benefit Services of America, Inc. (CBSA) is the HRA fiduciary for this Plan.                      Corporate Benefit Services of America, Inc                      PO Box 270520                      Golden Valley, MN 55427                      (800) 566 9311                      Or  <a href="https://services.cbsainc.com/eehome.asp">https://services.cbsainc.com/eehome.asp</a></p>
<b>Fees</b>	Set-up fee is paid by the HDHP.	Set-up fee paid by the HDHP
<b>Eligibility</b>	<ul style="list-style-type: none"> <li>• Enrolled in <i>Coventry Health Care of Georgia HDHP</i></li> <li>• No other health insurance coverage (does not apply to specific injury, accident, disability, dental, vision or long-term care coverage)</li> <li>• Not eligible for Medicare Part A or Part B</li> <li>• Not claimed as a dependent on someone else’s tax return</li> <li>• Complete and return all banking paperwork</li> <li>• Eligibility is determined on the first day of the month</li> </ul>	<ul style="list-style-type: none"> <li>• Enrolled in <i>Coventry Health Care of Georgia HDHP</i></li> <li>• Eligibility is determined on the first day of the month</li> </ul>

<b>Feature Comparison</b>	<b>Health Savings Account (HSA)</b>	<b>Health Reimbursement Arrangement (HRA) Provided when you are ineligible for an HSA</b>
<p><b>Funding</b></p> <ul style="list-style-type: none"> <li>• Self Only coverage</li> <li>• Self and Family coverage</li> </ul>	<p>\$1,250 annual premium pass through by HDHP directly into account, prorated on a monthly basis</p> <p>\$2,500 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>\$1,250 annual credit (prorated monthly and credited to the account) provided by the HDHP upon effective date</p> <p>\$2,500 annual credit (prorated monthly) 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><b>Contributions/credits</b></p> <ul style="list-style-type: none"> <li>• Self Only coverage</li> <li>• Self and Family coverage</li> </ul>	<p>The maximum that can be contributed to your HSA is an annual combination of HDHP premium pass through and enrollee contribution funds, which when combined, do not exceed the amount of the deductible, which is \$2,250 self/\$4,500 family</p> <p>For each month you are eligible for HSA contributions,</p> <p>The HDHP will make a premium pass through of \$104.17 per month. You may make a maximum annual contribution of \$1,000</p> <p>The HDHP will make a premium pass through of \$208.33 per month. Your annual maximum contribution cannot exceed \$2,000.</p> <p>If you choose to contribute to your HSA,</p> <ul style="list-style-type: none"> <li>- You must deduct 1/12 of total annual maximum contribution for every month you are not eligible for the HDHP the whole month. For instance, if your enrollment in this Plan was not effective on January 1, 2005, you cannot receive a credit for January and you would need to deduct 1/12 of the annual maximum contribution.</li> <li>- You may rollover funds you have in other HSAs to this HDHP HSA (rollover funds do not affect your annual maximum contribution under this HDHP).</li> <li>- HSAs earn tax-free interest (does not affect your annual maximum contribution).</li> </ul>	<p>The full HRA credit will be available, subject to monthly proration, on the effective date of enrollment. The HRA does not earn interest. You cannot contribute to the HRA.</p> <p>The HDHP will credit the HRA account \$104.17 per month.</p> <p>The HDHP will credit the HRA account \$208.33 per month.</p>

