Humana Medical Plan, Inc.

http://www.humana.com

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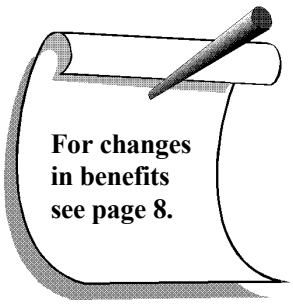
2002

A Health Maintenance Organization

Serving: South Florida



Enrollment in this Plan is limited. You must live or work in our Geographic service area to enroll. See page 7 for requirements.

This plan has a commendable accreditation from the NCQA. See the 2002 Guide for more information on NCQA.

Enrollment codes for this Plan:

EE1 Self Only
EE2 Self and Family

Authorized for distribution by the:

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

FEHB
Federal Employees
Health Benefits Program

RI73-278

Table of Contents

Introduction……4

Plain Language……4

Inspector General Advisory……5

Section 1. Facts about this HMO plan 6-7

How we pay providers 6

Who provides my health care?……6

Your Rights 6

Service Area 7

Section 2. How we change for 2002…….. 8

Program-wide changes 8

Changes to this Plan 8

Section 3. How you get care …….. 9-11

Identification cards 9

Where you get covered care 9

- Plan providers 9
- Plan facilities 9

What you must do to get covered care 9-10

- Primary care 9
- Specialty care 9-10
- Hospital care 10-11

Circumstances beyond our control 11

Services requiring our prior approval 11

Section 4. Your costs for covered services 12

- Copayments 12
- Coinsurance 12

Your out-of-pocket maximum 12

Section 5. Benefits…… 13-39

Overview 13

(a) Medical services and supplies provided by physicians and other health care professionals 14-22

(b) Surgical and anesthesia services provided by physicians and other health care professionals 23-26

(c) Services provided by a hospital or other facility, and ambulance services 27-29

(d) Emergency services/accidents 30-31

(e) Mental health and substance abuse benefits 32-33

(f) Prescription drug benefits 34-36

(g) Special features 37

- Services for deaf and hearing impaired…….
- High risk pregnancies……

- Centers of excellence for transplants/heart surgery/etc……
- 24-hour nurse line…….
- Smoking cessation……

(h) Dental benefits 38

(i) Non-FEHB benefits available to Plan members 39

Section 6. General exclusions – things we don't cover 40

Section 7. Filing a claim for covered services 41

Section 8. The disputed claims process 42-43

Section 9. Coordinating benefits with other coverage 44-47

When you have…

- Other health coverage 44
- Original Medicare 46
- Medicare managed care plan 47

TRICARE/Workers' Compensation/Medicaid 48

Other Government agencies 48

When others are responsible for injuries 48

Section 10. Definitions of terms we use in this brochure 49-50

Section 11. FEHB facts 51-53

Coverage information 51

- No pre-existing condition limitation 51
- Where you get information about enrolling in the FEHB Program 51
- Types of coverage available for you and your family 51
- When benefits and premiums start 51
- Your medical and claims records are confidential 52
- When you retire 52

When you lose benefits 52-53

- When FEHB coverage ends 52
- Spouse equity coverage 52
- Temporary Continuation of Coverage (TCC) 52
- Converting to individual coverage 53
- Getting a Certificate of Group Health Plan Coverage 53

Long term care insurance is coming later in 2002……54-55

Index 56

Summary of benefits 58

Rates ..... Back cover

Introduction

Humana Medical Plan, Inc.
P.O. Box 19080F
Jacksonville, FL 32245-9080

This brochure describes the benefits of Humana Health Plan, under our contract (CS 2110) with the Office of Personnel Management (OPM), as authorized by the Federal Employees Health Benefits law. This brochure is the official statement of benefits. No oral statement can modify or otherwise affect the benefits, limitations, and exclusions of this brochure.

If you are enrolled in this Plan, you are entitled to the benefits described in this brochure. If you are enrolled for 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, 2002, unless those benefits are also shown in this brochure.

OPM negotiates benefits and rates with each plan annually. Benefit changes are effective January 1, 2002, and changes are summarized on page 8. Rates are shown at the end of this brochure.

Plain Language

Teams of Government and health plans' staff worked on all FEHB brochures 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 Humana Health Plan, Inc.
- We limit acronyms to ones you know. FEHB is the Federal Employees Health Benefit Program. OPM is the Office of Personnel Management. If we use others, we tell you what they mean first.
- Our brochure and other FEHB plans' brochures have the same format and similar descriptions to help you compare plans.

