

Coventry Health Care of Louisiana

<http://www.chclouisiana.com>



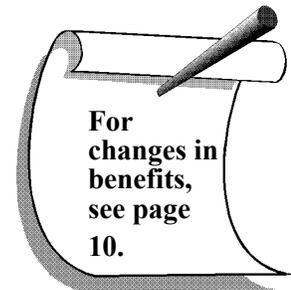
COVENTRY
Health Care of Louisiana, Inc.

2008

Health Maintenance Organization (High and Standard Option) and a High Deductible Health Plan (HDHP)

Serving: The New Orleans and Baton Rouge.

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



Enrollment codes for this Plan:

Baton Rouge area

JA1 High Option – Self Only
JA2 High Option – Self and Family
JA4 Standard Option – Self Only
JA5 Standard Option - Self and Family
LT1 HDHP – Self Only
LT2 HDHP – Self and Family

New Orleans area

BJ1 High Option – Self Only
BJ2 High Option – Self and Family
BJ4 Standard Option – Self Only
BJ5 Standard Option - Self and Family
HB1 HDHP – Self Only
HB2 HDHP – Self and Family



Authorized for distribution by the:



United States
Office of Personnel Management
Center for
Retirement and Insurance Services
<http://www.opm.gov/insure>

RI 73-244

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

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

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

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

Please be advised

If you lose or drop your FEHB coverage, 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, or call the SSA at 1-800-772-1213 (TTY 1-800-325-0778).

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

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

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Introduction

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

Coventry Health Care Of Louisiana - 3838 North Causeway Blvd., Ste 3350 Metairie, La 70002

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

If you are enrolled in this Plan, you are entitled to the benefits described in this brochure. If you are enrolled in Self and Family coverage, each eligible family member is also entitled to these benefits. You do not have a right to benefits that were available before January 1, 2008, unless those benefits are also shown in this brochure.

OPM negotiates benefits and rates with each plan annually. Benefit changes are effective January 1, 2008, and changes are summarized on page 11. Rates are shown at the end of this brochure.

Plain Language

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

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

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

Stop Health Care Fraud!

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

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

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

- Do not give your plan identification (ID) number over the telephone or to people you do not know, except to your doctor, other provider, or authorized plan or OPM representative.
- Let only the appropriate medical professionals review your medical record or recommend services.
- Avoid using health care providers who say that an item or service is not usually covered, but they know how to bill us to get it paid.
- Carefully review explanations of benefits (EOBs) 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 800-341-6613 and explain the situation.
- If we do not resolve the issue:

CALL - THE HEALTH CARE FRAUD HOTLINE

202-418-3300

OR WRITE TO:

United States Office of Personnel Management

Office of the Inspector General Fraud Hotline

1900 E Street NW Room 6400

Washington, DC 20415-1100

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

Preventing medical mistakes

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

1. Ask questions if you have doubts or concerns.

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

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

- Bring the actual medicines or give your doctor and pharmacist a list of all the medicines that you take, including non-prescription (over-the-counter) medicines.
- Tell them about any drug allergies you have.
- Ask about any risks or side effects of the medication and what to avoid while taking it. Be sure to write down what your doctor or pharmacist says.
- Make sure your medicine is what the doctor ordered. Ask the pharmacist about your medicine if it looks different than you expected.
- Read the label and patient package insert when you get your medicine, including all warnings and instructions.

- Know how to use your medicine. Especially note the times and conditions when your medicine should and should not be taken.
- Contact your doctor or pharmacist if you have questions.

3. Get the results of any test or procedure.

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

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

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

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

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

Want more information on patient safety?

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

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

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

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

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

www.quic.gov/report. Find out what federal agencies are doing to identify threats to patient safety and help prevent mistakes in the nation's health care delivery system.

Section 1. Facts about this Plan

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

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

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

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

General features of our High and Standard Options :

We have Open Access benefits

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

How we pay providers

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

General features of our High Deductible Health Plan (HDHP)

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

Preventive care services

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

Annual deductible

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

Health Savings Account (HSA)

You are eligible for an 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 coverage), not enrolled in Medicare, and are not claimed as a dependent on someone else's tax return.

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

- For each month that you are enrolled in an HDHP and eligible for an HSA, the HDHP will pass through (contribute) a portion of the health plan premium to your HSA. In addition, you (the account holder) may contribute your own money to your HSA up to an allowable amount determined by IRS rules. Your HSA dollars earn tax-free interest.
- You may allow the contributions in your HSA to grow over time, like a savings account. The HSA is portable – you may take the HSA with you if you leave the Federal government or switch to another plan.

Health Reimbursement Arrangement (HRA)

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

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

Catastrophic protection

We protect you against catastrophic out-of-pocket expenses for covered services. Your annual out-of-pocket expenses for covered services, including deductibles and copayments, cannot exceed \$5,250 for Self Only enrollment, or \$10,500 family coverage.

We have network providers

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

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

How we pay providers

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

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

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

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

Your rights

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

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

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

Your Medical and claims records are confidential

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

Service Area

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

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

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

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

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

Section 2. How we change for 2008

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

Changes to All Options (High Option, Standard Option, and High Deductible Health Plan)

- United States Postal Service non-law enforcement career employees may now be covered either by Postal Category 1 or Postal Category 2 premium rates. See page 102.
- We have no benefit changes.

Changes to High Option only

- Baton Rouge Area – Your share of the non-Postal premium will increase for Self-Only and Self and Family. See page 102.
- New Orleans Area – Your share of the non-Postal premium will increase for Self-Only and Self and Family. See page 102.

Changes to Standard Option only

- Baton Rouge Area – Your share of the non-Postal premium will increase for Self-Only and Self and Family. See page 102.
- New Orleans Area – Your share of the non-Postal premium will increase for Self-Only and Self and Family. See page 102.

Changes to High Deductible Health Plan only

- Baton Rouge Area – Your share of the non-Postal premium will increase for Self-Only and Self and Family. See page 102.
- New Orleans Area – Your share of the non-Postal premium will increase for Self-Only and Self and Family. See page 102.

Section 3. How you get care

Identification cards	<p>We will send you an identification (ID) card when you enroll. You should carry your ID card with you at all times. You must show it whenever you receive services from a Plan provider, or fill a prescription at a Plan pharmacy. Until you receive your ID card, use your copy of the Health Benefits Election Form, SF-2809, your health benefits enrollment confirmation (for annuitants), or your electronic enrollment system (such as Employee Express) confirmation letter.</p> <p>If you do not receive your ID card within 30 days after the effective date of your enrollment, or if you need replacement cards, call us at 800-341-6613. You may also request replacement cards through our Web site at www.chclouisiana.com</p>
Where you get covered care	<p>You get care from “Plan providers” and “Plan facilities.” You will only pay copayments, deductibles, and/or coinsurance, if you use our Open Access program you can receive covered services from a participating provider without a required referral from your primary care physician or by another participating provider in the network.</p>
<ul style="list-style-type: none">• Plan providers	<p>Plan providers are physicians and other health care professionals in our service area that we contract with to provide covered services to our members. We credential Plan providers according to national standards.</p> <p>We list Plan providers in the provider directory, which we update periodically. The list is also on our Web site.</p>
<ul style="list-style-type: none">• Plan facilities	<p>Plan facilities are hospitals and other facilities in our service area that we contract with to provide covered services to our members. We list these in the provider directory, which we update periodically. The list is also on our Web site.</p>
What you must do to get covered care	<p>It depends on the type of care you need.</p>
<ul style="list-style-type: none">• Primary care	<p>Coventry does not require you to select a primary care physician.</p>
<ul style="list-style-type: none">• Specialty care	<p>You may see a Specialist in the network without a referral.</p> <ul style="list-style-type: none">• Here are some other things you should know about specialty care:• If you have a chronic and disabling condition and lose access to your specialist because we:<ul style="list-style-type: none">- Terminate our contract with your specialist for other than cause; or- Drop out of the Federal Employees Health Benefits (FEHB) Program and you enroll in another FEHB program Plan; or- Reduce our service area and you enroll in another FEHB Plan, <p>you may be able to continue seeing your specialist for up to 90 days after you receive notice of the change. Contact us, or if we drop out of the Program, contact your new plan.</p> <p>If you are in the second or third trimester of pregnancy and you lose access to your specialist based on the above circumstances, you can continue to see your specialist until the end of your postpartum care, even if it is beyond the 90 days.</p>
<ul style="list-style-type: none">• Hospital care	<p>Your Plan primary care physician or specialist will make necessary hospital arrangements and supervise your care. This includes admission to a skilled nursing or other type of facility.</p>

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

We pay for covered services from the effective date of your enrollment. However, if you are in the hospital when your enrollment in our Plan begins, call our customer service department immediately at (800) 341-6613. If you are new to the FEHB Program, we will arrange for you to receive care and provide benefits for your covered services while you are in the hospital beginning on the effective date of your coverage.

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

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

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

Circumstances beyond our control

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

- **Services requiring our prior approval**

For certain services your physician must obtain approval from us. Before giving approval, we consider if the service is covered, medically necessary, and follows generally accepted medical practice.

We call this review and approval process prior authorization. Your physician must obtain prior authorization.

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

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

Section 4. Your costs for covered services

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

Copayments

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

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

Cost-Sharing

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

Deductible

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

High Option: We have no deductible.

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

High Deductible Health Plan:

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

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

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

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

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

Coinsurance

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

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

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

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

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

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

Your catastrophic protection out-of-pocket maximum

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

- Certain Outpatient Facility Services
- Infertility treatment

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

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

High Deductible Health Plan:

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

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

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

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

Differences between our allowance and the bill

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

When Government facilities bill us

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

Section 5. High and Standard Option Benefits

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

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

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan physicians must provide or arrange your care.
- A facility copay applies to services that appear in this section but are performed in an ambulatory surgical center or the outpatient department of a hospital.
- High Option – No deductible.
- Standard Option - The calendar year deductible is \$500 per person and \$1,000 per family. The calendar year deductible applies to almost all benefits in this section. We added "(no deductible)" to show when the calendar year deductible does not apply.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

Benefit Description	You Pay After the calendar deductible...	
	High Option	Standard Option
Diagnostic and treatment services		
Professional services of physicians • In physician’s office	No Deductible \$15 per visit to your primary care physician \$15 per visit to a specialist	\$20 per visit to a primary care physician \$30 per visit to a specialist
Professional services of physicians • In an urgent care center • Office medical consultation • Second surgical opinion	No deductible \$15 per office visit	\$20 per visit to a primary care physician \$30 per visit to a specialist
• At home	No deductible \$25 per visit	\$25 per visit
Lab, X-ray and other diagnostic tests		
Tests, such as: • Blood tests • Urinalysis • Non-routine Pap tests • Pathology • X-rays • Non-routine mammograms • Ultrasound • Electrocardiogram and EEG	Nothing if you receive these services during your office visit; otherwise, \$15 per office visit.	Nothing if you receive these services during your office visit; otherwise \$20 per office visit primary and \$30 per office visit/specialist.
• CAT Scans/MRI	Nothing	20% after deductible

Benefit Description	You Pay After the calendar deductible...	
	High Option	Standard Option
Preventive care, adult Routine screenings, such as: <ul style="list-style-type: none"> • Total Blood Cholesterol • Colorectal Cancer Screening, including <ul style="list-style-type: none"> - Fecal occult blood test - Sigmoidoscopy, screening – every five years starting at age 50 - Double contrast barium enema – every five years starting at age 50 - Colonoscopy screening – every ten years starting at age 50 	No Deductible \$15 per office visit \$100 out-patient department of a hospital or ambulatory surgical facility.	\$20 per office visit to a primary care physician \$30 per visit to a specialist \$100 in outpatient department of a hospital or ambulatory surgical facility
Routine Prostate Specific Antigen (PSA) test – one annually for men age 40 and older	No deductible 15 per office visit	\$20 per visit to a primary care physician \$30 per visit to a specialist
Routine Pap test Note: You do not pay a separate copay for a Pap test performed during your routine annual physical; see <i>Diagnostic and treatment services</i> .	No deductible \$15 per office visit	\$20 per visit to a primary care physician \$30 per visit to a specialist
Routine mammogram – covered for women age 35 and older, as follows: <ul style="list-style-type: none"> • From age 35 through 39, one baseline during this five year period • From age 40 through 49, one every 24 months or more frequently if recommended by a Participating Physician • At age 50 and older, one every 12 months 	Nothing	Nothing
Adult routine immunizations endorsed by the Centers for Disease Control and Prevention (CDC):	No deductible \$15 per office visit	\$20 per visit to a primary care physician \$30 per visit to a specialist
<i>Not covered: Physical exams and immunizations required for obtaining or continuing employment or insurance, attending schools or camp, or travel.</i>	All charges	All charges
Preventive care, children	High Option	Standard Option
<ul style="list-style-type: none"> • Childhood immunizations recommended by the American Academy of Pediatrics 	No deductible \$15 per office visit	\$20 per visit to a primary care physician \$30 per visit to a specialist
<ul style="list-style-type: none"> • Well-child care charges for routine examinations, immunizations and care (up to age 22) • Examinations, such as: <ul style="list-style-type: none"> - Eye exams through age 17 to determine the need for vision correction - Ear exams through age 17 to determine the need for hearing correction 	No deductible \$15 per office visit	\$20 per visit to a primary care physician \$30 per visit to a specialist

Preventive care, children - continued on next page

Benefit Description	You Pay After the calendar deductible...	
Preventive care, children (cont.)	High Option	Standard Option
- Examinations done on the day of immunizations (up to age 22)	No deductible \$15 per office visit	\$20 per visit to a primary care physician \$30 per visit to a specialist
Maternity care	High Option	Standard Option
Complete maternity (obstetrical) care, such as: <ul style="list-style-type: none"> • Prenatal care • Delivery • Postnatal care <p>Note: Here are some things to keep in mind:</p> <ul style="list-style-type: none"> • You do not need to precertify your normal delivery; see page 13 for other circumstances, such as extended stays for you or your baby. • You may remain in the hospital up to 48 hours after a regular delivery and 96 hours after a cesarean delivery. We will extend your inpatient stay if medically necessary. • We cover routine nursery care of the newborn child during the covered portion of the mother's maternity stay. We will cover other care of an infant who requires non-routine treatment only if we cover the infant under a Self and Family enrollment. • We pay hospitalization and surgeon services (delivery) the same as for illness and injury. See Hospital benefits (Section 5c) and Surgery benefits (Section 5b). 	No deductible \$15 per office visit for initial visit only	\$30 copayment for initial visit only
<i>Not covered: Routine sonograms to determine fetal age, size or sex.</i>	<i>All charges</i>	<i>All charges</i>
Family planning	High Option	Standard Option
A range of voluntary family planning services, limited to: <ul style="list-style-type: none"> • Surgically implanted contraceptives • Injectable contraceptive drugs (such as Depo provera) • Diaphragms <p>Note: We cover oral contraceptives under the prescription drug benefit.</p>	No deductible \$15 per office visit	20% coinsurance
• Voluntary sterilization (vasectomy or tubal ligation)	\$100 per procedure	20% coinsurance
<i>Not covered:</i> <ul style="list-style-type: none"> • <i>Reversal of voluntary surgical sterilization</i> 	<i>All charges</i>	<i>All charges</i>