Feature Comparison	<b>Health Savings Account (has)</b>	<b>Health Reimbursement Arrangement (HRA)</b> <b>Provided when you are ineligible for hasHSA</b>
<b>Access funds</b>	<p>You can access your HSA by the following methods:</p> <ul style="list-style-type: none"> <li>• Debit card</li> <li>• Withdrawal form</li> </ul>	<p>For qualified medical expenses under your HDHP, you will be automatically reimbursed when claims are submitted through Coventry's Health Care of Georgia HDHP. For expenses not covered by the HDHP, such as orthodontia, a reimbursement form will be sent to you.</p>
<b>Distributions/withdrawals</b> <ul style="list-style-type: none"> <li>• Medical</li> </ul>	<p>After meeting the deductible, pay the out-of-pocket expenses for yourself, your spouse or your dependents even if they are not covered by the HDHP from the funds available in your HSA. Medical expenses are not allowable if they occur before the first full month your enrollment is effective, and they are not reimbursable from your HSA until the first of the month following the effective date of your enrollment in this HDHP and the date your HSA account is established. For most Federal enrollees (those not paid on a monthly basis), the earliest date medical expenses will be allowable is February 1, 2006. 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. Non-reimbursed qualified medical expenses are allowable if they occur after the effective date of your enrollment in this Plan. See Availability of funds below for information on when funds are available in the HRA. See IRS Publication 502 for a complete list of eligible expenses.</p>
<ul style="list-style-type: none"> <li>• Non-medical</li> </ul>	<p>If you are under age 65, withdrawal of funds for non-medical expenses will create a 10% income tax penalty in addition to any other income taxes you may owe on the accumulated funds. When you turn age 65, distributions can be used for any reason without being subject to the 10% penalty.</p>	<p>Not applicable – distributions will not be made for anything other than non-reimbursed qualified medical expenses.</p>

<b>Feature Comparison</b>	<b>Health Savings Account (HSA)</b>	<b>Health Reimbursement Arrangement (HRA) Provided when you are ineligible for an HSA</b>
<b>Availability of funds</b>	<p>Funds are not available until: Your enrollment in this HDHP is effective (effective date is determined by your agency in accord with the event permitting the enrollment change) The HDHP receives record of your enrollment and initially establishes your HSA account with the fiduciary by providing information it must furnish and by contributing the minimum amount required to establish an HSA After the fiduciary receives the completed paperwork from the enrollee, the enrollee can withdraw funds for any expenses incurred on or after the date the HSA was initially established.</p>	<p>Funds are not available until: Your enrollment in this HDHP is effective (effective date is determined by your agency in accord with the event permitting the enrollment change) The HDHP receives record of your enrollment and initially establishes your HRA account with the fiduciary by providing information it must furnish to establish an HRA After the fiduciary receives the completed paperwork from the enrollee, the enrollee can withdraw funds for any expenses incurred on or after the date the HSA was initially established.</p>
<b>Account owner</b>	FEHB enrollee	HDHP
<b>Portable</b>	Yes, you can take this account with you when you separate or retire.	<p>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.</p>
<b>Annual rollover</b>	Yes, accumulates without a maximum cap.	Yes, accumulates without a maximum cap.

HSAs	
Is the “premium pass through” to my HSA considered taxable income?	“Premium pass through” contributions by the HDHP are not considered taxable income.
Can I contribute to my HSA?	<p>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.</p> <p>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 Corporate Benefit Services of America, Inc at <a href="https://services.cbsainc.com/eehome.asp">https://services.cbsainc.com/eehome.asp</a> for more details.</p>
Catch-up contributions	<p>If you are age 55 or older, the IRS permits you to make additional catch-up contributions to your HSA. In 2005, you may contribute up to \$500 in “catch-up” contributions. Catch-up contributions in later years increase up to a maximum of \$1,000 in 2009 and beyond. Contributions must stop once an individual is eligible for Medicare. Additional details are available on the IRS Web site at <a href="http://www.irs.gov">www.irs.gov</a>.</p>
Rate of interest earned	<p>Depending on how you choose to invest your HSA savings, the interest rate and payment of interest will vary. Contact CBSA at <a href="https://services.cbsainc.com/eehome.asp">https://services.cbsainc.com/eehome.asp</a> for more details on the investment options available to you.</p>
What happens to my HSA if I leave my health plan or job?	<p>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.</p>
What happens to my HSA if I die?	<p>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.</p>
What expenses can I pay for with my HSA?	<p>You can pay for “qualified medical expenses,” as defined by IRS Code 213(d). These expenses include, but are not limited to, medical plan deductibles, diagnostic services covered by your plan, long-term care premiums, and health insurance premiums if you are receiving Federal unemployment compensation, over-the-counter drugs, LASIK surgery, and some nursing services.</p> <p>When you become Medicare-eligible, you can use the account to purchase any health insurance other than a Medigap policy. You may not, however, continue to make contributions to your HSA once you are Medicare eligible.</p> <p>For the complete list of IRS-allowable expenses, request a copy of IRS Publication 502 by calling 1-800-829-3676, or visit the IRS Web site at <a href="http://www.irs.gov">www.irs.gov</a> and click on “Forms and Publications.”</p>
Non-qualified health expenses	<p>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.</p>
Tracking your HSA balance	<p>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.</p>
Minimum reimbursements from your HSA	<p>You can request reimbursement in any amount. However, funds will not be disbursed until your reimbursement totals at least \$25.</p>