If you have comments or suggestions about how to improve the structure of this brochure, let OPM know. Visit OPM's "Rate Us" feedback area at www.opm.gov/insure or email OPM at fehbpwebcomments@opm.gov. You may also write to OPM at the Office of Personnel Management, Office of Insurance Planning and Evaluation Division, 1900 E Street, NW Washington, DC 20415-3650

Inspector General Advisory

Stop health care fraud!

Fraud increases the cost of health care for everyone. If you suspect that a physician, pharmacy, or hospital 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 1-800/4HUMANA and explain the situation.
- If we do not resolve the issue, call or write

THE HEALTH CARE FRAUD HOTLINE

202/418-3300

The United States Office of Personnel Management

Office of the Inspector General Fraud Hotline

1900 E Street, NW, Room 6400

Washington, DC 20415

Penalties for Fraud

Anyone who falsifies a claim to obtain FEHB Program benefits can be prosecuted for fraud. Also, the Inspector General may investigate anyone who uses an ID card if the person tries to obtain services for someone who is not an eligible family member, or are no longer enrolled in the Plan and tries to obtain benefits. Your agency may also take administrative action against you.

Section 1. Facts about this HMO plan

This Plan is a health maintenance organization (HMO). We require you to see specific physicians, hospitals, and other providers that contract with us. These Plan providers coordinate your health care services.

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

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

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

How we pay providers

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

Who provides my healthcare?

The Plan's provider directory lists primary care doctors (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 **1-800/426-2173**; 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.

Your Rights

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

- Medical case management is a special Humana program that communicates the provision of care and the management of benefit in cases of catastrophic illness or injury, transplant management and disease management. The program strives to ensure that patients receive the most appropriate, cost-effective care and also derive maximum advantage from plan benefits.
- Humana has adopted preventative care guidelines based on the United States Preventative Health Task Force and subscribes to their Healthy People 2000 goals. Our Patterns of Preventative Care (POPC) program monitors the delivery of well care and uses an automated reminder system to help assure that our members schedule routine preventative services
- Humana provides comprehensive disease management programs to plan members. Key to each program is ongoing education, communication and coordination. Each contracted vendor offers plan members access to a staff of highly specialized nurses and doctors, experienced in the respective disease field. The programs focus on linking the plan member with a specialized nurse or interdisciplinary team to ensure an individualized care development approach. These nurses work closely with the plan member, member's family, member's primary care physician (PCP) and other involved providers to provide information, education and assistance when needed.
- Nationally, Humana has been in the health care business since 1961. Locally, Humana has been in existence since 1988.
- Humana is a for profit corporation which is publicly traded on the New York Stock Exchange (NYSE).

If you want more information about us, call 1-800/426-2173, or write to the Plan at P.O. Box 19080F, Jacksonville, FL 32245-9080. You may also contact us by fax at 904/376-1926 or visit our website at www.humana.com.

Service Area

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

The Florida counties of Broward, Miami/Dade and Palm Beach.

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 2002

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

Program-wide changes

- We no longer limit total blood cholesterol tests to certain age groups. (Section5(a))

Changes to this Plan

- Your share of the non-Postal premium will increase by 5% for Self Only and Self and Family.
- We increased speech therapy benefits by removing the requirement that services must be required to restore functional speech. (Section 5(a))
- We now cover certain intestinal transplants. (Section 5(b))
- You pay a $50copay for emergencies occurring within the service area.
- You pay a $20 copay for brand name drugs or a $40 copay for generic or brand name drugs not on our Drug List.
- Smoking cessation programs are covered for up to $100 per member per lifetime.

Section 3. How you get care

Identification cards

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

If you do not receive your ID card within 30 days after the effective date of your enrollment, or if you need replacement cards, call us at 1-800/426-2173.

Where you get covered care

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

- **Plan providers**

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

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

- **Plan facilities**

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

What you must do to get covered care

It depends on the type of care you need. First, you and each family member must choose a primary care physician by sending a selection form to the Plan. This decision is important since your primary care physician provides or arranges for most of your health care. You may choose your primary care physician from our Provider Directory or our website, or you may call us for assistance. You may change your doctor selection by notifying us 30 days in advance.

- **Primary care**

Your primary care physician can be a family practitioner, internist or pediatrician. Your primary care physician will provide most of your health care, or give you a referral to see a specialist.

If you want to change primary care physicians or if your primary care physician leaves the Plan, call us. We will help you select a new one.

If you are receiving services from a doctor who leaves the Plan, we will provide payment for covered services until we can make reasonable and medically appropriate provisions for the assumption of such services by a participating doctor.