Family planning - continued on next page

Benefit Description	You Pay After the calendar deductible...	
Family planning (cont.)	High Option	Standard Option
<ul style="list-style-type: none"> • Genetic counseling • Intrauterine Devices (IUDs) 	<i>All charges</i>	<i>All charges</i>
Infertility services	High Option	Standard Option
Diagnosis and treatment of infertility such as: <ul style="list-style-type: none"> • Artificial insemination: <ul style="list-style-type: none"> - intravaginal insemination (IVI) - intracervical insemination (ICI) - intrauterine insemination (IUI) 	No deductible 50% of charges	20% coinsurance
<i>Not covered:</i> <ul style="list-style-type: none"> • Assisted reproductive technology (ART) procedures, such as: <ul style="list-style-type: none"> - <i>in vitro</i> fertilization - embryo transfer, gamete intra-fallopian transfer (GIFT) and zygote intra-fallopian transfer (ZIFT) • Services and supplies related to ART procedures • Cost of donor sperm • Cost of donor egg. • Fertility Drugs 	<i>All charges</i>	<i>All Charges</i>
Allergy care	High Option	Standard Option
<ul style="list-style-type: none"> • Testing and treatment • Allergy injections 	No deductible 50% of charges \$15 per office visit	20% coinsurance \$20 per visit to a primary care physician \$30 per visit to a specialist
Allergy serum	Nothing	Nothing
<i>Not covered:</i> <ul style="list-style-type: none"> • Provocative food testing • Sublingual allergy desensitization 	<i>All charges</i>	<i>All charges</i>
Treatment therapies	High Option	Standard Option
<ul style="list-style-type: none"> • Chemotherapy and radiation therapy <p>Note: High dose chemotherapy in association with autologous bone marrow transplants is limited to those transplants listed under Organ/Tissue Transplants on page 33.</p> <ul style="list-style-type: none"> • Respiratory and inhalation therapy • Dialysis – hemodialysis and peritoneal dialysis • Intravenous (IV)/Infusion Therapy – Home IV and antibiotic therapy • Growth hormone therapy (GHT) 	No deductible \$15 per office visit	20% coinsurance

Treatment therapies - continued on next page
High and Standard Option Section 5(a)

Benefit Description	You Pay After the calendar deductible...	
Treatment therapies (cont.)	High Option	Standard Option
Note: Growth hormone is covered under the prescription drug benefit.	No deductible \$15 per office visit	20% coinsurance
Physical and occupational therapies	High Option	Standard Option
<p>60 consecutive days per condition for the services of each of the following:</p> <ul style="list-style-type: none"> • qualified physical therapists and • occupational therapists <p>Note: We only cover therapy to restore bodily function when there has been a total or partial loss of bodily function due to illness or injury.</p> <p>Cardiac rehabilitation following a heart transplant, bypass surgery or a myocardial infarction is provided for up to 60 days for physical therapy.</p>	No deductible 20% coinsurance	20% coinsurance
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Long-term rehabilitative therapy</i> • <i>Exercise programs</i> 	<i>All charges</i>	<i>All charges</i>
Speech therapy	High Option	Standard Option
60 consecutive days per condition	No deductible 20% of charges.	20% of charges.
Hearing services (testing, treatment, and supplies)	High Option	Standard Option
<ul style="list-style-type: none"> • Hearing testing for children through age 17, which include; (see <i>Preventive care, children</i>) 	No deductible \$15 per office visit	\$20 per visit to a primary care physician \$30 per visit to a specialist
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>All other hearing testing</i> • <i>Hearing aids, testing and examinations for them</i> 	<i>All charges</i>	<i>All charges</i>
Vision services (testing, treatment, and supplies)	High Option	Standard Option
<ul style="list-style-type: none"> • Diagnosis and treatment of diseases of the eye 	No deductible \$15 per office visit	\$30 per office visit
<ul style="list-style-type: none"> • Prosthetic devices, such as lenses following catarat removal 	No deductible 50% of charges	\$30 per office visit
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Eyeglasses or contact lenses and after age 17, examinations for them</i> • <i>Eye exercises and orthoptics</i> • <i>Radial keratotomy and other refractive surgery</i> • <i>Annual eye refractions</i> 	<i>All charges</i>	<i>All charges</i>

Benefit Description	You Pay After the calendar deductible...	
Foot care	High Option	Standard Option
<p>Routine foot care when you are under active treatment for a metabolic or peripheral vascular disease, such as diabetes.</p> <p>Note: See Orthopedic and prosthetic devices for information on podiatric shoe inserts.</p>	<p>No deductible</p> <p>\$15 per office visit</p>	<p>\$20 per visit to a primary care physician</p> <p>\$30 per visit to a specialist</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Cutting, trimming or removal of corns, calluses, or the free edge of toenails, and similar routine treatment of conditions of the foot, except as stated above</i> • <i>Treatment of weak, strained or flat feet or bunions or spurs; and of any instability, imbalance or subluxation of the foot (unless the treatment is by open cutting surgery)</i> 	<i>All charges</i>	<i>All charges</i>
Orthopedic and prosthetic devices	High Option	Standard Option
<p>High Option – Our maximum allowance for this benefit is \$1,000 per calendar year.</p> <p>Standard Option – Our maximum allowance for this benefit is \$5,000 per calendar year.</p> <ul style="list-style-type: none"> • Artificial limbs and eyes; stump hose • Externally worn breast prostheses and surgical bras, including necessary replacements following a mastectomy • Internal prosthetic devices, such as artificial joints, pacemakers, cochlear implants, and surgically implanted breast implant following mastectomy. Note: See 5(b) for coverage of the surgery to insert the device. • Orthopedic devices, such as braces • Foot orthotics • Corrective orthopedic appliances for non-dental treatment of temporomandibular joint (TMJ) pain dysfunction syndrome. 	<p>Nothing up to our maximum allowance of \$1,000 per calendar year.</p> <p>Responsible for all charges over the maximum.</p>	<p>20% coinsurance up to the maximum allowance of \$5,000 per calendar year.</p> <p>Responsible for all charges over the maximum.</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Heel pads and heel cups</i> • <i>Orthopedic and corrective shoes</i> • <i>Arch supports</i> • <i>Foot orthotics</i> • <i>Lumbosacral supports</i> • <i>Corsets, trusses, elastic stockings, support hose, and other supportive devices</i> 	<i>All charges</i>	<i>All charges</i>

Benefit Description	You Pay After the calendar deductible...	
Durable medical equipment (DME)	High Option	Standard Option
<p>High Option – Our maximum allowance for this benefit is \$1,000 per calendar year.</p> <p>Standard Option – Our maximum allowance for this benefit is \$5,000 per calendar year.</p> <p>Rental or purchase, at our option, including repair and adjustment, of durable medical equipment prescribed by your Plan physician, such as oxygen and dialysis equipment. Under this benefit, we also cover:</p> <ul style="list-style-type: none"> • Hospital beds; • Wheelchairs; • Crutches; • Walkers; • Blood glucose monitors; and • Insulin pumps. <p>Note: Call us at 800-341-6613 as soon as your Plan physician prescribes this equipment.</p>	<p>Nothing up to our maximum allowance of \$1,000 per calendar year..</p> <p>Responsible for all charges over the maximum.</p>	<p>20% coinsurance up to the maximum allowance of \$5,000 per calendar year.</p> <p>Responsible for all charges over the maximum.</p>
<i>Not covered: Motorized wheelchairs</i>	<i>All charges</i>	<i>All charges</i>
Home health services	High Option	Standard Option
<ul style="list-style-type: none"> • Home health care ordered by a Plan physician and provided by a registered nurse (R.N.), licensed practical nurse (L.P.N.), licensed vocational nurse (L.V.N.), or home health aide. • Services include oxygen therapy, intravenous therapy and medications. 	<p>Nothing</p>	<p>20% coinsurance</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Nursing care requested by, or for the convenience of, the patient or the patient's family;</i> • <i>Home care primarily for personal assistance that does not include a medical component and is not diagnostic, therapeutic, or rehabilitative.</i> • <i>Nursing aides</i> 	<i>All charges</i>	<i>All charges</i>
Chiropractic	High Option	Standard Option
<ul style="list-style-type: none"> • Manipulation of the spine and extremities <p>After initial evaluation, treatment plan must be submitted to Coventry Health Care to authorize additional visits.</p>	<p>No deductible</p> <p>\$15 per office visit</p>	<p>\$30 per office visit</p>

High and Standard Option

Benefit Description	You Pay After the calendar deductible...	
Alternative treatments	High Option	Standard Option
<i>No benefit</i>	<i>All charges</i>	<i>All charges</i>

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

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan physicians must provide or arrange your care.
- High Option – No deductible.
- Standard Option - The calendar year deductible is \$500 per person and \$1,000 per family. The calendar year deductible applies to almost all benefits in this section. We added "(no deductible)" to show when the calendar year deductible does not apply.
- Be sure to read Section 4, Your costs for covered services, for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- The amounts listed below are for the charges billed by a physician or other health care professional for your surgical care. Look in Section 5(c) for charges associated with the facility (i.e. hospital, surgical center, etc.).
- **YOUR PHYSICIAN MUST GET PRECERTIFICATION FOR SOME SURGICAL PROCEDURES.** Please refer to the precertification information shown in Section 3 to be sure which services require precertification and identify which surgeries require precertification.

Benefit Description	You pay	
	High Option	Standard Option
Surgical procedures		
A comprehensive range of services, such as: <ul style="list-style-type: none"> • Operative procedures • Treatment of fractures, including casting • Normal pre- and post-operative care by the surgeon • Endoscopy procedures • Biopsy procedures • Removal of tumors and cysts • Correction of congenital anomalies (see Reconstructive surgery) 	No deductible \$15 per office visit	\$20 per visit to a primary care physician \$30 per visit to a specialist
<ul style="list-style-type: none"> • Surgical treatment of morbid obesity (bariatric surgery) will be covered when <u>all</u> of the following criteria are met: <ul style="list-style-type: none"> - The patient is an adult (≥ 18 years of age) with morbid obesity that has persisted for at least 3 years, and for which there is no treatable metabolic cause for the obesity; 	\$15 per office visit	\$20 per visit to a primary care physician \$30 per visit to a specialist

Surgical procedures - continued on next page

Benefit Description	You pay	
Surgical procedures (cont.)	High Option	Standard Option
<ul style="list-style-type: none"> - There is presence of morbid obesity, defined as a body mass index (BMI) exceeding 40, or greater than 35 with documented co-morbid conditions (cardiopulmonary problems e.g., severe apnea, Pickwickian Syndrome, and obesity-related cardiomyopathy, severe diabetes mellitus, hypertension, or arthritis). (BMI is calculated by dividing a patient's weight (in kilograms) by height (in meters) squared. To convert pounds to kilograms, multiply pounds by 0.45. To convert inches to meters, multiply inches by .0254); - The patient has failed to lose weight (approximately 10% from baseline) or has regained weight despite participation in a three month physician-supervised multidisciplinary program within the past six months that included dietary therapy, physical activity and behavior therapy and support; - The patient has been evaluated for restrictive lung disease and received surgical clearance by a pulmonologist, if clinically indicated; has received cardiac clearance by a cardiologist if there is a history of prior phen-fen or redux use, and the patient has agreed, following surgery, to participate in a multidisciplinary program that will provide guidance on diet, physical activity and social support; and, - The patient has completed a psychological evaluation and has been recommended for bariatric surgery by a licensed mental health professional (this must be documented in the patient's medical record) and the patient's medical record reflects documentation by the treating psychotherapist that all psychosocial issues have been identified and addressed; and the psychotherapist indicates that the patient is likely to be compliant with the post-operative diet restrictions; • Insertion of internal prosthetic devices. See 5(a) – Orthopedic and prosthetic devices for device coverage information • Treatment of burns 	<p>\$15 per office visit</p>	<p>\$20 per visit to a primary care physician</p> <p>\$30 per visit to a specialist</p>
<ul style="list-style-type: none"> • Voluntary Sterilization (e.g., Tubal ligation, Vasectomy) 	<p>\$100 per procedure</p>	<p>20% coinsurance</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Reversal of voluntary sterilization</i> • <i>Routine treatment of conditions of the foot; see Foot care</i> 	<p><i>All charges</i></p>	<p><i>All charges</i></p>

Benefit Description	You pay	
	High Option	Standard Option
<p>Reconstructive surgery</p> <ul style="list-style-type: none"> • Surgery to correct a functional defect • Surgery to correct a condition caused by injury or illness if: <ul style="list-style-type: none"> - the condition produced a major effect on the member's appearance and - can reasonably be expected to be corrected by such surgery • Surgery to correct a condition that existed at or from birth and is a significant deviation from the common form or norm. Examples of congenital anomalies are: protruding ear deformities; cleft lip; cleft palate; birth marks; webbed fingers; and webbed toes. • All stages of breast reconstruction surgery following a mastectomy, such as: <ul style="list-style-type: none"> - surgery to produce a symmetrical appearance of breasts; - treatment of any physical complications, such as lymphedemas; - breast prostheses and surgical bras and replacements (see Prosthetic devices) <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>No deductible</p> <p>\$15 per office visit</p>	<p>\$20 per visit to a primary care physician</p> <p>\$30 per visit to a specialist</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Cosmetic surgery – any surgical procedure (or any portion of a procedure) performed primarily to improve physical appearance through change in bodily form, except repair of accidental injury</i> • <i>Surgeries related to sex transformation</i> 	<p><i>All charges</i></p>	<p><i>All charges</i></p>
<p>Oral and maxillofacial surgery</p> <p>Oral surgical procedures, limited to:</p> <ul style="list-style-type: none"> • Reduction of fractures of the jaws or facial bones; • Surgical correction of cleft lip, cleft palate or severe functional malocclusion; • Removal of stones from salivary ducts; • Excision of leukoplakia or malignancies; • Excision of cysts and incision of abscesses when done as independent procedures; and • Other surgical procedures that do not involve the teeth or their supporting structures. 	<p>No deductible</p> <p>\$15 per office visit</p>	<p>\$20 per visit to a primary care physician</p> <p>\$30 per visit to a specialist</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Oral implants and transplants</i> 	<p><i>All charges</i></p>	<p><i>All charges</i></p>

Oral and maxillofacial surgery - continued on next page

Benefit Description	You pay	
	High Option	Standard Option
Oral and maxillofacial surgery (cont.)		
<ul style="list-style-type: none"> • Procedures that involve the teeth or their supporting structures (such as the periodontal membrane, gingiva, and alveolar bone) • Dental care involved in treatment of temporomandibular joint (TMJ) pain dysfunction syndrome 	<i>All charges</i>	<i>All charges</i>
Organ/tissue transplants		
<p>Solid organ transplants are subject to medical necessity and experimental/investigational review. Refer to Other services in section 3 for prior authorization procedures. The medical necessity limitation is considered satisfied for other tissue transplants if the patient meets the staging description and can safely tolerate the procedure.</p> <ul style="list-style-type: none"> • Cornea • Heart • Heart/lung • Kidney • Liver • Lung: single, double, or lobar lung • Pancreas • Autologous pancreas islet cell transplant (as an adjunct to total or near total pancreatectomy) only for patients with chronic pancreatitis • Intestinal transplants <ul style="list-style-type: none"> - Small intestine - Small intestine with the liver - Small intestine with multiple organs, such as the liver, stomach, and pancreas 	<p>No deductible</p> <p>\$15 per doctor visit</p> <p>Inpatient- \$150 per day up to \$450 maximum per admission</p>	<p>\$20 per visit to a primary care physician</p> <p>\$30 per visit to a specialist</p> <p>Inpatient - \$250 per day up to \$750 maximum per admission</p>
<p>Blood or marrow stem cell transplants limited to the stages of the following diagnoses: (The medical necessity limitation is considered satisfied if the patient meets the staging description):</p> <ul style="list-style-type: none"> • Allogeneic transplants for <ul style="list-style-type: none"> - Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia - Advanced Hodgkin’s lymphoma - Advanced non-Hodgkin’s lymphoma - Chronic myelogenous leukemia - Severe combined immunodeficiency - Severe or very severe aplastic anemia • Autologous transplant for <ul style="list-style-type: none"> - Acute lymphocytic or nonlymphocytic (i.e., myelogenous) leukemia 	<p>No deductible</p> <p>\$15 per doctor visit</p> <p>Inpatient- \$150 per day up to \$450 maximum per admission</p>	<p>\$20 per visit to a primary care physician</p> <p>\$30 per visit to a specialist</p> <p>Inpatient - \$250 per day up to \$750 maximum per admission</p>