<b>HRAs</b>	
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	<p>Please review the chart at the beginning of this section which details the differences. The major differences are:</p> <ul style="list-style-type: none"> <li>• You cannot make contributions to an HRA</li> <li>• Funds are forfeited if you leave the HDHP</li> <li>• An HRA does not earn interest, and</li> <li>• HRAs can only pay for qualified medical expenses, such as deductibles, co-payments, and coinsurance expenses, for individuals covered by the HDHP.</li> </ul>

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## **Section 5.1(d) Catastrophic protection for out-of-pocket expenses**

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We will track and accumulate those expenses applicable to the determination of the out-of-pocket expenses for the HDHP. These expenses include co-payments, coinsurance payments, and deductibles applied to Covered Services. Some expenses may not apply to satisfying the out-of-pocket maximum; these include but are not limited to ancillary fees for pharmacy, and expenses for non-Covered Services.

## Section 5.1(e) Health education resources and account management tools

<b>Special features</b>	<b>Description</b>
<b>Health education resources</b>	<p>Visit our About Your Health section on our Web site at <a href="http://www.chcga.com">www.chcga.com</a> for information on:</p> <ul style="list-style-type: none"> <li>• General health topics</li> <li>• Links to health care news</li> <li>• Cancer and other specific diseases</li> <li>• Drugs/medication interactions</li> <li>• Kids' health</li> <li>• Patient safety information</li> <li>• and several helpful Web site links.</li> </ul>
<b>Account management tools</b>	<p>For each HSA and HRA account holder, we maintain a complete claims payment history online through <a href="http://www.chcga.com">www.chcga.com</a>.</p> <ul style="list-style-type: none"> <li>• Your balance will also be shown on your explanation of benefits (EOB) form.</li> <li>• You will receive an EOB after every claim.</li> <li>• If you have an HSA, <ul style="list-style-type: none"> <li>• You may access your account on-line at <a href="https://services.cbsainc.com/eehome.asp">https://services.cbsainc.com/eehome.asp</a> or <a href="http://www.chcga.com">www.chcga.com</a></li> </ul> </li> </ul> <p>If you have an HRA,</p> <p>Your HRA balance will be available online through <a href="https://services.cbsainc.com/eehome.asp">https://services.cbsainc.com/eehome.asp</a> or <a href="http://www.chcga.com">www.chcga.com</a></p> <ul style="list-style-type: none"> <li>•</li> </ul>
<b>Consumer choice information</b>	<ul style="list-style-type: none"> <li>• As a member of this HDHP, you may choose any provider. However, you will receive discounts when you see a network provider. Directories are available online at <a href="http://www.chcga.com">www.chcga.com</a>.</li> <li>• At the same web site you can also receive information on the cost of healthcare, online pharmacy information, educational materials for HSAs, HRAs and HDHPs. We also offer information on health conditions, maintaining a healthy lifestyle and other topical information.</li> <li>• Visit us at <a href="http://www.chcga.com">www.chcga.com</a>.</li> </ul>
<b>Care support</b>	<ul style="list-style-type: none"> <li>• Patient safety information is available online at <a href="http://www.chcga.com">www.chcga.com</a>.</li> <li>• Case Managers can be reached at (800) 395-2545.</li> </ul>

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## **Section 6 General exclusions – things we don't cover**

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The exclusions in this section apply to all benefits. Although we may list a specific service as a benefit, we will not cover it unless we determine 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
- Services, drugs, or supplies you receive without charge while in active military service

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## Section 7 Filing a claim for covered services

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

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

- **How to claim benefits**

To obtain claim forms or other claims filing advice or answers about our benefits, contact us at (800) 395-2545, or at our Web site at [www.chcga.com](http://www.chcga.com). In most cases, providers and facilities file claims for you. Your physician must file on the form HCFA-1500, Health Insurance Claim Form. Your facility must file on the UB-92 form. For claims questions and assistance, call us at (800) 395-2545.