- **Specialty care**

Your primary care physician will refer you to a specialist for needed care. When you receive a referral from your primary care physician, you must return to the primary care physician after the consultation, unless your primary care physician authorized certain number of visits without additional referrals. The primary care physician must provide or authorize all follow-up care. Do not go to the specialist for return visits unless your primary care physician gives you a referral. On referrals, the

primary care doctor will give specific instructions to the consultant as to what services are authorized. However, you may see the following participating providers without a referral:

- Mental health providers
- OB/GYN providers for your annual well-woman exam
- Podiatrists
- Chiropractors
- Dermatologists (for up to five visits each calendar year)
- Another doctor your primary care physician has designated to provide patient care when he or she is not available.

Here are other things you should know about specialty care:

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

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

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

- **Hospital care**

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

If you are in the hospital when your enrollment in our Plan begins, call our customer service department immediately at 1-800/426-2173. If you are new to the FEHB Program, we will arrange for you to receive care.

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

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

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

Circumstances beyond our control

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

Services requiring our prior approval

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

We call this review and approval process precertification. Your physician must obtain precertification for the following services:

- Growth hormone therapy
- Organ/Tissue transplants
- All elective medical and surgical hospitalizations
- MRI of the lumbar and cervical spine
- Uvulopalatopharyngoplasty (UPPP)
- Gastric bypass
- All durable medical equipment (DME) over $750
- Acute rehabilitation services
- Home health care services
- Genetic testing
- Infertility services
- Pain Management services
- PET and SPECT scans
- Sclerotherapy
- Occupational and Physical therapies

Your physician must obtain our approval before sending you to a hospital, referring you to a specialist, or recommending follow-up care from a specialist.

Section 4. Your costs for covered services

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

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

  Example: When you see your primary care physician you pay a copayment of $10 per office visit and when you go in the hospital, you pay nothing.

- **Deductible** — We do not have a deductible.

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

  Example: In our Plan, you pay 50% of our allowance for infertility services after the Plan has paid for the first $2,000 in charges.

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

After your copayments total $1,500 per person or $3,000 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 out-of-pocket maximum, and you must continue to pay copayments for these services:

- Prescription drugs

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

Section 5. Benefits – OVERVIEW

(See page 7 for how our benefits changed this year and page 52 for a benefits summary.)

NOTE: This benefits section is divided into subsections. Please read the important things you should keep in mind at the beginning of each subsection. Also read the General Exclusions in Section 6; they apply to the benefits in the following subsections. To obtain claims forms, claims filing advice, or more information about our benefits, contact us 1-800/426-2173 or at our website at www.humana.com.

(a) Medical services and supplies provided by physicians and other health care professionals 14-22

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

(b) Surgical and anesthesia services provided by physicians and other health care professionals 23-26

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

(c) Services provided by a hospital or other facility, and ambulance services 27-29

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

(d) Emergency services/accidents 30-31

- Medical emergency
- Ambulance

(e) Mental health and substance abuse benefits 32-33

(f) Prescription drug benefits 34-36

(g) Special features 37

- Services for deaf and hearing impaired
- High risk pregnancies
- Centers of excellence for transplants/heart surgery/etc.
- Smoking cessation
- 24-hour nurse line

(h) Dental benefits 38

(i) Non-FEHB benefits available to Plan members 39

Summary of benefits 58

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

IMPORTANT

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

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan physicians must provide or arrange your care.
- Be sure to read Section 4, *Your costs for covered services* for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

IMPORTANT

Benefit Description	
Diagnostic and treatment services	**You pay**
Professional services of physicians • In physician's office • In an urgent care center • Office medical consultations • At home	$10 per office visit
Professional services of physicians • During a hospital stay • In a skilled nursing facility • Second surgical opinion	Nothing
Lab, x-ray and other diagnostic tests	
Tests, such as: • Blood tests • Urinalysis • Non-routine pap tests • Pathology • X-rays • Non-routine Mammograms • CAT Scans/MRI • Ultrasound • Electrocardiogram and EEG	Nothing if you receive these services during your office visit; otherwise, $10 per visit.

Preventive care, adult	You pay

Routine screenings, such as:
• Total Blood Cholesterol – once every three years.
• Colorectal Cancer Screening, including
  • Fecal occult blood test
  • Sigmoidoscopy, screening – every five years starting at age 50
• Prostate Specific Antigen (PSA test) – one annually for men age 40 and olderChlamydial infection screening
• Routine pap test – one annually
Note: The office visit is covered if pap test is received on the same day; see *Diagnostic and treatment services*, above.
Routine mammogram – covered for women age 35 and older, as follows:
• From age 35 through 39, one during this five year period
• From age 40 through 64, one every calendar year
• At age 65 and older, one every two consecutive calendar years
• When prescribed by the doctor as medically necessary to diagnose or treat illness
	Nothing if you receive these services during your office visit; otherwise, $10 per visit

Not covered: physical exams and immunizations required for obtaining or continuing employment or insurance, attending schools or camp, or travel.	*All charges*
Routine immunizations, limited to: • Tetanus-diphtheria (Td) booster – once every 10 years, ages19 and over (except as provided for under Childhood immunizations) • Influenza/Pneumococcal vaccines, annually, age 65 and over, or in the presence of high risk, chronic conditions	Nothing if you receive these services during your office visit; otherwise, $10 per visit .