Benefit Description	You pay	
Organ/tissue transplants (cont.)	High Option	Standard Option
<ul style="list-style-type: none"> - Advanced Hodgkin’s lymphoma - Advanced non-Hodgkin’s lymphoma - Advanced neuroblastoma • Autologous tandem transplants for recurrent germ cell tumors (including testicular cancer) 	<p>No deductible</p> <p>\$15 per doctor visit</p> <p>Inpatient- \$150 per day up to \$450 maximum per admission</p>	<p>\$20 per visit to a primary care physician</p> <p>\$30 per visit to a specialist</p> <p>Inpatient - \$250 per day up to \$750 maximum per admission</p>
<p>Blood or marrow stem cell transplants limited to the stages of the following diagnoses: (The medical necessity limitation is considered satisfied if the patient meets the staging description):</p> <ul style="list-style-type: none"> • Allogeneic transplants for <ul style="list-style-type: none"> - Phagocytic deficiency diseases (e.g., Wiskott-Aldrich syndrome) - Advanced forms of myelodysplastic syndromes - Advanced neuroblastoma - Infantile malignant osteoporosis - Kostmann’s syndrome - Leukocyte adhesion deficiencies - Mucopolysaccharidosis (e.g., Gaucher’s disease, metachromatic leukodystrophy, adrenoleukodystrophy) - Mucopolysaccharidosis (e.g., Hunter’s syndrome, Hurler’s syndrome, Sanfilippo’s syndrome, Maroteaux-Lamy syndrome variants) - Myeloproliferative disorders - Sickle cell anemia - Thalassemia major (homozygous beta-thalassemia) - X-linked lymphoproliferative syndrome • Autologous transplants for <ul style="list-style-type: none"> - Multiple myeloma - Testicular, mediastinal, retroperitoneal, and ovarian germ cell tumors - Breast cancer - Epithelial ovarian cancer - Amyloidosis - Ependyoblastoma - Ewing’s sarcoma - Medulloblastoma - Pineoblastoma 	<p>No deductible</p> <p>\$15 per doctor visit</p> <p>Inpatient- \$150 per day up to \$450 maximum per admission</p>	<p>\$20 per visit to a primary care physician</p> <p>\$30 per visit to a specialist</p> <p>Inpatient - \$250 per day up to \$750 maximum per admission</p>

Organ/tissue transplants - continued on next page

Benefit Description	You pay	
Organ/tissue transplants (cont.)	High Option	Standard Option
<p>Blood or marrow stem cell transplants covered only 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 for:</p> <ul style="list-style-type: none"> • Allogeneic transplants for <ul style="list-style-type: none"> - Chronic lymphocytic leukemia - Early stage (indolent or non-advanced) small cell lymphocytic lymphoma - Multiple myeloma • Nonmyeloablative allogeneic transplants for <ul style="list-style-type: none"> - Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia - Advanced forms of myelodysplastic syndromes - Advanced Hodgkin's lymphoma - Advanced non-Hodgkin's lymphoma - Breast cancer - Chronic lymphocytic leukemia - Chronic myelogenous leukemia - Colon cancer - Early stage (indolent or non-advanced) small cell lymphocytic lymphoma - Multiple myeloma - Myeloproliferative disorders - Non-small cell lung cancer - Ovarian cancer - Prostate cancer - Renal cell carcinoma - Sarcomas • Autologous transplants for <ul style="list-style-type: none"> - Chronic lymphocytic leukemia - Chronic myelogenous leukemia - Early stage (indolent or non-advanced) small cell lymphocytic lymphoma - Multiple sclerosis - Systemic lupus erythematosus - Systemic sclerosis • National Transplant Program (NTP) - <p>Note: We cover related medical and hospital expenses of the donor when we cover the recipient.</p>	<p>No deductible</p> <p>\$15 per doctor visit</p> <p>Inpatient- \$150 per day up to \$450 maximum per admission</p>	<p>\$20 per visit to a primary care physician</p> <p>\$30 per visit to a specialist</p> <p>Inpatient - \$250 per day up to \$750 maximum per admission</p>
<i>Not covered:</i>	<i>All charges</i>	<i>All charges</i>

Organ/tissue transplants - continued on next page
High and Standard Option Section 5(b)

Benefit Description	You pay	
Organ/tissue transplants (cont.)	High Option	Standard Option
<ul style="list-style-type: none"> • Donor screening tests and donor search expenses, except those performed for the actual donor • Implants of artificial organs • Transplants not listed as covered 	<i>All charges</i>	<i>All charges</i>
Anesthesia	High Option	Standard Option
Professional services provided in – <ul style="list-style-type: none"> • Hospital (inpatient) 	Nothing	20% coinsurance
Professional services provided in – <ul style="list-style-type: none"> • Hospital outpatient department • Skilled nursing facility • Ambulatory surgical center • Office 	No deductible \$15 per office visit	20% coinsurance \$20 per visit to a primary care physician \$30 per visit to a specialist

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

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan physicians must provide or arrange your care and you must be hospitalized in a Plan facility.
- High Option – No deductible.
- Standard Option - In this section, unlike sections 5(a) and 5(b), the calendar year deductible applies to only a few benefits. We added "(calendar year deductible applies)" when it applies. The calendar year deductible is \$500 per person and \$1,000 per family.
- Be sure to read Section 4, *Your costs for covered services* for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- The amounts listed below are for the charges billed by the facility (i.e., hospital or surgical center) or ambulance service for your surgery or care. Any costs associated with the professional charge (i.e., physicians, etc.) are in Sections 5(a) or (b).
- **YOUR PHYSICIAN MUST GET PRECERTIFICATION FOR HOSPITAL STAYS.** Please refer to Section 3 to be sure which services require precertification.

Benefit Description	You pay	
	High Option	Standard Option
Inpatient hospital Room and board, such as <ul style="list-style-type: none"> • 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.	\$150 per day up to a \$450 maximum per admission	Calendar year deductible applies, once it is met then \$250 per day up to a \$750 maximum per admission
Other hospital services and supplies, such as: <ul style="list-style-type: none"> • Operating, recovery, maternity, and other treatment rooms • Prescribed drugs and medicines • Diagnostic laboratory tests and X-rays • Administration of blood, blood plasma, and other biologicals • Dressings, splints, casts, and sterile tray services • Medical supplies and equipment, including oxygen • Anesthetics, including nurse anesthetist services • Take-home items • Medical supplies, appliances, medical equipment, and any covered items billed by a hospital for use at home (Note: calendar year deductible applies.) 	Nothing for other hospital services after you pay the hospital admission copayment.	Nothing for other hospital services after you pay the hospital admission copayment.
<i>Not covered:</i>	<i>All charges</i>	<i>All charges</i>

Inpatient hospital - continued on next page
 High and Standard Option Section 5(c)

Benefit Description	You pay	
Inpatient hospital (cont.)	High Option	Standard Option
<ul style="list-style-type: none"> • Custodial care • Non-covered facilities, such as nursing homes, schools • Personal comfort items, such as telephone, television, barber services, guest meals and beds • Private nursing care 	<i>All charges</i>	<i>All charges</i>
Outpatient hospital or ambulatory surgical center	High Option	Standard Option
<ul style="list-style-type: none"> • Operating, recovery, and other treatment rooms • Prescribed drugs and medicines • Diagnostic laboratory tests, X-rays , and pathology services • Administration of blood, blood plasma, and other biologicals • Pre-surgical testing • Dressings, casts , and sterile tray services • Medical supplies, including oxygen • Anesthetics and anesthesia service <p>Note: We cover hospital services and supplies related to dental procedures when necessitated by a non-dental physical impairment. We do not cover the dental procedures.</p>	\$100 copayment per facility use	Calendar year deductible applies, once it is met then 20% coinsurance
<i>Not covered: Blood and blood derivatives not replaced by the member</i>	<i>All charges</i>	<i>All charges</i>
Extended care benefits/Skilled nursing care facility benefits	High Option	Standard Option
<p>High Option – We limit our coverage to 100 days per calendar year</p> <p>Standard Option - We limit our coverage to 30 days per calendar year</p> <p>Comprehensive range of benefits will be provided when full-time skilled nursing care is necessary and confinement in a skilled nursing facility is in lieu of hospitalization..</p> <p>Covered services include:</p> <ul style="list-style-type: none"> • Bed, board and general nursing care <p>Drugs, biologicals, supplies, and equipment ordinarily provided or arranged by the skilled nursing facility when prescribed by a Plan doctor</p>	Nothing	<p>Calendar year deductible applies, once it is met then</p> <p>\$250 per day up to a \$750 maximum per admission</p>
<i>Not covered: Custodial care</i>	<i>All charges</i>	<i>All charges</i>

High and Standard Option

Benefit Description	You pay	
Hospice care	High Option	Standard Option
Supportive and palliative care for a terminally ill member in the home or hospice facility. Services include inpatient and outpatient care, and family counseling. Services are provided under the direction of a Plan doctor who certifies that the patient is in the terminal stages of illness, with a life expectancy of approximately six months or less.	Nothing	Calendar year deductible applies, once it is met then 20% coinsurance
<i>Not covered: Independent nursing, homemaker services</i>	<i>All charges</i>	<i>All charges.</i>
Ambulance	High Option	Standard Option
Local professional ambulance service when medically appropriate	\$100 per transport	Calendar year deductible applies,once it is met then 20% coinsurance

Section 5(d). Emergency services/accidents

Important things to keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- High Option – No deductible.
- Standard Option - The calendar year deductible is \$500 per person and \$1,000 per family. The calendar year deductible applies to almost all benefits in this section. We added "(no deductible)" to show when the calendar year deductible does not apply.

What is a medical emergency?

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

What to do in case of emergency:

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

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

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

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

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

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

High and Standard Option

Benefit Description	You pay	
Emergency within our service area	High Option	Standard Option
<ul style="list-style-type: none"> • Emergency care at a doctor’s office • Emergency care at an urgent care center 	No deductible \$15 per office visit	\$20 per office visit
<ul style="list-style-type: none"> • Emergency care as an outpatient at a hospital, including doctors’ services 	\$100 per visit	\$150 per visit
<i>Not covered: Elective care or non-emergency care</i>	<i>All charges</i>	<i>All charges</i>
Emergency outside our service area	High Option	Standard Option
<ul style="list-style-type: none"> • Emergency care at a doctor’s office • Emergency care at an urgent care center 	\$15 per office visit	\$20 per visit
<ul style="list-style-type: none"> • Emergency care as an outpatient at a hospital, including doctors’ services 	\$100 per visit	\$150 per visit
<i>Not covered:</i> <ul style="list-style-type: none"> • <i>Elective care or non-emergency care</i> • <i>Emergency care provided outside the service area if the need for care could have been foreseen before leaving the service area</i> • <i>Medical and hospital costs resulting from a normal full-term delivery of a baby outside the service area</i> 	<i>All charges</i>	<i>All charges</i>
Ambulance	High Option	Standard Option
Professional ambulance service when medically appropriate. Note: See 5(c) for non-emergency service.	\$100 per transport	20% coinsurance

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

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

Important things to keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- High Option – No deductible.
- Standard Option - The calendar year deductible is \$500 per person and \$1,000 per family. The calendar year deductible or, for facility care, the inpatient deductible applies to almost all benefits in this section. we added "(no deductible)" to show when a deductible does not apply.
- **YOU MUST GET PREAUTHORIZATION FOR THESE SERVICES.** See the instructions after the benefits description below.

Benefit Description	You pay	
	High Option	Standard Option
Mental health and substance abuse benefits		
All diagnostic and treatment services recommended by a Plan provider and contained in a treatment plan that we approve. The treatment plan may include services, drugs, and supplies described elsewhere in this brochure. Note: Plan benefits are payable only when we determine the care is clinically appropriate to treat your condition and only when you receive the care as part of a treatment plan that we approve.	Your cost sharing responsibilities are no greater than for other illnesses or conditions.	Your cost sharing responsibilities are no greater than for other illnesses or conditions.
<ul style="list-style-type: none"> • Professional services, including individual or group therapy by providers such as psychiatrists, psychologists, or clinical social workers • Medication management 	No deductible \$15 per visit	\$20 per visit to a primary care physician \$30 per visit to a specialist
<ul style="list-style-type: none"> • Diagnostic tests 	Nothing	Nothing
<ul style="list-style-type: none"> • Cat Scan, MRI, PET Scan, MRA 	Nothing	20% coinsurance
Services provided by a hospital or other facility Services in approved alternative care settings such as partial hospitalization, half-way house, residential treatment, full-day hospitalization, facility based intensive outpatient treatment	No deductible \$150 per day up to a \$450 maximum per admission	\$250 per day up to a \$750 maximum per admission

Mental health and substance abuse benefits - continued on next page

Benefit Description	You pay	
Mental health and substance abuse benefits (cont.)	High Option	Standard Option
We may allow Members to exchange one inpatient day of treatment for four (4) outpatient visits or exchange four (4) outpatient visits for one inpatient day of treatment. We may also allow a Member to exchange two (2) days of Transitional Partial Hospitalization or two (2) days of residential treatment center hospitalization for each inpatient day of treatment.	No deductible \$150 per day up to a \$450 maximum per admission	\$250 per day up to a \$750 maximum per admission
<i>Not covered: Services we have not approved.</i> <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>	<i>All charges</i>	<i>All charges</i>

Preauthorization

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

Limitation

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

Section 5(f). Prescription drug benefits

Important things to keep in mind about these benefits:

- We cover prescribed drugs and medications, as described in the chart beginning on the next page.
- 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.
- Some prescriptions do require prior authorization form the medical director. Your physician obtains the authorization by completing a form and sending it to Coventry.
- High Option – No deductible.
- Standard Option - The calendar year deductible is \$500 per person and \$1,000 per family. The calendar year deductible applies to all benefits in this section. We added "(No deductible)" to show when the calendar year deductible does not apply.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