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

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

Submit your claims to:

Coventry Health Care of Georgia, Inc., P.O. Box 7711, London KY 40742
  
- **Records**

Keep a separate record of the medical expenses of each covered family member. Save copies of all medical bills, including those you accumulate to satisfy a deductible. In most instances they will serve as evidence of your claim. We will not provide duplicate or year-end statements. We will maintain records on the status of your deductibles, catastrophic maximums, and when family maximum limits have been met. You may request this information by calling us at (800) 395-2545 or visiting us online.
  
- **Deadline for filing your claim**

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

For covered services you receive in hospitals outside the United States and Puerto Rico and performed by physicians outside the United States, send a completed Overseas Claim Form and the itemized bills to: Coventry Health Care of Georgia, PO Box 7711, London, KY 40742. Obtain Overseas Claim Forms from the address above or call (800) 395-2545. Send any written inquiries concerning the processing of overseas claims to this address.
  
- **When we need more information**

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

## Section 8 The disputed claims process

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

Step	Description
<b>1</b>	<p>Ask us in writing to reconsider our initial decision. You must:</p> <ul style="list-style-type: none"> <li>a) Write to us within 6 months from the date of our decision; and</li> <li>b) Send your request to us at: Coventry Health Care of Georgia, Inc., 1100 Circle 75 Parkway, Suite 1400, Atlanta, Georgia 30339 (800) 395-2545; and</li> <li>c) Include a statement about why you believe our initial decision was wrong, based on specific benefit provisions in this brochure; and</li> <li>d) Include copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms.</li> </ul>
<b>2</b>	<p>We have 30 days from the date we receive your request to:</p> <ul style="list-style-type: none"> <li>a) Pay the claim (or, if applicable, arrange for the health care provider to give you the care); or</li> <li>b) Write to you and maintain our denial — go to step 4; or</li> </ul> <p>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.</p>
<b>3</b>	<p>You or your provider must send the information so that we receive it within 60 days of our request. We will then decide within 30 more days.</p> <p>If we do not receive the information within 60 days, we will 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>
<b>4</b>	<p>If you do not agree with our decision, you may ask OPM to review it.</p>
	<p>You must write to OPM within:</p> <ul style="list-style-type: none"> <li>90 days after the date of our letter upholding our initial decision; or</li> <li>120 days after you first wrote to us -- if we did not answer that request in some way within 30 days; or</li> <li>120 days after we asked for additional information.</li> </ul>
	<p>Write to OPM at: United States Office of Personnel Management, Insurance Services Programs, Health Insurance Group 3, 1900 E Street, NW, Washington, DC 20415-3630.</p>

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**The disputed claims process** *(continued)*

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	<p>Send OPM the following information:</p> <p>A statement about why you believe our decision was wrong, based on specific benefit provisions in this brochure;</p> <p>Copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms;</p> <p>Copies of all letters you sent to us about the claim;</p> <p>Copies of all letters we sent to you about the claim; and</p> <p>Your daytime phone number and the best time to call.</p> <p>Note: If you want OPM to review more than one claim, you must clearly identify which documents apply to which claim.</p>
	<p>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.</p> <p>Note: The above deadlines may be extended if you show that you were unable to meet the deadline because of reasons beyond your control.</p>
<b>5</b>	<p>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.</p>
	<p>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.</p> <p>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.</p>
	<p>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.</p>

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

We haven't responded yet to your initial request for care or preauthorization/prior approval, then call us at (800) 395-2545 and we will expedite our review; or

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 at 202-606-0745 between 8 a.m. and 5 p.m. eastern time.