Preventive care, children	You pay
• Childhood immunizations recommended by the American Academy of Pediatrics	Nothing

• Well-child care charges for routine examinations, immunizations and care (under age 22)
• Examinations, such as:
  • Eye exams through age 17 to determine the need for vision correction.
  • Ear exams through age 17 to determine the need for hearing correction
  • Examinations done on the day of immunizations (under age 22)
	$10 per office visit.

Maternity care	
Complete maternity (obstetrical) care, such as: • Prenatal care • Delivery • Postnatal care Note: Here are some things to keep in mind: • 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).	$10 for the first pre-natal office visit. Subsequent visits are provided with no copay charge.
Not covered: routine sonograms to determine fetal age, size or sex	*All charges*

Family planning	You pay
A broad range of voluntary family planning services, limited to: • Surgically implanted contraceptives (such as Norplant) • Injectable contraceptive drugs (such as Depo Provera) • Intrauterine devices (IUD's) • Diaphragms • Voluntary sterilization Note: We cover oral contraceptives under the prescription drug benefit.	$10 per office visit
Not covered: reversal of voluntary surgical sterilization	*All charges*
Infertility services	

Diagnosis and treatment of infertility, such as:
• Artificial insemination:
  • *intravaginal insemination (IVI)*
  • *intracervical insemination (ICI)*
  • *intrauterine insemination (IUI)*
• Fertility drugs
	50% of all charges after the Plan has paid for the first $2,000 in charges.

Not covered:
• *Assisted reproductive technology (ART) procedures, such as:*
  • *in vitro fertilization*
  • *embryo transfer, gamete GIFT and zygote ZIFT*
  • *Zygote transfer*
• *Services and supplies related to excluded ART procedures*
• *Cost of donor sperm*
• *Cost of donor egg*
	All charges

Allergy care	
• Testing and treatment, including test and treatment materials	Nothing if you receive these services during your office visit; otherwise, $10 per visit.
• Allergy serum	Nothing
Not covered: provocative food testing and sublingual allergy desensitization	*All charges*

Treatment therapies	You pay
• Chemotherapy and radiation therapy Note: High dose chemotherapy in association with autologous bone marrow transplants is limited to those transplants listed under Organ/Tissue Transplants on page 24. • Respiratory and inhalation therapy • Dialysis – Hemodialysis and peritoneal dialysis	$10 per office visit
• Intravenous (IV)/Infusion Therapy – Home IV and antibiotic therapy • Growth hormone therapy (GHT) Note: Growth hormone is covered under the prescription drug benefit. Note: We will only cover Growth Hormone Therapy if the treatment is precertified and there is a laboratory confirmed diagnosis of Growth Hormone Deficiency. You will need to call the precertification telephone number on the back of your medical ID (identification) card. We will also ask that your physician submit information that establishes that the GHT is medically necessary. GHT must be authorized before you begin treatment. See *Services requiring our prior approval* in Section 3.	$10 per office visit

Physical and occupational therapies	You pay

• Up to two consecutive months per condition for the services of each of the following if significant improvement can be expected within two months:
  • qualified physical therapists; and
  • occupational therapists.
 	
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. Occupational therapy is limited to services that assist the member to achieve and maintain self-care and improved functioning in other activities of daily living.
	Nothing

• Cardiac rehabilitation following a heart transplant, bypass surgery or a myocardial infarction, is provided for up to 12 weeks.	Nothing
Not covered: • *long-term rehabilitative therapy* • *exercise programs*	*All charges*
Speech therapy	
• Speech therapy provided by speech therapists	Nothing
Hearing services (testing, treatment, and supplies)	
• Screening hearing testing for children through age 17 (see *Preventive care, children*)	$10 per office visit
Not covered: • *all other hearing testing* • *hearing aids, testing and examinations for them*	*All charges*
Vision services (testing, treatment, and supplies)	
• One pair of eyeglasses or contact lenses to correct an impairment directly caused by accidental ocular injury or intraocular surgery (such as for cataracts) • Diagnosis and treatment of diseases of the eye. • Screening eye exam to determine the need for vision correction for children through age 17 (see preventive care)	$10 per office visit