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

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

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

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

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

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

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

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

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

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

Benefit Description	You pay	
Covered medications and supplies	High Option	Standard Option
<p>We cover the following medications and supplies prescribed by a Plan physician and obtained from a Plan pharmacy or through our mail order program:</p> <ul style="list-style-type: none"> • Drugs and medicines that by Federal law of the United States require a physician’s prescription for their purchase, except as excluded below. • Insulin • Insulin syringes and medication • Disposable needles and syringes for the administration of covered medications • Drugs for sexual dysfunction (see Notebelow) • Contraceptive drugs and devices • Growth hormones <p>Note: Contact the Plan for drug dose limits for sexual dysfunction.</p> <p>Note: If there is no generic equivalent available, you will still have to pay the brand name copay.</p>	<p>Retail Pharmacy</p> <p>No Deductible</p> <p>\$10 per generic</p> <p>\$25 per formulary name brand</p> <p>\$50 per non-formulary</p> <p>Mail Order (Maintenance medications only)</p> <p>\$20 per generic</p> <p>\$50 per formulary name brand</p> <p>\$100 per non-formulary</p>	<p>Retail Pharmacy</p> <p>\$10 per generic</p> <p>\$25 per formulary name brand</p> <p>\$50 per non-formulary</p> <p>Mail Order (Maintenance medications only)</p> <p>\$20 per generic</p> <p>\$50 per formulary name brand</p> <p>\$100 per non-formulary</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Drugs and supplies for cosmetic purposes</i> • <i>Drugs to enhance athletic performance</i> • <i>Fertility drugs</i> • <i>Drugs obtained at a non-Plan pharmacy; except for out-of-area emergencies</i> • <i>Vitamins, nutrients and food supplements even if a physician prescribes or administers them</i> • Nonprescription medicines 	<i>All charges</i>	<i>All charges</i>

Section 5(g). Dental benefits

Important things to keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary
- If you are enrolled in a Federal Employees Dental/Vision Insurance program (FEDVIP) Dental plan, your FEHB plan will be First/Primary payer of any Benefits payments and your FEDVIP plan is secondary to your FEHB plan. See section 9 coordinating benefits with other coverage.
- Plan dentists must provide or arrange your care.
- High Option – No deductible.
- Standard Option - The calendar year deductible is \$500 per person and \$1,000 per family. The calendar year deductible applies to all benefits in this section. We added "(no Deductible)" to show when the calendar year deductible does not apply.
- We cover hospitalization for dental procedures only when a non-dental physical impairment exists which makes hospitalization necessary to safeguard the health of the patient. See Section 5(c) for inpatient hospital benefits. We do not cover the dental procedure unless it is described below.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

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

Section 5(h). Special features

<p>24 hour nurse line</p>	<p>For any of your health concerns, 24 hours a day, 7 days a week, you may call First Help at 1-800-622-9528 and talk with a registered nurse who will discuss treatment options and answer your health questions.</p>
<p>Flexible benefits option</p>	<p>Under the flexible benefits option, we determine the most effective way to provide services.</p> <ul style="list-style-type: none"> • We may identify medically appropriate alternatives to traditional care and coordinate other benefits as a less costly alternative benefit. • Alternative benefits are subject to our ongoing review. • By approving an alternative benefit, we cannot guarantee you will get it in the future. • The decision to offer an alternative benefit is solely ours, and we may withdraw it at any time and resume regular contract benefits. • Our decision to offer or withdraw alternative benefits is not subject to OPM review under the disputed claims process.

Section f(I). Non-FEHB benefits available to Plan members

Vision Care	Routine eye exams are covered once every 12 months for a \$15 copayment through Avesis providers. Providers may be found at www.avesis.com or contact customer service at 800-341-6613.
Louisiana Discount Program	This program entitles you to receive dental, hearing, massage therapy and cosmetic procedures at a discounted rate using contracted providers. To obtain a listing of providers please contact 800-341-6613.

Section 6. High Deductible Health Plan Option

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Section 6. High Deductible Health Plan Option

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

HDHP Section 6, which describes the HDHP benefits, is divided into subsections. Please read *Important things you should keep in mind about these benefits* at the beginning of each subsection. Also read the General Exclusions in Section 6; they apply to benefits in the following subsections. To obtain claim forms, claims filing advice, or more information about HDHP benefits, contact us at 800-341-6613 or at our Web site at www.chclouisiana.com

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

When you enroll in this HDHP, we establish either a Health Savings Account (HSA) or a Health Reimbursement Arrangement (HRA) for you. We automatically pass through a portion of the total health Plan premium to your HSA or credit an equal amount to your HRA based upon your eligibility. Your full annual HRA credit will be available on your effective date of enrollment.

With this Plan, preventive care is covered in full per person per year. As you receive other non-preventive medical care, you must meet the Plan's deductible before we pay benefits according to the benefits described on page 100. 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: preventive care; traditional medical coverage health care that is subject to the deductible; savings; catastrophic protection for out-of-pocket expenses; and health education resources and account management tools.

- **In-network Preventive care** The Plan covers preventive care services, such as periodic health evaluations (e.g., annual physicals), screening services (e.g., mammograms), routine prenatal and well-child care, child and adult immunizations, tobacco cessation programs, obesity weight loss programs, disease management and wellness programs. These services are covered at 80% if you use a network provider and the services are described in Section 6 *Preventive care*. *You do not have to meet the deductible before using these services.*

- **Traditional in-network medical coverage** After you have paid the Plan's deductible, we pay benefits under traditional medical coverage described in Section 5. The Plan typically pays 80% for in-network.

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

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

• **Health Savings Accounts (HSA)**

By law, HSAs are available to members who are not enrolled in Medicare, cannot be claimed as a dependent on someone else’s tax return, have not received VA benefits within the last three months or do not have other health insurance coverage other than another high deductible health plan. In 2008, for each month you are eligible for an HSA premium pass through, we will contribute to your HSA \$41.67 per month for a Self Only enrollment or \$83.33 per month for a Self and Family enrollment. In addition to our monthly contribution, you have the option to make additional tax-free contributions to your HSA, so long as total contributions do not exceed the limit established by law, which is \$2,900. You can use funds in your HSA to help pay your health plan deductible. You own your HSA, so the funds can go with you if you change plans or employment.

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

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

• **Health Reimbursement Arrangements (HRA)**

If you aren’t eligible for an HSA, for example you are enrolled in Medicare or have another health plan, we will administer and provide an HRA instead. You must notify us that you are ineligible for an HSA.

In 2008, we will give you an HRA credit of \$500 per year for a Self Only enrollment and \$1,000 per year for a Self and Family enrollment. You can use funds in your HRA to help pay your health plan deductible and/or for certain expenses that don’t count toward the deductible.

HRA features include:

- For our HDHP option, the HRA is administered by Coventry Consumer Advantage
- Entire HRA credit (prorated from your effective date to the end of the plan year) is available from your effective date of enrollment
- 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.

An HRA does not affect your ability to participate in an FSAFEDS Health Care Flexible Spending Account (HCFSA). However, you must meet FSAFEDS eligibility requirements. See *Who is eligible to enroll?* in Section 12 under The Federal Flexible Spending Account Program – *FSAFEDS*.

• Catastrophic protection for out-of-pocket expenses

When you use network providers, your annual maximum for out-of-pocket expenses (deductibles, coinsurance and copayments) for covered services is limited to \$ 4,000 per person or \$ 8,000 per family enrollment. However, certain expenses do not count toward your out-of-pocket maximum and you must continue to pay these expenses once you reach your out-of-pocket maximum (such as expenses in excess of the Plan’s allowable amount or benefit maximum). Refer to Section 4 Your catastrophic protection out-of-pocket maximum and HDHP Section 5 *Traditional medical coverage subject to the deductible* for more details.

Health education resources and account management tools

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

Section 6(a). Preventive care

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

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

Benefit Description	You pay HDHP
Preventive care,adult	HDHP
Routine screenings, such as: <ul style="list-style-type: none"> • Blood tests • Urinalysis • Total Blood Cholesterol • Routine Prostate Specific Antigen (PSA) test — one annually for men age 50 and older • Colorectal Cancer Screening, including • Fecal occult blood test yearly starting at age 50, • Sigmoidoscopy screening — every five years starting at age 50, • Double contrast barium enema — every five years starting at age 50; • Colonoscopy screening — every 10 years starting at age 50 • Routine annual digital rectal exam (DRE) for men age 40 and older • Routine well-woman exam including Pap test, one visit every 12 months from last date of service • Routine mammogram — covered for women age 35 and older, as follows: <ul style="list-style-type: none"> • From age 35 through 39, one during this five year period • From age 40 through 64, one every calendar year At age 65 and older, one every two consecutive calendar years	In-network – 20% of the plan allowance Out-of-Network – 30% of the plan allowance
Adult routine immunizations endorsed by the Centers for Disease Control and Prevention (CDC):	In-network – 20% of the plan allowance Out-of-Network – 30% of the plan allowance
<ul style="list-style-type: none"> • Routine physicals which include: <ul style="list-style-type: none"> • One exam every 24 months up to age 65 • One exam every 12 months age 65 and older • Routine exams limited to: 	In-network – 20% of the plan allowance Out-of-Network – 30% of the plan allowance

Preventive care,adult - continued on next page

Benefit Description	You pay
Preventive care, adult (cont.)	HDHP
<ul style="list-style-type: none"> • 1 routine OB/GYN exam every 12 months including 1 Pap smear and related services 1 routine hearing exam every 24 months 	<p>In-network – 20% of the plan allowance</p> <p>Out-of-Network – 30% of the plan allowance</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Physical exams and immunizations required for obtaining or continuing employment or insurance, attending schools or camp, athletic exams or travel.</i> • <i>Immunizations, boosters, and medications for travel or work-related exposure.</i> 	<p><i>All charges</i></p>
Preventive care, children	HDHP
<ul style="list-style-type: none"> • Professional services, such as: • Well-child visits for routine examinations, immunizations and care (up to age 22) • Childhood immunizations recommended by the American Academy of Pediatrics • Examinations, such as: • Eye exam through age 17 to determine the need for vision correction • Hearing exams through age 17 to determine the need for hearing correction 	<p>In-network – 20% of the plan allowance</p> <p>Out-of-Network – 30% of the plan allowance</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Physical exams and immunizations required for obtaining or continuing employment or insurance, attending schools or camp, or travel.</i> • <i>Immunizations, boosters, and medications for travel.</i> 	<p><i>All charges</i></p>

Section 6(b). Traditional medical coverage subject to the deductible

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

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- **In Network** - The calendar year deductible is \$1,100 per person or \$2,200 per family enrollment. The family deductible can be satisfied by one or more family members. The deductible applies to almost all benefits in Section 6.2. You must pay your deductible before your Traditional Medical Coverage may begin. Most benefits after the deductible is met are covered at 80%; you are responsible for 20% of allowed charges up to the Out-of-Pocket maximum.
- **Out of Network** - The calendar year deductible is \$2,000 per person or \$4,000 per family enrollment. The family deductible can be satisfied by one or more family members. The deductible applies to almost all benefits in Section 6.2. You must pay your deductible before your Traditional Medical Coverage may begin. Most benefits after the deductible is met are covered at 70%; you are responsible for 30% of allowed charges up to the Out-of-Pocket maximum.
- Under Traditional Medical Coverage, you are responsible for your coinsurance for covered expenses.
- When you use network providers, you are protected by an annual catastrophic maximum on out-of-pocket expenses for covered services. After your coinsurance, deductibles total \$4,000 per person or \$8,000 per family enrollment in any calendar year, you do not have to pay any more for covered services from network providers. However, certain expenses do not count toward your out-of-pocket maximum and you must continue to pay these expenses once you reach your out-of-pocket maximum (such as expenses in excess of the Plan’s benefit maximum, or if you use out-of-network providers, amounts in excess of the Plan allowance).
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage.

Benefit Description	After the calendar year deductible You pay
Deductible before traditional medical coverage begins	HDHP
The deductible applies to almost all benefits in this Section. In the <i>You pay</i> column, we say “No deductible” when it does not apply. When you receive covered services from network providers, you are responsible for paying the allowable charges until you meet the deductible.	In network - 100% of allowable charges until you meet the deductible of \$1,100 per person or \$2,200 per family enrollment. Out of network - 100% of allowable charges until you meet the deductible of \$2,000 per person or \$4,000 per family enrollment. You may choose to pay deductible expenses from your HSA or HRA, or you can pay for them out-of-pocket.
After you meet the deductible, we pay the allowable charge (less your coinsurance or copayment) until you meet the annual catastrophic out-of-pocket maximum.	In-network: After you meet the deductible, you pay the 20% coinsurance or listed copayments for covered services. You may choose to pay the coinsurance and copayments from your HSA or HRA, or you can pay for them out-of-pocket. Out-of-network: After you meet the deductible, you pay the 30% coinsurance based on our Plan allowance and any difference between our allowance and the billed amount.

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

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan physicians must provide or arrange your care.
- The deductible is \$1,100 for Self Only enrollment and \$2,200 for Self and Family enrollment each calendar year. The Self and Family deductible can be satisfied by one or more family members. The deductible applies to all benefits in this Section unless we indicate differently.
- After you have satisfied your deductible, coverage begins for traditional medical services.
- Under your Traditional medical coverage, you will be responsible for your coinsurance amounts or copayments for eligible medical expenses and prescriptions.

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

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

Benefit Description	After the calendar year deductible You pay
Maternity care	
<p>Complete maternity (obstetrical) care, such as:</p> <ul style="list-style-type: none"> • Prenatal care • Delivery • Postnatal care <p>Note: Here are some things to keep in mind:</p> <ul style="list-style-type: none"> • You do not need to precertify your normal delivery; see below for other circumstances, such as extended stays for you or your baby. • You may remain in the hospital up to 48 hours after a regular delivery and 96 hours after a cesarean delivery. We will extend your inpatient stay if medically necessary. • We cover routine nursery care of the newborn child during the covered portion of the mother’s maternity stay. We will cover other care of an infant who requires non-routine treatment only if we cover the infant under a Self and Family enrollment. Surgical benefits, not maternity benefits, apply to circumcision. • We pay hospitalization and surgeon services (delivery) the same as for illness and injury. See Hospital benefits and Surgery benefits. 	<p>HDHP</p> <p>In-network: 20% of the Plan allowance</p> <p>Out-of-network: 30% of the Plan allowance and any difference between our allowance and the billed amount.</p>
<i>Not covered: Routine sonograms to determine fetal age, size or sex.</i>	<i>All charges</i>
Family planning	
<p>A range of voluntary family planning services, limited to:</p> <ul style="list-style-type: none"> • Surgically implanted contraceptives (such as Norplant) • Injectable contraceptive drugs (such as Depo provera) • Diaphragm (fitting only) • Voluntary sterilization (vasectomy or tubal ligation) <p>Note: We cover oral contraceptives under the prescription drug benefit.</p>	<p>HDHP</p> <p>In-network: 20% of the Plan allowance</p> <p>Out-of-network: 30% of the Plan allowance and any difference between our allowance and the billed amount.</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Reversal of voluntary surgical sterilization</i> • <i>Genetic counseling.</i> • <i>Intrauterine Devices (IUDs).</i> 	<i>All charges</i>
Infertility services	
<p>In-network – We limit coverage to a maximum plan benefit of \$1,500.</p> <p>Out of network – Not covered.</p> <p>Diagnosis and treatment of infertility such as:</p> <ul style="list-style-type: none"> • Artificial insemination: <ul style="list-style-type: none"> - intravaginal insemination (IVI) - intracervical insemination (ICI) - intrauterine insemination (IUI) 	<p>HDHP</p> <p>In-network: 20% of the Plan allowance</p> <p>Out-of-network: 30% of the Plan allowance and any difference between our allowance and the billed amount.</p>
<i>Not covered:</i>	<i>All charges</i>