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## Section 9 Coordinating benefits with other coverage

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### When you have other health coverage

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

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

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

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

### 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. We do not offer a Medicare Advantage plan. Please review the information on coordinating benefits with Medicare Advantage plans on the next page.
- Part D (Medicare prescription drug coverage). There is a monthly premium for Part D coverage. If you have limited savings and a low income, you may be eligible for Medicare’s Low Income Benefits. For people with limited income and resources, extra help in paying for a Medicare prescription drug plan is available. Information regarding this program is available through the Social Security Administration (SSA). For more information about this extra help, visit SSA online at [www.socialsecurity.gov](http://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 or see our Web site at [www.chcga.com](http://www.chcga.com).

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

- Medical services and supplies provided by physicians and other health care professionals.

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

**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](http://www.medicare.gov).

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

This Plan and our Medicare Advantage plan:

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

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

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

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

Medicare always makes the final determination as to whether they are the primary 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>B. When you or a covered family member...</b>		
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	✓	
<b>C. When either you or a covered family member are eligible for Medicare solely due to disability and you...</b>		
1) Have FEHB coverage on your own as an active employee or through a family member who is an active employee		✓
2) Have FEHB coverage on your own as an annuitant or through a family member who is an annuitant	✓	
<b>D. When you are covered under the FEHB Spouse Equity provision as a former spouse</b>		
	✓	

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

## TRICARE and CHAMPVA

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

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

## Workers' Compensation

We do not cover services that:

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

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

## Medicaid

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

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

## When other Government agencies are responsible for your care

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

## When others are responsible for injuries

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

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

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## Section 10 Definitions of terms we use in this brochure

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- **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 12.
- **Co-payment** A co-payment is a fixed amount of money you pay when you receive covered services. See page 12.
- **Covered services** Services we provide benefits for, as described in this brochure.
- **Custodial care** Custodial care is care that:
  - primarily helps with or supports daily living activities (such as bathing, dressing, eating and eliminating body wastes); *or*
  - can be given by people other than trained medical personnel.Care can be custodial even if it is prescribed by a provider or given by trained medical personnel, and even if it involves artificial methods such as feeding tubes or catheters. Custodial care that lasts 90 days or more is sometimes known as Long term care.
- **Deductible** A deductible is a fixed amount of covered expenses you must incur for certain covered services and supplies before we start paying benefits for those services. See page 12.
- **Experimental or investigational services** A health product or service is deemed Experimental or Investigational if one or more of the following conditions are met:

Any drug not approved for use by the FDA; any drug that is classified as an Investigational New Drug by the FDA; any drug requiring pre-authorization that is proposed for off-label prescribing; Any health product or service that is subject to Investigational Review Board review or approval; Any health product or service that is the subject of a clinical trial that meets criteria for Phase I, II or III as set forth by FDA regulations.

Any health product or service that is considered not to have demonstrated value based on clinical evidence reported by Peer-Review Medical Literature and by generally recognized academic experts.
- **Medical necessity and Medically Necessary** Medical necessity or medically necessary means those services, supplies, equipment and facilities charges that are not expressly excluded under the plan and determined by us to be:
  - Medically appropriate, so that expected health benefits exceed the expected health risks (examples: increased life expectancy, improved functional capacity, prevention of complications, relief of pain);
  - Necessary to meet your health, improve physiological function and required for a reason other than improving appearance;
  - Within generally accepted standards of medical care in the community;
  - Rendered in the most cost-efficient manner and setting appropriate for the delivery of the health service;
  - Consistent in type, frequency and duration of treatment with scientifically-based guidelines of national medical research, professional medical specialty organizations or governmental agencies that are generally accepted as national authorities on the services, supplies, equipment or facilities requested;
  - Consistent with the diagnosis of the condition at issue;
  - Required for reasons other than your comfort and/or the convenience of your physician;

and  
Not experimental or investigational as determined by us.

- **Plan allowance**

The Plan allowance is the amount we pay non-participating providers for covered services. The Plan allowance is called the “Out-of-Network Rate” or the “ONR.”