Vision services (testing, treatment, and supplies) *(Continued)*	**You pay**
Not covered: • *eyeglasses or contact lenses and, after age 17, examinations for them* • *eye exercises and orthoptics* • *radial keratotomy and other refractive surgery*	*All charges*
Foot care	
Routine foot care when you are under active treatment for a metabolic or peripheral vascular disease, such as diabetes. See orthopedic and prosthetic devices for information on podiatric shoe inserts.	$10 per office visit
Not covered,: • *cutting, trimming or removal of corns, calluses, or the free edge of toenails, and similar routine treatment of conditions of the foot, unless primary medical condition requires such care* • *treatment of weak, strained or flat feet or bunions or spurs; and of any instability, imbalance or subluxation of the foot (unless the treatment is by open cutting surgery)*	*All charges*
Orthopedic and prosthetic devices	
• Artificial limbs • Orthopedic devices such as braces (except for dental braces) that are custom-fitted or custom-made. • Externally worn breast prostheses and surgical bras, including necessary replacements, following a mastectomy • Internal prosthetic devices, such as artificial joints and pacemakers. NOTE: See 5(b) for coverage of the surgery to insert the device. • Corrective orthopedic appliances for non-dental treatment of temporomandibular joint (TMJ) pain dysfunction syndrome.	Nothing

Orthopedic and prosthetic devices *(Continued)*	**You pay**
Not covered: • *foot orthotics* • *orthopedic and corrective shoes* • *arch supports* • *heel pads and heel cups* • *lumbosacral supports* • *corsets, trusses, elastic stockings, support hose, and other supportive devices* • *prosthetic replacements*	*All charges*
Durable medical equipment (DME)	
Rental or purchase, at our option, including repair and adjustment, of durable medical equipment prescribed by your Plan physician, such as oxygen and dialysis equipment. Under this benefit, we also cover: • Hospital beds • Wheelchairs • Crutches • Walkers • Insulin pumps	Nothing
Home health services	
• Home health care ordered by a Plan physician and provided by a registered nurse (R.N.), licensed practical nurse (L.P.N.), licensed vocational nurse (L.V.N.), or home health aide. • Services includes intravenous therapy and medications.	$10 per visit
Not covered: • *Nursing care requested by, or for the convenience of, the patient or the patient's family;* • *Home care primarily for personal assistance that does not include a medical component and is not diagnostic, therapeutic, or rehabilitative* .	*All charges*

Chiropractic	You pay
• Chiropractic services • Manipulation of the spine and extremities; • Adjunctive procedures such as ultrasound, electrical muscle stimulation, vibratory therapy, and cold pack application.	$10 per office visit
Alternative treatments	
• No benefit	All charges
Educational classes and programs	
• Smoking cessation - Up to $100 for one (1) smoking cessation program per member per lifetime. • Primary care visits for smoking cessation	Nothing

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

IMPORTANT

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

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan physicians must provide or arrange your care.
- Be sure to read Section 4, *Your costs for covered services* for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- The amounts listed below are for the charges billed by a physician or other health care professional for your surgical care. Look in Section 5(c) for charges associated with the facility (i.e. hospital, surgical center, etc.).
- YOUR PHYSICIAN MUST GET PRECERTIFICATION OF SOME SURGICAL PROCEDURES. Please refer to the precertification information shown in Section 3 to be sure which services require precertification and identify which surgeries require precertification.

IMPORTANT

Benefit Description	
Surgical procedures	**You pay**
A comprehensive range of services, such as: • Operative procedures • Treatment of fractures, including casting • Normal pre- and post-operative care by the surgeon • Endoscopy procedures • Biopsy procedures • Removal of tumors and cysts • Correction of congenital anomalies (see reconstructive surgery) • Surgical treatment of morbid obesity – a condition in which an individual weighs 100 pounds or 100% over his or her normal weight according to current underwriting standards; eligible members must be age 18 or over. • Insertion of internal prosthetic devices. See 5(a) – Orthopedic and prosthetic devices for device coverage information. • Treatment of burns • Voluntary sterilization Note: Generally, we pay for internal prostheses (devices) according to where the procedure is done. For example, we pay Hospital benefits for a pacemaker and Surgery benefits for insertion of the pacemaker.	Nothing for inpatient services; $10 per office visit.
Not covered: • *reversal of voluntary sterilization*	*All charges*