Infertility services - continued on next page

Benefit Description	After the calendar year deductible You pay
Infertility services (cont.)	
<ul style="list-style-type: none"> • Assisted reproductive technology (ART) procedures, such as: <ul style="list-style-type: none"> - in vitro fertilization - embryo transfer, gamete intra-fallopian transfer (GIFT) and zygote intra-fallopian transfer (ZIFT) • Services and supplies related to ART procedures • Cost of donor sperm • Cost of donor egg • Fertility drugs 	<p><i>All charges</i></p>
Allergy care	
<ul style="list-style-type: none"> • Testing and treatment • Allergy injections • Allergy serum 	<p>In-network: 20% of the Plan allowance</p> <p>Out-of-network: 30% of the Plan allowance and any difference between our allowance and the billed amount.</p>
<p><i>Not covered: Provocative food testing and sublingual allergy desensitization</i></p>	<p><i>All charges</i></p>
Treatment therapies	
<ul style="list-style-type: none"> • Chemotherapy and radiation therapy <p>Note: High dose chemotherapy in association with autologous bone marrow transplants is limited to those transplants listed under Organ/Tissue Transplants on page 66.</p> <ul style="list-style-type: none"> • Respiratory and inhalation therapy • Dialysis – hemodialysis and peritoneal dialysis • Intravenous (IV)/Infusion Therapy – Home IV and antibiotic therapy • Oxygen for home use and equipment • Growth hormone therapy (GHT) <p>Note: Growth hormone is covered under the prescription drug benefit.</p>	<p>In-network: 20% of the Plan allowance</p> <p>Out-of-network: 30% of the Plan allowance and any difference between our allowance and the billed amount.</p>
Physical and occupational therapies	
<p>60 consecutive days per condition for the services of each of the following:</p> <ul style="list-style-type: none"> • qualified physical therapists and • occupational therapists <p>Note: We only cover therapy to restore bodily function when there has been a total or partial loss of bodily function due to illness or injury.</p> <ul style="list-style-type: none"> • Cardiac rehabilitation following a heart transplant, bypass surgery or a myocardial infarction is provided for up to 60 days for physical therapy. 	<p>In-network: 20% of the Plan allowance</p> <p>Out-of-network: 30% of the Plan allowance and any difference between our allowance and the billed amount.</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • Long-term rehabilitative therapy • Exercise programs 	<p><i>All Charges</i></p>

Benefit Description	After the calendar year deductible You pay
Speech therapy	HDHP
60 consecutive days per condition	In-network: 20% of the Plan allowance Out-of-network: 30% of the Plan allowance and any difference between our allowance and the billed amount.
Hearing services (testing, treatment, and supplies)	HDHP
<ul style="list-style-type: none"> Hearing testing for children through age 17 (see <i>Preventive care, children</i>) 	In-network: 20% of the Plan allowance Out-of-network: 30% of the Plan allowance and any difference between our allowance and the billed amount.
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> All other hearing testing Hearing aids, testing and examinations for them 	<i>All Charges</i>
Vision services (testing, treatment, and supplies)	HDHP
<ul style="list-style-type: none"> Diagnosis and treatment of diseases of the eye Prosthetic devices, such as lenses following cataract removal 	In-network: 20% of the Plan allowance Out-of-network: 30% of the Plan allowance and any difference between our allowance and the billed amount.
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> Eyeglasses or contact lenses and after age 17, examinations for them Eye exercises and orthoptics Radial keratotomy and other refractive surgery Annual eye refractions 	<i>All charges</i>
Foot care	HDHP
Routine foot care when you are under active treatment for a metabolic or peripheral vascular disease, such as diabetes.	In-network: 20% of the Plan allowance Out-of-network: 30% of the Plan allowance and any difference between our allowance and the billed amount.
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> Cutting, trimming or removal of corns, calluses, or the free edge of toenails, and similar routine treatment of conditions of the foot, except as stated above Treatment of weak, strained or flat feet or bunions or spurs; and of any instability, imbalance or subluxation of the foot (unless the treatment is by open cutting surgery) 	<i>All Charges</i>

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

Benefit Description	After the calendar year deductible You pay
Home health services	HDHP
<ul style="list-style-type: none"> • Home health care ordered by a Plan physician and provided by a registered nurse (R.N.), licensed practical nurse (L.P.N.), licensed vocational nurse (L.V.N.), or home health aide. • Services include oxygen therapy, intravenous therapy and medications. 	<p>In-network: 20% of the Plan allowance</p> <p>Out-of-network: 30% of the Plan allowance and any difference between our allowance and the billed amount.</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Nursing care requested by, or for the convenience of, the patient or the patient's family;</i> • <i>Home care primarily for personal assistance that does not include a medical component and is not diagnostic, therapeutic, or rehabilitative.</i> • <i>Nursing aides</i> 	<i>All charges</i>
Chiropractic	HDHP
<ul style="list-style-type: none"> • Manipulation of the spine and extremities <p>After initial evaluation, treatment plan must be submitted to Coventry Health Care to authorize additional visits.</p>	<p>In-network: 20% of the Plan allowance</p> <p>Out-of-network: 30% of the Plan allowance and any difference between our allowance and the billed amount.</p>
Alternative treatments	HDHP
<i>No benefits</i>	<i>All charges</i>

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

Benefit Description	After the calendar year deductible You pay
<p>Surgical procedures</p> <p>YOUR PHYSICIAN MUST GET PRECERTIFICATION OF SOME SURGICAL PROCEDURES. Please refer to the precertification information shown in Section 3 to be sure which services require precertification and identify which surgeries require precertification.</p> <p>A comprehensive range of services, such as:</p> <ul style="list-style-type: none"> • Operative procedures • Treatment of fractures, including casting • Normal pre- and post-operative care by the surgeon • Endoscopy procedures • Biopsy procedures • Removal of tumors and cysts • Correction of congenital anomalies (see Reconstructive surgery) 	<p align="center">HDHP</p> <p>In-network: 20% of the Plan allowance</p> <p>Out-of-network: 30% of the Plan allowance and any difference between our allowance and the billed amount.</p>
<ul style="list-style-type: none"> • Surgical treatment, vertical-banded gastroplasty (gastric stapling) and roux-en-y gastric bypass (Roux-en-Y), of morbid obesity will be covered by the health plans of Coventry Health Care, Inc. (Coventry) when <u>all</u> of the following criteria are met: <ul style="list-style-type: none"> - The patient is an adult (≥ 18 years of age) with morbid obesity that has persisted for at least 3 years, and for which there is no treatable metabolic cause for the obesity; - There is presence of morbid obesity, defined as a body mass index (BMI) exceeding 40, or greater than 35 with documented co-morbid conditions (cardiopulmonary problems e.g., severe apnea, Pickwickian Syndrome, and obesity-related cardiomyopathy, severe diabetes mellitus, hypertension, or arthritis). (BMI is calculated by dividing a patient’s weight (in kilograms) by height (in meters) squared. To convert pounds to kilograms, multiply pounds by 0.45. To convert inches to meters, multiply inches by .0254); - The patient has failed to lose weight (approximately 10% from baseline) or has regained weight despite participation in a three month physician-supervised multidisciplinary program within the past six months that included dietary therapy, physical activity and behavior therapy and support; - The patient has been evaluated for restrictive lung disease and received surgical clearance by a pulmonologist, if clinically indicated; has received cardiac clearance by a cardiologist if there is a history of prior phen-fen or redux use, and the patient has agreed, following surgery, to participate in a multidisciplinary program that will provide guidance on diet, physical activity and social support; and, 	<p>In-network: 20% of the Plan allowance</p> <p>Out-of-network: 30% of the Plan allowance and any difference between our allowance and the billed amount.</p>

Surgical procedures - continued on next page

Benefit Description	After the calendar year deductible You pay
Surgical procedures (cont.)	HDHP
<ul style="list-style-type: none"> - The patient has completed a psychological evaluation and has been recommended for bariatric surgery by a licensed mental health professional (this must be documented in the patient’s medical record) and the patient’s medical record reflects documentation by the treating psychotherapist that all psychosocial issues have been identified and addressed; and the psychotherapist indicates that the patient is likely to be compliant with the post-operative diet restrictions; • Insertion of internal prosthetic devices. See 6(c) – Orthopedic and prosthetic devices for device coverage information • Treatment of burns • Voluntary sterilization (e.g., Tubal ligation, Vasectomy) 	<p>In-network: 20% of the Plan allowance</p> <p>Out-of-network: 30% of the Plan allowance and any difference between our allowance and the billed amount.</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Reversal of voluntary sterilization</i> • <i>Routine treatment of conditions of the foot; see Foot care</i> 	<p><i>All charges</i></p>
Reconstructive surgery	HDHP
<ul style="list-style-type: none"> • Surgery to correct a functional defect • Surgery to correct a condition caused by injury or illness if: <ul style="list-style-type: none"> - the condition produced a major effect on the member’s appearance and - the condition can reasonably be expected to be corrected by such surgery • Surgery to correct a condition that existed at or from birth and is a significant deviation from the common form or norm. Examples of congenital anomalies are: protruding ear deformities; cleft lip; cleft palate; birth marks; and webbed fingers and toes. • All stages of breast reconstruction surgery following a mastectomy, such as: <ul style="list-style-type: none"> - surgery to produce a symmetrical appearance of breasts; - treatment of any physical complications, such as lymphedemas; - breast prostheses and surgical bras and replacements (see Prosthetic devices) <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% of the Plan allowance</p> <p>Out-of-network: 30% of the Plan allowance and any difference between our allowance and the billed amount.</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Cosmetic surgery – any surgical procedure (or any portion of a procedure) performed primarily to improve physical appearance through change in bodily form, except repair of accidental injury</i> • <i>Surgeries related to sex transformation</i> 	<p><i>All charges</i></p>

Benefit Description	After the calendar year deductible You pay
Oral and maxillofacial surgery	HDHP
<p>Oral surgical procedures, limited to:</p> <ul style="list-style-type: none"> • Reduction of fractures of the jaws or facial bones; • Surgical correction of cleft lip, cleft palate or severe functional malocclusion; • Removal of stones from salivary ducts; • Excision of leukoplakia or malignancies; • Excision of cysts and incision of abscesses when done as independent procedures; and • Other surgical procedures that do not involve the teeth or their supporting structures. • TMJ treatment and services (non-dental) 	<p>In-network: 20% of the Plan allowance</p> <p>Out-of-network: 30% of the Plan allowance and any difference between our allowance and the billed amount.</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Oral implants and transplants</i> • <i>Procedures that involve the teeth or their supporting structures (such as the periodontal membrane, gingiva, and alveolar bone)</i> • <i>Dental care involved in treatment of temporomandibular joint (TMJ) pain dysfunction syndrome.</i> 	<i>All charges</i>
Organ/tissue transplants	HDHP
<p>Solid organ transplants are subject to medical necessity and experimental/investigational review. Refer to other services in Section 3 for prior authorization procedures. The medical necessity limitation is considered satisfied for other tissue transplants if the patient meets the staging description and can safely tolerate the procedure.</p> <ul style="list-style-type: none"> • Cornea • Heart • Heart/lung • Kidney • Liver • Lung: single, double, or lobar lung • Pancreas • Autologous pancreas islet cell transplant (as an adjunct to total or near total pancreatectomy) only for patients with chronic pancreatitis • Intestinal transplants <ul style="list-style-type: none"> - Small intestine - Small intestine with the liver - Small intestine with multiple organs, such as the liver, stomach, and pancreas 	<p>In-network: 20% of the Plan allowance</p> <p>Out-of-network: 30% of the Plan allowance and any difference between our allowance and the billed amount.</p>
<p>Blood or marrow stem cell transplants limited to the stages of the following diagnoses: (The medical necessity limitation is considered satisfied if the patient meets the staging description):</p> <ul style="list-style-type: none"> • Allogeneic transplants for <ul style="list-style-type: none"> - Acute lymphocytic or non-lymphocytic (i.e., myelogeneous) leukemia 	<p>In-network: 20% of the Plan allowance</p> <p>Out-of-network: 30% of the Plan allowance and any difference between our allowance and the billed amount.</p>

Organ/tissue transplants - continued on next page

Benefit Description	After the calendar year deductible You pay
Organ/tissue transplants (cont.)	HDHP
<ul style="list-style-type: none"> - Advanced Hodgkin’s lymphoma - Advanced non-Hodgkin’s lymphoma - Chronic myelogenous leukemia - Severe combined immunodeficiency - Severe or very severe aplastic anemia • Autologous transplant for <ul style="list-style-type: none"> - Acute lymphocytic or nonlymphocytic (i.e., myelogenous) leukemia - Advanced Hodgkin’s lymphoma - Advanced non-Hodgkin’s lymphoma - Advanced neuroblastoma • Autologous tandem transplants for recurrent germ cell tumors (including testicular cancer) 	<p>In-network: 20% of the Plan allowance</p> <p>Out-of-network: 30% of the Plan allowance and any difference between our allowance and the billed amount.</p>
<p>Blood or marrow stem cell transplants limited to the stages of the following diagnoses: (The medical necessity limitation is considered satisfied if the patient meets the staging description):</p> <ul style="list-style-type: none"> • Allogeneic transplants for <ul style="list-style-type: none"> - Phagocytic deficiency diseases (e.g., Wiskott-Aldrich syndrome) - Advanced forms of myelodysplastic syndromes - Advanced neuroblastoma - Infantile malignant osteoporosis - Kostmann’s syndrome - Leukocyte adhesion deficiencies - Mucopolysaccharidosis (e.g., Gaucher’s disease, metachromatic leukodystrophy, adrenoleukodystrophy) - Mucopolysaccharidosis (e.g., Hunter’s syndrome, Hurler’s syndrome, Sanfilippo’s syndrome, Maroteaux-Lamy syndrome variants) - Myeloproliferative disorders - Sickle cell anemia - Thalassemia major (homozygous beta-thalassemia) - X-linked lymphoproliferative syndrome • Autologous transplants for <ul style="list-style-type: none"> - Multiple myeloma - Testicular, mediastinal, retroperitoneal, and ovarian germ cell tumors - Breast cancer - Epithelial ovarian cancer - Amyloidosis - Ependymoblastoma - Ewing’s sarcoma - Medulloblastoma - Pineoblastoma 	<p>In-network: 20% of the Plan allowance</p> <p>Out-of-network: 30% of the Plan allowance and any difference between our allowance and the billed amount.</p>

Organ/tissue transplants - continued on next page

Benefit Description	After the calendar year deductible You pay
Organ/tissue transplants (cont.)	HDHP
<p>Blood or marrow stem cell transplants covered only 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 for:</p> <ul style="list-style-type: none"> • Allogeneic transplants for <ul style="list-style-type: none"> - Chronic lymphocytic leukemia - Early stage (indolent or non-advanced) small cell lymphocytic lymphoma - Multiple myeloma • Nonmyeloablative allogeneic transplants for <ul style="list-style-type: none"> - Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia - Advanced forms of myelodysplastic syndromes - Advanced Hodgkin’s lymphoma - Advanced non-Hodgkin’s lymphoma - Breast cancer - Chronic lymphocytic leukemia - Chronic myelogenous leukemia - Colon cancer - Early stage (indolent or non-advanced) small cell lymphocytic lymphoma - Multiple myeloma - Myeloproliferative disorders - Non-small cell lung cancer - Ovarian cancer - Prostate cancer - Renal cell carcinoma - Sarcomas • Autologous transplants for <ul style="list-style-type: none"> - Chronic lymphocytic leukemia - Chronic myelogenous leukemia - Early stage (indolent or non-advanced) small cell lymphocytic lymphoma - Multiple sclerosis - Systemic lupus erythematosus - Systemic sclerosis • National Transplant Program (NTP) - <p>Note: We cover related medical and hospital expenses of the donor when we cover the recipient.</p>	<p>In-network: 20% of the Plan allowance</p> <p>Out-of-network: 30% of the Plan allowance and any difference between our allowance and the billed amount.</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Donor screening tests and donor search expenses, except those performed for the actual donor</i> • <i>Implants of artificial organs</i> • <i>Transplants not listed as covered</i> 	<i>All charges</i>

Benefit Description	After the calendar year deductible You pay
Anesthesia	HDHP
Professional services provided in – <ul style="list-style-type: none"> • Hospital (inpatient) 	In-network: 20% of the Plan allowance Out-of-network: 30% of the Plan allowance and any difference between our allowance and the billed amount.
Professional services provided in – <ul style="list-style-type: none"> • Hospital outpatient department • Skilled nursing facility • Ambulatory surgical center • Office 	In-network: 20% of the Plan allowance Out-of-network: 30% of the Plan allowance and any difference between our allowance and the billed amount.