The ONR is based on Medicare’s Atlanta region fee schedule. If Medicare does not have a comparable procedure code, then the rate is based on:

- St. Anthony’s Atlanta region fee schedule, if available; or
- a percentage of billed charges for that procedure code.

If the non-participating provider charges more than our ONR, you will be responsible to pay the amount over the ONR, in addition to any applicable copayment, deductible and coinsurance amounts. Amounts you pay in excess of the ONR do not count towards your out-of-pocket maximum.

- **Us/We**

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

- **You**

You refers to the enrollee and each covered family member.

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## Section 11 FEHB Facts

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### Coverage information

- **No pre-existing condition limitation**

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

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

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

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

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

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

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

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

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

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

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

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

- **Children's Equity Act**

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

benefits for your child(ren).

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

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

retirement office to get RI 70-5, the *Guide To Federal Employees Health Benefits Plans for Temporary Continuation of Coverage and Former Spouse Enrollees*, or other information about your coverage choices. You can also download the guide from OPM's Web site, [www.opm.gov/insure](http://www.opm.gov/insure).

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

If you leave Federal service, or if you lose coverage because you no longer qualify as a family member, you may be eligible for Temporary Continuation of Coverage (TCC). For example, you can receive TCC if you are not able to continue your FEHB enrollment after 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](http://www.opm.gov/insure). It explains what you have to do to enroll.

- **Converting to individual coverage**

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

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

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

Your benefits and rates will differ from those under the FEHB Program; however, you will not have to answer questions about your health, and 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](http://www.opm.gov/insure/health); refer to the "TCC and HIPAA" frequently asked questions. These highlight HIPAA rules, such as the requirement that Federal employees must exhaust any TCC eligibility as one condition for guaranteed access to individual health coverage under HIPAA, and information about Federal and State agencies you can contact for more information.

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## Section 12 Two Federal Programs complement FEHB benefits

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

### The Federal Flexible Spending Account Program – FSAFEDS

- **What is an FSA?** It is a tax-favored benefit that allows you to set aside pre-tax money from your paychecks to pay for a variety of eligible expenses. *By using an FSA, you can reduce your taxes while paying for services you would have to pay for anyway, producing a discount that can be over 40%.*  
There are two types of FSAs offered by FSAFEDS:
  - Health Care Flexible Spending Account (HCFSA)**
    - Covers eligible health care expenses not reimbursed by this Plan, or any other medical, dental, or vision care plan you or your dependents may have.
    - Eligible dependents for this account include anyone you claim on your Federal Income Tax return as a qualified dependent under the U.S. Internal Revenue Service (IRS) definition and/or with whom you jointly file your Federal Income Tax return, even if you don't have self and family health benefits coverage. *Note:* The IRS has a broader definition of a "family member" than is used under the FEHB Program to provide benefits by your FEHB Plan.
    - The maximum annual amount that can be allotted for the HCFSA is \$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. The limit includes any child care subsidy you may receive.
- **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](http://www.fsafeds.com) and click on [Enroll](#).
  - Telephone: call an FSAFEDS Benefits Counselor toll-free at 1-877-FSAFEDS (372-3337), Monday through Friday, from 9 a.m. until 9 p.m. Eastern Time. TTY: 1-800-952-0450.

**What is SHPS?**

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

**Who is eligible to enroll?**

If you are a Federal employee eligible for FEHB – even if you’re not enrolled in FEHB – you can choose to participate in either, or both, of the FSAFED accounts. *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 on eligible expenses 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 1/2 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 you’re your eligible expenses incurred from January 1 through March 15 of the following year. For example if you enroll in FSAFEDS for the 2006 Plan Year, you will have until March 15, 2007 to incur eligible expenses and you may submit claims for those expenses through May 31, 2007.

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

• **What can my HCFSA pay for?**

Every FEHB plan includes cost sharing features, such as deductibles you must meet before the Plan provides benefits, coinsurance or co-payments 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.

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 AER 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 [www.FSAFEDS.com/fsafeds/eligibleexpenses.asp](http://www.FSAFEDS.com/fsafeds/eligibleexpenses.asp). If you do not see your service or expense listed, please call an FSAFEDS Benefits Counselor at 1-877-FSAFEDS (372-3337), who will be able to answer your specific questions.