Reconstructive surgery	You pay

• Surgery to correct a functional defect
• Surgery to correct a condition caused by injury or illness if:
  • the condition produced a major effect on the member's appearance and
  • the condition can reasonably be expected to be corrected by such surgery
• Surgery to correct a condition that existed at or from birth and is a significant deviation from the common form or norm. Examples of congenital anomalies are: protruding ear deformities; cleft lip; cleft palate; birth marks; webbed fingers; and webbed toes.
• All stages of breast reconstruction surgery following a mastectomy, such as:
  • surgery to produce a symmetrical appearance on the other breast;
  • treatment of any physical complications, such as lymphedemas;
  • breast prostheses and surgical bras and replacements (see Prosthetic devices)
Note: If you need a mastectomy, you may choose to have the procedure performed on an inpatient basis and remain in the hospital up to 48 hours after the procedure.
	Nothing for inpatient services;
	$10 copay per office visit.

Not covered: • *cosmetic surgery – any surgical procedure (or any portion of a procedure) performed primarily to improve physical appearance through change in bodily form, except repair of accidental injury* • *Surgeries related to sex transformation*	*All charges*

Oral and maxillofacial surgery	You Pay
Oral surgical procedures, such as: • Reduction of fractures of the jaws or facial bones; • Surgical correction of congenital defects such as cleft lip, cleft palate or severe functional malocclusion; • Removal of stones from salivary ducts; • Excision of leukoplakia or malignancies; • Excision of cysts and incision of abscesses when done as independent procedures; • Other surgical procedures that do not involve the teeth or supporting stuctures; • Diagnosis and non-dental treatment of temporomandibular joint (TMJ) pain dysfunction syndrome.	Nothing for inpatient services; $10 copay per office visit.
Not covered: • *procedures that involve the teeth or their supporting structures (such as the periodontal membrane, gingiva, and alveolar bone)* • *dental work related to treatment for temporomandibular joint (TMJ)*	*All charges*

Organ/tissue transplants	You pay
Limited to: • Cornea • Heart • Kidney/Pancreas • Liver • Pancreas • Allogeneic (donor) bone marrow transplants • Autologous bone marrow transplants (autologous stem cell and peripheral stem cell support) for the following conditions: acute lymphocytic or non-lymphocytic leukemia; advanced Hodgkin's lymphoma; advanced non-Hodgkin's lymphoma; advanced neuroblastoma; breast cancer; multiple myeloma; epithelial ovarian cancer; Wiskott-Aldrich syndrome; severe combined immunodeficiency syndrome; aplastic anemia; ewings sarcoma; and testicular, mediastinal, retroperitoneal and ovarian germ cell tumors. • Intestinal transplants (small intestine) and the small intestine with the liver or small intestine with multiple organs such as the liver, stomach, and pancreas. Limited Benefits – Treatment for breast cancer, multiple myeloma, and epithelial ovarian cancer may be provided in an NCI- or NIH-approved clinical trial at a Plan-designated center of excellence and if approved by the Plan's medical director in accordance with the Plan's protocols. Note: We cover related medical and hospital expenses of the donor when we cover the recipient. All transplants must be precertified.	Nothing.
Not covered: • *donor screening tests and donor search expenses, except those performed for the actual donor* • *implants of artificial organs* • *transplants not listed as covered*	*All charges*
Anesthesia	
Professional services provided in – • Hospital (inpatient)	Nothing
Professional services provided in – • Hospital outpatient department • Skilled nursing facility • Ambulatory surgical center	Nothing
Professional services provided in – • Office	$10 per office visit

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

IMPORTANT

Here are some important things to remember about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan physicians must provide or arrange your care and you must be hospitalized in a Plan facility.
- Be sure to read Section 4, *Your costs for covered services* for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- The amounts listed below are for the charges billed by the facility (i.e., hospital or surgical center) or ambulance service for your surgery or care. Any costs associated with the professional charge (i.e., physicians, etc.) are covered in Section 5(a) or (b).
- **YOUR PHYSICIAN MUST GET PRECERTIFICATION OF HOSPITAL STAYS.** Please refer to Section 3 to be sure which services require precertification.