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

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan physicians must provide or arrange your care and you must be hospitalized in a Plan facility.
- The deductible is \$1,100 for Self Only enrollment and \$2,200 for Self and Family enrollment each calendar year. The Self and Family deductible can be satisfied by one or more family members. The deductible applies to all benefits in this Section.
- Be sure to read Section 4, *Your costs for covered services* for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- The amounts listed below are for the charges billed by the facility (i.e., hospital or surgical center) or ambulance service for your surgery or care. Any costs associated with the professional charge (i.e., physicians, etc.) are in Sections 6(c) or (d).
- **YOUR PHYSICIAN MUST GET PRECERTIFICATION FOR HOSPITAL STAYS.** Please refer to Section 3 to be sure which services require precertification.

Benefit Description	After the calendar year deductible You Pay
Inpatient hospital	
<p>Room and board, such as</p> <ul style="list-style-type: none"> • Ward, semiprivate, or intensive care accommodations; • General nursing care; and • Meals and special diets. <p>Note: If you want a private room when it is not medically necessary, you pay the additional charge above the semiprivate room rate.</p>	<p>In-network: 20% of the Plan allowance</p> <p>Out-of-network: 30% of the Plan allowance and any difference between our allowance and the billed amount.</p>
<p>Other hospital services and supplies, such as:</p> <ul style="list-style-type: none"> • Operating, recovery, maternity, and other treatment rooms • Prescribed drugs and medicines • Diagnostic laboratory tests and X-rays • Blood or blood plasma, if not donated or replaced • Dressings , splints , casts , and sterile tray services • Medical supplies and equipment, including oxygen • Anesthetics, including nurse anesthetist services • Take-home items • Medical supplies, appliances, medical equipment, and any covered items billed by a hospital for use at home (Note: calendar year deductible applies.) 	<p>In-network: 20% of the Plan allowance</p> <p>Out-of-network: 30% of the Plan allowance and any difference between our allowance and the billed amount.</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Custodial care</i> • <i>Non-covered facilities, such as nursing homes, schools</i> • <i>Personal comfort items, such as telephone, television, barber services, guest meals and beds</i> 	<i>All charges</i>

Inpatient hospital - continued on next page

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

Section 6(f). Emergency services/accidents

What is a medical emergency?

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

What to do in case of emergency:

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

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

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

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

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

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

Benefit Description	After the calendar year deductible You pay
Emergencies within our service area	HDHP
<ul style="list-style-type: none"> • Emergency care at a doctor’s office • Emergency care at an urgent care center • Emergency care as an outpatient in a hospital, including doctors’ services 	<p>In-network: 20% of the Plan allowance</p> <p>Out-of-network: 30% of the Plan allowance and any difference between our allowance and the billed amount.</p>
<i>Not covered: Elective care or non-emergency care</i>	<i>All charges</i>
Emergencies outside our service area	HDHP
<ul style="list-style-type: none"> • Emergency care at a doctor’s office • Emergency care at an urgent care center • Emergency care as an outpatient in a hospital, including doctors’ services 	<p>In-network: 20% of the Plan allowance</p> <p>Out-of-network: 30% of the Plan allowance and any difference between our allowance and the billed amount.</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Elective care or non-emergency care</i> • <i>Emergency care provided outside the service area if the need for care could have been foreseen before leaving the service area</i> 	<i>All charges</i>

Emergency outside our service area - continued on next page

Benefit Description	After the calendar year deductible You pay
Emergency outside our service area (cont.)	HDHP
<ul style="list-style-type: none"> • <i>Medical and hospital costs resulting from a normal full-term delivery of a baby outside the service area</i> 	<i>All charges</i>
Ambulance	HDHP
Professional ambulance service when medically appropriate. Note: See 5(c) for non-emergency service.	In-network: 20% of the Plan allowance Out-of-network: 30% of the Plan allowance and any difference between our allowance and the billed amount.
<i>Not covered: Air ambulance</i>	<i>All charges</i>

Section 6(g). Mental health and substance abuse benefits

Benefit Description	After the calendar year deductible You pay
Mental health and substance abuse benefits	HDHP
<p>All diagnostic and treatment services recommended by a Plan provider and contained in a treatment plan that we approve. The treatment plan may include services, drugs, and supplies described elsewhere in this brochure.</p> <p>Note: Plan benefits are payable only when we determine the care is clinically appropriate to treat your condition and only when you receive the care as part of a treatment plan that we approve.</p>	<p>In Network - Your cost sharing responsibilities are no greater than for other illnesses or conditions...</p> <p>Out of Network – No benefit</p>
<ul style="list-style-type: none"> • Professional services, including individual or group therapy by providers such as psychiatrists, psychologists, or clinical social workers • Medication management 	<p>In-network: 20% of the Plan allowance</p> <p>Out of Network – No benefit</p>
<ul style="list-style-type: none"> • Diagnostic tests 	<p>In-network: 20% of the Plan allowance</p> <p>Out of Network – No benefit</p>
<ul style="list-style-type: none"> • Services provided by a hospital or other facility • Services in approved alternative care settings such as partial hospitalization, half-way house, residential treatment, full-day hospitalization, facility based intensive outpatient treatment <p>We may allow Members to exchange one inpatient day of treatment for four (4) outpatient visits or exchange four (4) outpatient visits for one inpatient day of treatment. We may also allow a Member to exchange two (2) days of Transitional Partial Hospitalization or two (2) days of residential treatment center hospitalization for each inpatient day of treatment.</p>	<p>In-network: 20% of the Plan allowance</p> <p>Out of Network – No benefit</p>
<p><i>Not covered: Services we have not approved.</i></p> <p><i>Note: OPM will base its review of disputes about treatment plans on the treatment plan's clinical appropriateness. OPM will generally not order us to pay or provide one clinically appropriate treatment plan in favor of another.</i></p>	<p><i>All charges</i></p>
<p>Preauthorization</p>	<p>To be eligible to receive these benefits you must obtain a treatment plan and follow all of the following network authorization processes: please call 800-245-8327 for authorization.</p>
<p>Limitation</p>	<p>We may limit your benefits if you do not obtain a treatment plan.</p>

Preauthorization

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

Limitation

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

Section 6(h). Prescription drug benefits

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

- **Who can write your prescription.** A licensed physician must write the prescription
- **Where you can obtain them.** You may fill the prescription at a contracted Plan pharmacy or by mail.
- **We use a formulary.** We use a committee of doctors, pharmacists and other health care professionals to develop a formulary that gives you access to quality medications. FDA-approved brand-name and generic medications are reviewed for safety, side effects, effectiveness and overall value. We continually update the formulary based on the latest research. If your doctor prescribes a medication that is not on the list, you can get that medication, but you will share in a greater portion of the cost.
- **These are the dispensing limitations.** The quantity of each prescription is limited to that sufficient to treat the acute phase of illness or a 30-day supply maximum, whichever is less, per copayment. **Members called to active duty in a time of national or other emergency who need to obtain a greater than normal supply of prescribed medications should call 1-866-320-0697.**
- **A generic equivalent will be dispensed if it is available,** unless your physician specifically requires a name brand. If you receive a name brand drug when a Federally-approved generic drug is available, and your physician has not specified Dispense as Written for the name brand drug, you have to pay the difference in cost between the name brand drug and the generic.
- **Mail Order.** You can obtain through Mail Order covered "maintenance" prescription drugs use to treat chronic or long-term health conditions such as high blood pressure or diabetes) for a 90-day supply. You pay \$20 copay per prescription unit or refill for formulary generic drugs, \$40 copay for formulary name brand drugs and \$90 for non formulary.

Benefit Description	After the calendar year deductible You pay
Covered medications and supplies	HDHP
<p>We cover the following medications and supplies prescribed by a Plan physician and obtained from a Plan pharmacy or through our mail order program:</p> <ul style="list-style-type: none"> • Drugs and medicines that by Federal law of the United States require a physician’s prescription for their purchase, except as excluded below. • Insulin • Insulin syringes and medication • Disposable needles and syringes for the administration of covered medications • Drugs for sexual dysfunction (see Notebelow) • Contraceptive drugs and devices • Growth hormones <p>Note: Contact the Plan for drug dose limits for sexual dysfunction.</p>	<p>In - Network</p> <p>Retail Pharmacy</p> <p>\$10 per generic</p> <p>\$35 per formulary name brand</p> <p>\$60 per non-formulary</p> <p>Mail Order (Maintenance medications only)</p> <p>\$20 per generic</p> <p>\$70 per formulary name brand</p> <p>\$120 per non-formulary</p> <p>Note: If there is no generic equivalent available, you will still have to pay the brand name copay.</p> <p>Out of Network: No benefit</p>
<p>Here are some things to keep in mind about our prescription drug program:</p> <p>A generic equivalent will be dispensed if it is available, unless your physician specifically requires a name brand. If you receive a name brand drug when a Federally-approved generic drug is available, you have to pay the difference in cost between the name brand drug and the generic.</p>	

Covered medications and supplies - continued on next page

Benefit Description	After the calendar year deductible You pay
Covered medications and supplies (cont.)	HDHP
<p>We administer a formulary. If your physician believes a name brand product is necessary or there is no generic available, your physician may prescribe a name brand drug from a formulary list. This list of name brand drugs is a preferred list of drugs that we selected to meet patient needs at a lower cost. You must pay a \$45 copay for a non-formulary drug. To order a prescription drug brochure, call 800/341-6613.</p>	
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Drugs and supplies for cosmetic purposes</i> • <i>Drugs to enhance athletic performance</i> • <i>Fertility drugs</i> • <i>Drugs obtained at a non-Plan pharmacy; except for out-of-area emergencies</i> • <i>Vitamins, nutrients and food supplements even if a physician prescribes or administers them</i> • <i>Nonprescription medicines</i> • <i>Smoking cessation drugs</i> 	<i>All charges</i>

Section 6(i). Dental benefits

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

Section 6(j). Special features

24 hour nurse line	For any of your health concerns, 24 hours a day, 7 days a week, you may call First Help at 1-800-622-9528 and talk with a registered nurse who will discuss treatment options and answer your health questions.
Flexible benefits option	Under the flexible benefits option, we determine the most effective way to provide services. <ul style="list-style-type: none">• We may identify medically appropriate alternatives to traditional care and coordinate other benefits as a less costly alternative benefit.• Alternative benefits are subject to our ongoing review• By approving an alternative benefit is solely ours, and we may withdraw it at any time and resume regular contract benefits.• Our decision to offer or withdraw alternative benefits is not subject to OPM review under the disputed claims process.

Section 6(k). Non- FEHB benefits available to Plan members

Vision Care

Routine eye exams are covered once every 12 months for \$15 copayment through the Avesis providers. Providers may be found at www.avesis.com or contact customer service at 800-341-6613.

Louisiana Discount Program

This program entitles you to receive dental, hearing, massage therapy and cosmetic procedures at a discounted rate using contracted providers. To obtain a listing of providers please contact 800-341-6613.

Section 6(l). Savings – HSAs and HRAs

Feature Comparison	Health Savings Account (HSA)	Health Reimbursement Arrangement (HRA) Provided when you are ineligible for an HSA
Administrator	<p>The Plan will establish an HSA for you with Corporate Benefit Services of America (CBSA), this HDHP’s fiduciary (an administrator, trustee or custodian as defined by Federal tax code and approved by IRS.)</p> <p>Name: Corporate Benefit Services of America (CBSA)</p> <p>Street Address: P.O. Box 270520</p> <p>City, State ZIP Code: Golden Valley, MN 55427</p> <p>Phone: 800-566-9311</p> <p>Or https://services.cbsainc.com/eehome.asp</p>	<p>The administrator for the HRA will be:</p> <p>Coventry Consumer Advantage</p> <p>P O Box 7758</p> <p>London, KY 40742</p>
Fees	None.	None.
Eligibility	<p>You must:</p> <ul style="list-style-type: none"> • Enroll in this HDHP • Have no other health insurance coverage (does not apply to specific injury, accident, disability, dental, vision or long-term care coverage) • Not be enrolled in Medicare • Not be claimed as a dependent on someone else’s tax return • Not have received VA benefits in the last three months • Complete and return all banking paperwork. 	<p>You must:</p> <ul style="list-style-type: none"> • Enroll in Coventry Health Care Flex choice High Deductible plan. • Eligibility is determined on the first day of the month following your effective day of enrollment and will be prorated for length of enrollment. • You must be eligible for Medicare Part A or Part B
Funding	<p>If you are eligible for HSA contributions, a portion of your monthly health plan premium is deposited to your HSA each month. Premium pass through contributions are based on the effective date of your enrollment in the HDHP.</p> <p>In addition, you may establish pre-tax HSA deductions from your paycheck to fund your HSA up to IRS limits using the same method that you use to establish other deductions (i.e., Employee Express, MyPay, etc.).</p>	<p>Eligibility for the annual credit will be determined on the first day of the month and will be prorated for length of enrollment. The entire amount of your HRA will be available to you upon your enrollment.</p>
<ul style="list-style-type: none"> • Self only coverage 	<p>For 2008, a monthly premium pass through of \$41.67 will be made by the HDHP directly into your HSA each month.</p>	<p>For 2008, your HRA annual credit is \$41.67 (prorated for mid-year).</p>

<p>• Self and Family coverage</p>	<p>The HDHP will make a premium pass through of \$83.33 per month.</p>	<p>The HDHP will make a premium pass through of \$83.33 per month.</p>
<p>Contributions/credits</p>	<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 maximum contribution amount set by the IRS.</p> <p>If you enroll during Open Season, you are eligible to fund your account up to the maximum contribution limit set by the IRS. To determine the amount you may contribute, subtract the amount the Plan will contribute to your account for the year from the maximum allowable contribution.</p> <p>You are eligible to contribute up to the IRS limit for partial year coverage as long as you maintain your HDHP enrollment for 12 months. If you do not remain enrolled in your HDHP for 12 months, a portion of your tax reduction is lost and a 10% penalty is imposed. There is an exception for death or disability.</p> <p>If you do not maintain your HDHP enrollment for 12 months, the maximum contribution amount is reduced by 1/12 for any month you were ineligible to contribute to an HSA.</p> <ul style="list-style-type: none"> • To determine the maximum allowable contribution, take the amount of your deductible divided by 12, times the number of full months enrolled in the HDHP. Subtract the amount the Plan will contribute to your account for the year from the maximum allowable contribution to determine the amount you may contribute. • 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). • HSAs earn tax-free interest (does not affect your annual maximum contribution). <p>Catch-up contribution discussed on page 76.</p>	<p>The full HRA credit will be available, subject to proration, on the effective date of enrollment. The HRA does not earn interest. You cannot contribute to the HRA.</p>
<p>Access funds</p>	<p>You can access your HSA by the following methods:</p> <ul style="list-style-type: none"> • Debit card • Withdrawal form 	<p>For qualified medical expenses under your HDHP, you will be automatically reimbursed when claims are submitted through your Coventry Health Care Flex Choice HDHP.</p>

		For expenses not covered by the HDHP, such as orthodontia, a reimbursement form will be sent to you.
Distributions/withdrawals Medical	You can pay the out-of-pocket expenses for yourself, your spouse or your dependents (even if they are not covered by the HDHP) from the funds available in your HSA. See IRS Publication 502 for a list of eligible medical expenses, including over-the-counter drugs.	You can pay the out-of-pocket expenses for yourself, your spouse or your dependents (even if they are not covered by the HDHP) from the funds available in your HSA. See IRS Publication 502 for a list of eligible medical expenses, including over-the-counter drugs.
Non-medical	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	Not applicable – distributions will not be made for anything other than non-reimbursed qualified medical expenses
Availability of funds	Funds are not available for withdrawal until all the following steps are completed: <ul style="list-style-type: none"> Your enrollment in this HDHP is effective (effective date is determined by your agency in accord with the event permitting the enrollment change). 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. <p>The fiduciary sends you HSA paperwork for you to complete and the fiduciary receives the completed paperwork back from you.</p>	The entire amount of your HRA will be available to you upon your enrollment in the HDHP.
Account owner	FEHB enrollee	HDHP
Portable	You can take this account with you when you change plans, separate or retire. If you do not enroll in another HDHP, you can no longer contribute to your HSA.	If you retire and remain in this HDHP, you may continue to use and accumulate credits in your HRA. If you terminate employment or change health plans, only eligible expenses incurred while covered under the HDHP will be eligible for reimbursement subject to timely filing requirements. Unused funds are forfeited.
Annual rollover	Yes, accumulates without a maximum cap.	Yes, accumulates without a maximum cap.