- **Tax savings with an FSA**

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

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

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

- **Tax credits and deductions**

- Health care expenses**

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.

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. You must re-enroll every Open Season to remain in the paperless reimbursement program. 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](http://www.FSAFEDS.com) and download the Dependent Care Tax Credit Worksheet from the Forms and Literature page to help you determine what is best for your situation. You may also wish to consult a tax professional for more details.

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

No. Section 1127 of the National Defense Authorization Act (Public Law 108-136) requires agencies that offer FSAFEDS to employees to cover the administrative fee(s) on behalf of their employees. However, remember that participating in FSAFEDS can cost you money if you don't spend your entire account balance during your period of coverage for the Plan Year plus 2 ½ 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](http://www.FSAFEDS.com), or contact SHPS directly via email or by phone. FSAFEDS Benefits Counselors are available Monday through Friday, from 9:00 a.m. until 9:00 p.m. Eastern Time.

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

## **The Federal Long Term Care Insurance Program**

- **It's important protection**

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

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

- **To 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](http://www.ltcfeds.com).

## Index

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 Deductible Health Plan 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 \$xx calendar year deductible.

Benefits	After the deductible, You pay	Page
Medical services provided by physicians:		
Preventive Care – Preventive care services are not subject to the deductible	In-Network: 20% Coinsurance Out-of-Network: 40% Coinsurance Services based on the Out-of-Network Rate	
Diagnostic and treatment services provided in the office	In-Network: 20% Coinsurance Out-of-Network: 40% Coinsurance Services based on the Out-of-Network Rate	xx
Services provided by a hospital:		
Inpatient	In-Network: 20% Coinsurance Out-of-Network: 40% Coinsurance Services based on the Out-of-Network Rate	xx
Outpatient	In-Network: 20% Coinsurance Out-of-Network: 40% Coinsurance Services based on the Out-of-Network Rate	xx

<b>Emergency benefits:</b>		
In-area	\$150 co-payment for services in the ER which is waived if admitted to inpatient	xx
Out-of-area	\$150 co-payment for services in the ER which is waived if admitted to inpatient	xx
Mental health and substance abuse treatment:	Regular cost sharing	xx
Prescription drugs:		xx
Retail pharmacy	\$10 per generic formulary drug \$25 per brand name formulary drug \$40 per non-formulary drug	
Mail order	\$20 per generic formulary drug \$50 per brand name formulary drug \$80 per non-formulary drug	
Dental care (Accidental injury benefit only)	In-Network: 20% Coinsurance Out-of-Network: 40% Coinsurance	xx
Vision care:	No benefit.	xx
Special features: Flexible Benefits Option; Complex Case Management Services; Health Assessment and Health Information; Centers of Excellence; Travel Benefit		
Protection against catastrophic costs (out-of-pocket maximum):	In-Network: nothing after \$5,000 for self and \$10,000 for family  Out-of-Network: nothing after \$10,000 for self and \$20,000 for family  Some costs do not count toward this protection	xx

## 2006 Rate Information for Coventry Health Care of Georgia, Inc.

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	Enrollment Code	<i>Non-Postal Premium <u>Biweekly</u> Government Share</i>	<i>Non-Postal Premium <u>Biweekly</u> Your Share</i>	<i>Non-Postal Premium <u>Monthly</u> Government Share</i>	<i>Non-Postal Premium <u>Monthly</u> Your Share</i>	<i>Postal Premium <u>Biweekly</u> USPS Share</i>	<i>Postal Premium <u>Biweekly</u> Your Share</i>
<b>HDHP Self Only</b>	<b>L51</b>	<b>\$102.89</b>	<b>\$34.29</b>	<b>\$222.92</b>	<b>\$74.30</b>	<b>\$121.75</b>	<b>\$15.43</b>
<b>HDHP Self and Family</b>	<b>L52</b>	<b>\$238.28</b>	<b>\$79.42</b>	<b>\$516.26</b>	<b>\$172.09</b>	<b>\$281.96</b>	<b>\$35.74</b>