IMPORTANT

Benefit Description	
Inpatient hospital	**You pay**
Room and board, such as • Semiprivate, intensive care or cardiac care accommodations; • General nursing care; • Private accommodations when a Plan doctor determines it is medically necessary; • Private duty nursing when Plan doctor determines medically necessary; 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.	Nothing
Other hospital services and supplies, such as: • Operating, recovery, maternity, and other treatment rooms • Prescribed drugs and medicines • Diagnostic laboratory tests and x-rays • Administration of blood and blood products • 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	Nothing

Inpatient hospital *(Continued)*	**You pay**
Not covered: • *Non-covered facilities, such as nursing homes, schools* • *personal comfort items, such as telephone, television, barber services, guest meals and beds* • *blood and blood derivatives not replaced by the member*	*All charges*
Outpatient hospital or ambulatory surgical center	
• Operating, recovery, and other treatment rooms • Prescribed drugs and medicines • Laboratory tests, x-rays, and pathology services • Administration of blood, blood plasma, and other biologicals • Pre-surgical testing • Dressings, casts, and sterile tray services • Medical supplies, including oxygen • Anesthetics and anesthesia service Note: We cover hospital services and supplies related to dental procedures when necessitated by a non-dental physical impairment. We do not cover the dental procedures.	Nothing
Not covered: blood and blood derivatives not replaced by the member	*All charges*
Extended care benefits/skilled nursing care facility benefits	

Extended care benefit:
• Up to 100 days per calendar year, including
  • bed and board;
  • general nursing care
  • drugs, biologicals, supplies and equipment provided by the facility
Note: Coverage is provided when full-time skilled nursing care is necessary and confinement in a skilled nursing facility is medically appropriate as determined by a Plan doctor and approved by the Plan.
	Nothing

Not covered: custodial care, rest cures, convalescent care	*All charges*

Ambulance	You pay
• Local professional ambulance service when medically appropriate.	Nothing

Section 5 (d). Emergency services/accidents

IMPORTANT

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

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure.
- Be sure to read Section 4, *Your costs for covered services* for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

IMPORTANT

What is a medical emergency?

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

What to do in case of emergency:

Emergencies within our service area: If you are in an emergency situation, please call your primary care doctor. In extreme emergencies, if you are unable to contact your doctor, 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. You or a family member must notify the Plan within 48 hours unless it was not reasonably possible to do so. It is your responsibility to ensure that the Plan has been timely notified.

If you need to be hospitalized, the Plan must be notified within 48 hours or on the first working day following your admission, unless it was not reasonably possible to notify the Plan within that time. If you are hospitalized in non-Plan facilities and 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.

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

To be covered by this Plan, 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 48 hours or on the first working day following your admission, unless it was not reasonably possible to notify the Plan within that time. If a Plan doctor believes 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	
Emergency within our service area	**You pay**
• Emergency care at a doctor's office • Emergency care at an urgent care center	$10 per visit
• Emergency care as an outpatient at a hospital, including doctors' services If the emergency results in an admission to the hospital, the emergency care copay is waived.	$50 per visit
Not covered: elective care or non-emergency care	*All charges*
Emergency outside our service area	
• Emergency care as an outpatient at a hospital, including doctor's services If the emergency results in admission to a hospital, the emergency care copay is waived.	25% of charges up to a $50 maximum per visit
Not covered: • *elective care or non-emergency care* • *emergency care provided outside the service area if the need for care could have been foreseen before leaving the service area* • *medical and hospital costs resulting from a normal full-term delivery of a baby outside the service area*	*All charges*
Ambulance	
• Professional ambulance service when ordered or authorized by a Plan doctor, . See 5(c) for non-emergency service. Note: Air ambulance is covered only when point of pick-up is inaccessible by land vehicle; or great distances or other obstacles are involved in getting a patient to the nearest hospital with appropriate facilities when prompt admission is essential.	Nothing

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

IMPORTANT	When you get our approval for services and follow a treatment plan we approve, cost-sharing and limitations for Plan mental health and substance abuse benefits will be no greater than for similar benefits for other illnesses and conditions. **Here are some important things to keep in mind about these benefits:** • All benefits are subject to the definitions, limitations, and exclusions in this brochure. • Be sure to read Section 4, *Your costs for covered services* for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare. • **YOU MUST GET PREAUTHORIZATION OF THESE SERVICES.** See the instructions after the benefits description below.	IMPORTANT

Description	
Mental health and substance abuse benefits	**You pay**
All diagnostic and treatment services recommended by a Plan provider and contained in a treatment plan that we approve. The treatment plan may include services, drugs, and supplies described elsewhere in this brochure. Note: Plan benefits are payable only when we determine the care is clinically appropriate to treat your condition and only when you receive the care as part of a treatment plan that we approve.	Your cost sharing responsibilities are no greater than for other illness or conditions.
• Professional services, including individual or group therapy by providers such as psychiatrists, psychologists, or clinical social workers • Medication management	$10 per office visit
• Diagnostic tests	Nothing
• Services provided by a hospital or other facility • Services in approved alternative care settings such as partial hospitalization, half-way house, residential treatment, full-day hospitalization, facility based intensive outpatient treatment	Nothing

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

Mental health and substance abuse benefits – *CONTINUED*

Not covered: services we have not approved. *Note:OPM will base its review of disputes about treatment plans on the treatment plan's clinical appropriateness. OPM will generally not order us to pay or provide one clinically appropriate treatment plan in favor of another.*	*All charges*

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Preauthorization

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

- Please contact Magellan Behavioral Health at 1-800/741-1017 to obtain Mental Health/Substance Abuse treatment services.