Section 6 (m). If you have an HSA

<p>Contributions</p>	<p>All contributions are aggregated and cannot exceed the maximum contribution amount set by the IRS . You may contribute your own money to your account through payroll deductions, or you may make lump sum contributions at any time, in any amount not to exceed an annual maximum limit. If you contribute, you can claim the total amount you contributed for the year as a tax deduction when you file your income taxes. Your own HAS contributions are either tax-deductible or pre-tax (if made by payroll deduction). You receive tax advantages in any case. To determine the amount you may contribute, subtract the amount the plan will contribute to your account for the year from the maximum contribution amount set by the IRS. You have until April 15 of the following year to make HSA contributions for the current year.</p> <p>If you newly enroll in an HDHP during Open Season and your effective date is after January 1st or you otherwise have partial year coverage, you are eligible to fund your account up to the maximum contribution limit set by the IRS as long as you maintain your HDHP enrollment for 12 months following the last month of the year of your first year of eligibility.</p> <p>To determine the amount you may contribute, subtract the amount the Plan will contribute to your account for the year from the maximum allowable contribution. If you do not meet this requirement, a portion of your tax reduction is lost a 10% penalty is imposed. There is an exception for death or disability.</p>
<p>Catch-up contributions</p>	<p>If you are age 55 or older, the IRS permits you to make additional “catch-up” contributions to your HSA. In 2008, you may contribute up to \$900 in catch-up contributions. The allowable catch-up contribution will be \$1,000 in 2009 and beyond. Contributions must stop once an individual is enrolled in Medicare. Additional details are available on the U.S. Department of Treasury Web site at www.ustreas.gov/offices/public-affairs/hsa/.</p>
<p>If you die</p>	<p>If you do not have a named beneficiary, if you are married, it becomes your spouse’s HSA; otherwise, it becomes part of your taxable estate.</p>
<p>Qualified expenses</p>	<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, health insurance premiums if you are receiving Federal unemployment compensation, over-the-counter drugs, LASIK surgery, and some nursing services.</p> <p>When you enroll in Medicare, you can use the account to pay Medicare premiums or to purchase health insurance other than a Medigap policy. You may not, however, continue to make contributions to your HSA once you are enrolled in Medicare.</p> <p>For a detailed list of IRS-allowable expenses, request a copy of IRS Publication 502 by calling 1-800-829-3676, or visit the IRS Web site at www.irs.gov and click on “Forms and Publications.” Note: Although over-the-counter drugs are not listed in the publication, they are reimbursable from your HSA. Also, insurance premiums are reimbursable under limited circumstances.</p>
<p>Non-qualified expenses</p>	<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>
<p>Tracking your HSA balance</p>	<p>You will receive a periodic statement that shows the “premium pass through”, withdrawals, and interest earned on your account. In addition, you will receive an Explanation of Payment statement when you withdraw money from your HSA.</p>

Minimum reimbursements from your HSA	You can request reimbursement in any amount. However, funds will not be disbursed until your reimbursement totals at least the amount needed to covered the requested amount.
If you have an HRA	
Why an HRA is established	If you don't qualify for an HSA when you enroll in this HDHP, or later become ineligible for an HSA, we will establish an HRA for you. If you are enrolled in Medicare, you are ineligible for an HSA and we will establish an HRA for you. You must tell us if you become ineligible to contribute to an HSA.
How an HRA differs	<p>Please review the chart on page 50 which details the differences between an HRA and an HSA. The major differences are:</p> <ul style="list-style-type: none"> • You cannot make contributions to an HRA • Funds are forfeited if you leave the HDHP • An HRA does not earn interest, and <p>HRAs can only pay for qualified medical expenses, such as deductibles, copayments, and coinsurance expenses, for individuals covered by the HDHP. FEHB law does not permit qualified to abortions, except whne the life of the mohter would be endangered if the fetus were carried to term, or when the pregnancy is the result of an act of rape or incest.</p>

Section 6(n). Health education resources and account management tools

Health education resources

Visit the Health Information section of our website at www.chclouisiana.com for information to help you take command of your health. This section is organized in simple, user-friendly, sections:

- **Assess Your Health** – where you will find a simple, free, online health risk assessment tool to benchmark your wellness, and better understand your overall health status and risks.
- **About Your Health** – for information about a specific condition or general preventive guidelines.
- **Patient Safety**
- **WebMD** – our link to this health site also provides wellness and disease information to help improve health.

Prescription Drug educational materials are also accessible through our website, through a link to our pharmacy benefit manager, Caremark. There, you will find:

- Detailed information about a wide range of prescription drugs;
- A drug interaction tool to help easily determine if a specific drug can have any adverse interactions with each other, with over-the-counter drugs, or with herbals and vitamins;
- Facts about why FDA-approved generic drugs should be a first choice for effective, economical treatment.

Another key health information tool that we make available to you is our online quality tools, powered by HealthShare[®]. You can review the frequency of procedures performed by a provider, knowing the correlation between frequency of service and quality of outcomes. We post additional quality outcome information, such as re-admission rates within 30 days, post operative complications, and even death rates.

We also publish an e-newsletter to keep you informed on a variety of issues related to your good health. Visit our Web site at www.chclouisiana.com for back editions of this publication, *Living Well*.

In addition, we augment our health education tools with access to our **Nurse Advisor Services**. Experienced RNs are available through an inbound call center 24x7x365 to assist you and help you to maximize your benefits, by providing clinical and economic information to make an informed decision on how to proceed with care.

Account management tools

For each HSA and HRA account holder, we maintain a complete claims payment history online through Coventry's password-protected, self-service functionality, My Online Services, at www.chclouisiana.com.

You will receive an EOB after every claim.

If you have an HSA,

You will receive a quarterly statement by mail outlining your account balance and activity.

ü You may also access your account and review your activity on a daily basis online, via My Online Services, at www.chclouisiana.com.

If you have an HRA,

You will receive a quarterly statement by mail outlining your account balance and activity.

Consumer choice

As a member of this HDHP, you may choose any provider. However, you will receive discounts when you see a network provider. Directories are available online at www.chclouisiana.com.

information

As a member of this HDHP, you may choose any provider. However, you will receive discounts when you see a network provider. Our provider search function on our website www.chclouisiana.com is updated every week. It lets you easily search for a participating physician based on the criteria *you* choose, such as provider specialty, gender, secondary languages spoken, or hospital affiliation. You can even specify the maximum distance you're willing to travel and, in most instances, get driving directions and a map to the offices of identified providers.

Pricing information for medical care is available at www.chclouisiana.com. There, you will find our **Health Services Pricing Tools**, which provide average cost information for some the most common categories of service. The easy-to-understand information is sorted by categories of service, including physician office visits, diagnostic tests, surgical procedures, and hospitalization.

Pricing information for prescription drugs is available through our link to the website of our pharmacy benefit manager, Caremark (which you can access via www.chclouisiana.com). Through a password-protected account, you will have the ability to estimate prescription costs before ordering.

Link to online pharmacy through to the website of our pharmacy benefit manager, Caremark (which you can access via www.chclouisiana.com.)

Educational materials on the topics of HSAs, HRAs and HDHPs are available at www.chclouisiana.com.

Care support

Our complex case management programs offer special assistance to members with intricate, long-term medical needs. Our disease management program fosters a proactive approach to managing care from prevention through treatment and management. Your physician can help arranged for participation in these programs, or you can simply contact our member service department.

Patient safety information is available online at www.chclouisiana.com.

Care support is also available to you, in the form of a relationship that we have established with the *College of American Pathologists* for e-mail reminder notifications. We'll send a message to the e-mail address you provide on a scheduled basis, reminding you to arrange for screening tests.

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

The exclusions in this section apply to all benefits. **There may be other exclusions and limitations listed in Section 5 of this brochure. Although we may list a specific service as a benefit, we will not cover it unless your Plan doctor determines it is medically necessary to prevent, diagnose, or treat your illness, disease, injury, or condition** (see specifics regarding transplants).

We do not cover the following:

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

Section 8. Filing a claim for covered services

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

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

Medical and hospital benefits

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

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

Covered member’s name and ID number;

Name and address of the physician or facility that provided the service or supply;

Dates you received the services or supplies;

Diagnosis;

Type of each service or supply;

The charge for each service or supply;

A copy of the explanation of benefits, payments, or denial from any primary payer – such as the Medicare Summary Notice (MSN); and

Receipts, if you paid for your services.

Submit your claims to:

CHC Louisiana/Claims

P.O. Box 7707

London, KY 40742

Prescription drugs

Submit your claims to:

Caremark Claims Department

P.O. Box 686005

San Antonio, Texas 78268-6005

Deadline for filing your claim

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

When we need more information

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

Section 9. The disputed claims process

Follow this Federal Employees Health Benefits Program disputed claims process if you disagree with our decision on your claim or request for services, drugs, or supplies – including a request for preauthorization/prior approval required by Section 3. Disagreements between you and the CDHP or HDHP fiduciary regarding the administration of an HSA or HRA are not subject to the disputed claims process.

- 1** Ask us in writing to reconsider our initial decision. You must:
 - a) Write to us within 6 months from the date of our decision; and
 - b) Send your request to us at: CHC Louisiana, Inc., 3838 North Causeway Blvd., Suite 3350, Metairie, LA 70002; and
 - c) Include a statement about why you believe our initial decision was wrong, based on specific benefit provisions in this brochure; and

Include copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms.

- 2** We have 30 days from the date we receive your request to:
 - a) Pay the claim (or, if applicable, arrange for the health care provider to give you the care); or
 - b) Write to you and maintain our denial - go to step 4; or
 - c) Ask you or your provider for more information. If we ask your provider, we will send you a copy of our request—go to step 3.

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

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

We will write to you with our decision.

- 4** If you do not agree with our decision, you may ask OPM to review it.

You must write to OPM within

- 90 days after the date of our letter upholding our initial decision; or
- 120 days after you first wrote to us - if we did not answer that request in some way within 30 days; or
- 120 days after we asked for additional information.

Write to OPM at: United States Office of Personnel Management, Insurance Services Programs, Health Insurance Group 3, 1900 E Street, NW, Washington, DC 20415-3630.

Send OPM the following information:

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

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

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

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

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

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

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

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

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

- a) We haven't responded yet to your initial request for care or preauthorization/prior approval, then call us at 800-341-6613 and we will expedite our review; or
- b) We denied your initial request for care or preauthorization/prior approval, then:
 - If we expedite our review and maintain our denial, we will inform OPM so that they can give your claim expedited treatment too, or
 - You may call OPM's Health Insurance Group x at 202/606-0737 between 8 a.m. and 5 p.m. eastern time.

Section 10. Coordinating benefits with other coverage

When you have other health coverage

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

When you has 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. (If you were a Federal employee at any time both before and during January 1983, you will receive credit for your Federal employment before January 1983.) Otherwise, if you are age 65 or older, you may be able to buy it. Contact 1-800-MEDICARE for more information.
- Part B (Medical Insurance). Most people pay monthly for Part B. Generally, Part B premiums are withheld from your monthly Social Security check or your retirement check.
- Part C (Medicare Advantage). You can enroll in a Medicare Advantage plan to get your Medicare benefits. Please review the information on coordinating benefits with Medicare Advantage plans on the next page.
- Part D (Medicare prescription drug coverage). There is a monthly premium for Part D coverage. If you have limited savings and a low income, you may be eligible for Medicare’s Low-Income Benefits. For people with limited income and resources, extra help in paying for a Medicare prescription drug plan is available. Information regarding this program is available through the Social Security Administration (SSA). For more information about this extra help, visit SSA online at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778). Before enrolling in Medicare Part D, please review the important disclosure notice from us about the FEHB prescription drug coverage and Medicare. The notice is on the first inside page of this brochure. The notice will give you guidance on enrolling in Medicare Part D.

• Should I enroll in Medicare?

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

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

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

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

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

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

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

Claims process when you have the Original Medicare Plan – You probably will never have to file a claim form when you have both our Plan and the Original Medicare Plan. If your plan physician does not participate in Medicare, you will have to file a claim with Medicare.

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. To find out if you need to do something to file your claim, call us at 800-341-6613 or see our Web site at www.chclouisiana.com

Office visit copayments if you have Medicare Part B

- **Medicare Advantage (Part C)**

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

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

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

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

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

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. When you or a covered family member...		
1) Have Medicare solely based on end stage renal disease (ESRD) and • It is within the first 30 months of eligibility for or entitlement to Medicare due to ESRD (30-month coordination period)		✓
• It is beyond the 30-month coordination period and you or a family member are still entitled to Medicare due to ESRD	✓	
2) Become eligible for Medicare due to ESRD while already a Medicare beneficiary and • This Plan was the primary payer before eligibility due to ESRD		✓ for 30-month coordination period
• Medicare was the primary payer before eligibility due to ESRD	✓	
C. When either you or a covered family member are eligible for Medicare solely due to disability and you...		
1) Have FEHB coverage on your own as an active employee or through a family member who is an active employee		✓
2) Have FEHB coverage on your own as an annuitant or through a family member who is an annuitant	✓	
D. When you are covered under the FEHB Spouse Equity provision as a former spouse		
	✓	

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

**TRICARE and
CHAMPVA**

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

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

Workers' Compensation

We do not cover services that:

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

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

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

Medicaid

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

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

**When other Government
agencies are responsible
for your care**

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

**When others are
responsible for injuries**

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

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

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

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

Coverage provided under your FEHB plan remains as your primary coverage. FEDVIP coverage pays secondary to that coverage. When you enroll in a dental and/or vision plan on BENEFEDS.com, you will be asked to provide information on your FEHB plan so that your plans can coordinate benefits. Providing your FEHB information may reduce your out-of-pocket cost.

Section 11. Definitions of terms we use in this brochure

Calendar year	January 1 through December 31 of the same year. For new enrollees, the calendar year begins on the effective date of their enrollment and ends on December 31 of the same year.
Coinsurance	Coinsurance is the percentage of our allowance that you must pay for your care. You may also be responsible for additional amounts. See page 15.
Copayment	A copayment is a fixed amount of money you pay when you receive covered services. See page 15.
Cost-sharing	Cost-sharing is the general term used to refer to your out-of-pocket costs (e.g., deductible, coinsurance, and copayments) for the covered care you receive.
Covered services	Care we provide benefits for, as described in this brochure.
Deductible	A deductible is a fixed amount of covered expenses you must incur for certain covered services and supplies before we start paying benefits for those services. See page 15.
Experimental or investigational service	A health product or service is deemed experimental or investigational and excluded from coverage under this Agreement if one or more of the following conditions are met: (i) any drug not approved for use by the FDA; any drug that is classified as IND (investigational new drug) by the FDA; (ii) any drug requiring pre-authorization that is proposed for off-label prescribing; (iii) any health product or service that is subject to Investigational Review Board (IRB) review or approval; (iv) any health product or service that is subject of a clinical trial that meets criteria for Phase I, II or III as set forth by FDA regulations; or (v) any health product or service that does not have a demonstrated value based on clinical evidence reported by peer-review medical literature and by generally recognized academic experts
Group health coverage	<p>If you leave the FEHB Program, we will give you a Certificate of Group Health Plan Coverage that indicates how long you have been enrolled with us. You can use this certificate when getting health insurance or other health care coverage. You must arrange for the other coverage within 63 days of leaving this Plan. Your new plan must reduce or eliminate waiting periods, limitations or exclusions for health related conditions based on the information in the certificate.</p> <p>If you have been enrolled with us for less than 12 months, but were previously enrolled in other FEHB plans, you may request a certificate from them, as well.</p>
Plan allowance	Plan allowance is the amount we use to determine our payment and your coinsurance for covered services. Plans determine their allowances in different ways. We determine our allowance as follows:
Us/We	Us and We refer to Coventry Health Care of Louisiana, Inc.
You	You refers to the enrollee and each covered family member.

Section 12. FEHB Facts

Coverage information

No pre-existing condition limitation

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

Where you can get information about enrolling in the FEHB Program

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

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

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

- When you may change your enrollment;
- How you can cover your family members;
- What happens when you transfer to another Federal agency, go on leave without pay, enter military service, or retire;
- 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 family members are added or lose coverage for any reason, including your marriage, divorce, annulment, or when your child under age 22 turns age 22 or has a change in marital status, divorcé, or when your child under age 22 marries.

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 2008 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 2007 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.

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

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

Upon divorce

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

Temporary Continuation of Coverage (TCC)

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

Converting to individual coverage

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

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

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

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

Getting a Certificate of Group Health Plan Coverage

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

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

Section 13. Three Federal Programs complement FEHB benefits

Important information

OPM wants to be sure you are aware of three Federal programs that complement the FEHB Program.

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

Second, the **Federal Flexible Spending Account 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.

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

The Federal Long Term Care Insurance Program – *FLTCIP*

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.** 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. 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 about your health. 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.

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. Annuitants are not eligible to enroll.

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

Health Care FSA (HCFSAs)

- **Limited Expense Health Care FSA (LEX HCFSA)** – Designed for employees enrolled in or covered by a High Deductible Health Plan with a Health Savings Account. Eligible expenses are limited to dental and vision care expenses for you and your dependents, which are not covered or reimbursed, by FEHBP or FEDVIP coverage or other insurance.
- **Dependent Care FSA (DCFSA)** – Pays for eligible dependent care expenses that allow you (and your spouse if married) to work, look for work (as long as you have earned income for the year), or attend school full-time.

What expenses can I pay with an FSAFEDS account?

For the HCFSA– Health plan copayments, deductibles, over-the-counter medications and products, sunscreen, eyeglasses, contacts, other vision and dental expenses (but not insurance premiums).

For the LEX HCFSA– Dental and vision care expenses including eligible over-the-counter medicines and products related to dental and vision care (but not insurance premiums).

For the DCFSA – Daycare expenses (including summer camp) for your child(ren) under age 13, dependent care expenses for dependents unable to care for themselves.

AND MUCH MORE! Visit www.FSAFEDS.com.

Who is eligible to enroll?

Most Federal employees in the Executive branch and many in non-Executive branch agencies are eligible. For specifics on eligibility, visit www.FSAFEDS.com or call an FSAFEDS Benefits Counselor toll-free at 1-877-FSAFEDS (1-877-372-3337), Monday through Friday, 9 a.m. until 9 p.m., Eastern Time. TTY: 1-800-952-0450.

When can I enroll?

If you wish to participate, you must make an election to enroll each year by visiting www.FSAFEDS.com or calling the number above during the FEHB Open Season or within 60 days of employment (for new employees).

Even if you enrolled for 2006, you must make a new election to continue participating in 2007. Enrollment DOES NOT carry over from year to year.

Who is SHPS?

SHPS is the Third Party Administrator hired by OPM to manage the FSAFEDS Program. SHPS is responsible for enrollment, claims processing, customer service, and day-to-day operations of FSAFEDS.

Who is BENEFEDS?

BENEFEDS is the name of the voluntary benefits portal hired by OPM to work with the FSAFEDS Program to set up payroll deductions for FSAFEDS allotments.

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

Important Information

The Federal Employees Dental and Vision Insurance Program (FEDVIP) is a new program, separate and different from the FEHB Program, established by the Federal Employee Dental and Vision Benefits Enhancement Act of 2004.



The Federal Employees Dental and Vision Insurance Program (FEDVIP) is a program, separate and different from the FEHB Program, established by the Federal Employee Dental and Vision Benefits Enhancement Act of 2004. This program has no pre-existing condition limitations. FEDVIP is available to eligible Federal and Postal service employees, retirees, and their eligible family members on an enrollee-pay-all basis. Premiums are withheld from salary on a pre-tax basis.

Dental Insurance

Dental plans provide a comprehensive range of services, including the following:

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

- Class B (Intermediate) services, which include restorative procedures such as fillings, prefabricated stainless steel crowns, periodontal scaling, tooth extractions, and denture adjustments.
- Class C (Major) services, which include endodontic services such as root canals, periodontal services such as gingivectomy, major restorative services such as crowns, oral surgery, bridges and prosthodontic services such as complete dentures.
- Class D (Orthodontic) services with up to 24-month waiting period

Please review the dental plans' benefits material for detailed information on the benefits covered, cost-sharing requirements, and preferred provider listings.

Vision Insurance

Vision plans provide comprehensive eye examinations and coverage for lenses, frames and contact lenses. Other benefits such as discounts on LASIK surgery may also be available.

Please review the vision plans' benefits material for detailed information on the benefits covered, cost-sharing requirements, and preferred provider listings.

What plans are available?

You can find a comparison of the plans available and their premiums on the OPM website at www.opm.gov/insure/dentalvision. This site also provides links to each plan's website, where you can view detailed information about benefits and preferred providers.

Premiums

The premiums will vary by plan and by enrollment type (self, self plus one, or self and family). There is no government contribution to the premiums. If you are an active employee, your premiums will be taken from your salary on a pre-tax basis when your salary is sufficient to make the premium withholding. If you are an annuitant, premiums will be withheld from your monthly annuity check when your annuity is sufficient. Pre-tax premiums are not available to annuitants. For information on each plan's specific premiums, visit www.opm.gov/insure/dentalvision.

Who is eligible to enroll?

Federal and Postal Service employees eligible for FEHB coverage (whether or not enrolled) and annuitants (regardless of FEHB status) are eligible to enroll in a dental plan and/or a vision plan.

Enrollment types available

- Self-only, which covers only the enrolled employee or annuitant;
- Self plus one, which covers the enrolled employee or annuitant plus one eligible family member specified by the enrollee; and
- Self and family, which covers the enrolled employee or annuitant and all eligible family members.

Which family members are eligible to enroll?

Eligible family members include your spouse, unmarried dependent children under age 22, and unmarried dependent children age 22 or over incapable of self-support because of a mental or physical disability that existed before age 22.

When can I enroll?

Eligible employees and annuitants can enroll in a dental and/or vision plan during this open season -- November 13 to December 11, 2006. You can enroll, disenroll, or change your enrollment during subsequent annual open seasons, or because of a qualified life event. New employees will have 60 days from their first eligibility date to enroll.

How do I enroll?

You enroll on the Internet at www.BENEFEDS.com. BENEFEDS is a secure enrollment website sponsored by OPM where you enter your name, personal information like address and Social Security Number, the agency you work for (or retirement plan that pays your annuity), and the dental and/or vision plan you select. For those without access to a computer, call 1-877-888- 5680. If you do not have access to a computer or a phone, contact your employing office or retirement system for guidance on how to enroll.

You cannot enroll in a FEDVIP plan using the Health Benefits Election Form (SF 2809) or through an agency self-service system, such as Employee Express, MyPay, or Employee Personal Page. However, those sites may provide a link to BENEFEDS.

When will coverage be effective?

The new Program will be effective December 31, 2006. Coverage for those who enroll during this year's open season (November 13 – December 11, 2006) will be effective December 31, 2006. Coverage for any other enrollments will be effective on/or after December 31, 2006.

How does this coverage work with my FEHB plan's dental or vision coverage?

Some FEHB plans already cover some dental and vision services. When you are covered by more than one health/dental plan, federal law permits your insurers to follow a procedure called "coordination of benefits" to determine how much each should pay when you have a claim. The goal is to make sure that the combined payments of all plans do not add up to more than your covered expenses.

Coverage provided under your FEHB plan remains as your primary coverage. FEDVIP coverage pays secondary to that coverage. When you enroll in a dental and/or vision plan on BENEFEDS.com, you will be asked to provide information on your FEHB plan so that your plans can coordinate benefits. Providing your FEHB information may reduce your out-of-pocket cost.

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Summary of benefits for the High Option of Coventry Health Care of Louisiana - 2008

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

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

Summary of benefits for the Standard Option of Coventry Health Care of Louisiana - 2008

- 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 \$500 self only and \$1,000 family calendar year deductible.

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

Summary of benefits for the HDHP of Coventry Health Care of Louisiana - 2008

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

In 2007 for each month you are eligible for the HSA, will deposit \$41.67 per month for Self Only enrollment or \$83.33 per month for Self and Family enrollment to your HSA. For the Health Savings Account (HSA), you must satisfy your calendar year deductible of \$1,100 for Self Only and \$2,200 for Self and Family before using your HSA. Once you satisfy your calendar year deductible, Traditional medical coverage begins.

For the Health Reimbursement Arrangement (HRA), your health charges are applied to your annual HRA Fund of \$41.67 for Self Only and \$83.33 for Self and Family. Once your HRA is exhausted, you must satisfy your calendar year deductible. Once your calendar year deductible is satisfied, Traditional medical coverage begins.

Below, an asterisk (*) means the item is subject to the calendar year deductible. And, after we pay, you generally pay any difference between our allowance and the billed amount if you use a Non-PPO physician or other health care professional.

HDHP Benefits	You Pay	Page
In-network medical and dental preventive care		
Medical services provided by physicians:	In-network: 20% of the Plan allowance Out-of-network: 30% of the Plan allowance and any difference between our allowance and the billed amount.	55
Diagnostic and treatment services provided in the office	In-network: 20% of the Plan allowance Out-of-network: 30% of the Plan allowance and any difference between our allowance and the billed amount.	55
Services provided by a hospital:		
• Inpatient	In-network: 20% of the Plan allowance	68
• Outpatient	Out-of-network: 30% of the Plan allowance and any difference between our allowance and the billed amount.	70
Emergency benefits:		
• In-area	In-network: 20% of the Plan allowance	72
• Out-of-area	Out-of-network: 30% of the Plan allowance and any difference between our allowance and the billed amount.	73
Mental health and substance abuse treatment:	Regular cost sharing	74
Prescription drugs:		75
• Retail pharmacy	\$10 generic, \$35 brand name, \$60 non-formulary, after the deductible	75
• Mail order	\$20 generic, \$70 brand name, \$120 non-formulary, after the deductible	75
Dental care:	In-network: 20% of the Plan allowance	78

	Out-of-network: 30% of the Plan allowance and any difference between	
Vision care:	No benefit.	
Special features:	Flexible benefits option; 24 hour nurse line	
Protection against catastrophic costs (out-of-pocket maximum):	In Network - Nothing after \$4,000/Self Only or \$8,000/Family enrollment per year Out-of-Network - Nothing after \$6,000/Self Only or \$12,000/Family enrollment per year	51

2008 Rate Information for Coventry Health Care of Louisiana

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

Postal Category 1 rates apply to certain career non-law enforcement Postal Service employees. **Postal Category 2 rates** apply to other non-law enforcement Postal Service employees. *PostalEASE*, the employee self-service system used for FEHB enrollment, automatically provides the applicable premium to individual employees. Career non-law enforcement employees may also refer to the *Guide to Federal Benefits for United States Postal Service Employees*, RI 70-2, to determine their rates.

Different rates apply and a special Guide is published for Postal Service Inspectors and Office of Inspector General (OIG) employees (see RI 70-2IN).

For further assistance, Postal Service employees should call.

Human Resources Shared Service Center

1-877-3273, Option 5

TTY: 1-866-260-7507

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 *Guide to Federal Benefits*.

Type of Enrollment	Enrollment Code	Non-Postal Premium				Postal Premium	
		Biweekly		Monthly		Biweekly	
		Gov't Share	Your Share	Gov't Share	Your Share	Category 1 Your Share	Category 2 Your Share

Baton Rouge

High Option Self Only	JA1	\$145.04	\$104.35	\$314.25	\$226.10	\$80.17	\$78.16
High Option Self and Family	JA2	\$329.30	\$249.91	\$713.48	\$541.48	\$195.03	\$190.45
Standard Option Self Only	JA4	\$145.04	\$125.31	\$314.25	\$271.51	\$101.13	\$99.12
Standard Option Self and Family	JA5	\$329.30	\$298.63	\$713.48	\$647.04	\$243.75	\$239.17
HDHP Option Self Only	LT1	\$131.35	\$43.78	\$284.59	\$94.86	\$21.89	\$19.70
HDHP Option Self and Family	LT2	\$304.10	\$101.36	\$658.88	\$219.62	\$50.68	\$45.61

Type of Enrollment	Enrollment Code	Non-Postal Premium				Postal Premium	
		Biweekly		Monthly		Biweekly	
		Gov't Share	Your Share	Gov't Share	Your Share	Category 1 Your Share	Category 2 Your Share

New Orleans

High Option Self Only	BJ1	\$141.01	\$47.00	\$305.52	\$101.84	\$23.50	\$21.15
High Option Self and Family	BJ2	\$327.46	\$109.15	\$709.49	\$236.50	\$54.58	\$49.12
Standard Option Self Only	BJ4	\$138.98	\$46.32	\$301.11	\$100.37	\$23.16	\$20.85
Standard Option Self and Family	BJ5	\$322.76	\$107.58	\$699.30	\$233.10	\$53.79	\$48.41
HDHP Option Self Only	HB1	\$114.05	\$38.01	\$247.10	\$82.36	\$19.01	\$17.11
HDHP Option Self and Family	HB2	\$264.89	\$88.29	\$573.92	\$191.30	\$44.15	\$39.73