Limitation

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

Section 5 (f). Prescription drug benefits

IMPORTANT	**Here are some important things to keep in mind about these benefits:** • We cover prescribed drugs and medications, as described in the chart beginning on the next page. • All benefits are subject to the definitions, limitations and exclusions in this brochure and are payable only when we determine they are medically necessary. • Be sure to read Section 4, *Your costs for covered services,* for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.	IMPORTANT

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

- **Who can write your prescription.** A licensed physician must write the prescription.
- **Where you can obtain them.** You must fill the prescription at a plan pharmacy, or by mail for a prescribed maintenance medication. Maintenance medications are drugs that are generally prescribed for the treatment of long term chronic sicknesses or injuries.
- **We use a Drug List.** Our Drug List, is a continually updated list of drug products including strengths, dispensing limits and any prior authorization requirements that represent the current clinical judgment of the members of our Pharmacy and Therapeutics Committee. This committee is comprised of both physicians and pharmacists. The Drug List contains both brand name and generic drugs, all of which have FDA approval. We cover non- Drug List drugs prescribed by a Plan doctor.

  A generic drug is a drug that is manufactured, distributed and available from several pharmaceutical manufacturers and identified by the chemical name; or as defined by the national pricing standard by Us.

  A brand name drug is a drug that is manufactured and distributed by only one pharmaceutical manufacturer; or as defined by the national pricing standard by Us.

  Proposed additions or deletions to the Drug List are welcomed at any time and will be reviewed by the Committee.

- We have an open Drug List. If your physician believe s name brand product is necessary or there is no generic available, your physician may prescribe a name brand drug from a formulary list. This list of name brand drugs is a preferred list of drugs that we selected to meet patient needs at a lower cost. To order a prescription drug brochure, call 1-800/4-HUMANA or 1-800/448-6262.**These are the dispensing limitations.** Prescription drugs dispensed at a Plan pharmacy will be dispensed for up to a 30-day supply. You may receive up to a 90-day supply of a prescribed maintenance medication through our mail-order program. A generic equivalent will be dispensed if it is available, unless your physician specifically requires a name brand. If you receive a name brand drug when a Federally-approved generic drugs is available, and your physician has not specified Dispense as Written for the name brand drug, you have to pay the difference in cost between the name brand drug and the generic.
- **Why use generic drugs?** Generic drugs are lower-priced drugs that are the therapeutic equivalent to more expensive brand-named drugs. They must contain the same active ingredients and must be equivalent in strength and dosage to the original brand-name product. Generics cost less that the equivalent brand-name product. The U.S. Food and Drug Administration sets quality standards for generic drugs to ensure that these drugs meet the same standards of quality and strength as brand-name drugs.

  You can save money by using generic drugs. However, you and your physician have the option to request a name-brand if a generic option is available. Using the most cost-effective medication saves money.

Prescription drug benefits begin on the next page.

Benefit Description	
Covered medications and supplies	**You pay**
We cover the following medications and supplies prescribed by a licensed physician and obtained from a Plan pharmacy or through our mail order program: • Drugs and medicines that by Federal law of the United States require a physician's prescription for their purchase, except those listed as *Not Covered*. • Insulin • Disposable needles and syringes for the administration of covered medications • Diabetic supplies including testing agents, lancet devices, alcohol swabs, glucose elevating agents, insulin delivery devices and blood glucose monitors. • Self administered injectable drugs • Oral fertility drugs. • Oral contraceptive drugs and devices. • Drugs for sexual dysfunction Note: Drugs to treat sexual dysfunction are limited. Contact the Plan for dosage limits. You pay the applicable drug copay up to the dosage limits, and all charges after that.	$5 for generic drugs on our Drug List $20 for brand name drugs with no generic equivalent on our Drug List. $40 for generic or brand name drugs not on our Drug List . 3 applicable copays for a 90-day supply of prescribed maintenance drugs, when ordered through our mail-order program. Note: If there is no generic equivalent available, you will still have to pay the applicable brand name formulary copay.

Covered medications and supplies *(Continued)*	**You pay**
Not covered: • *drugs available without a prescription, or for which there is a non-prescription equivalent available* • *drugs and supplies for cosmetic purposes (such as Rogaine)* • *vitamins, fluoride, nutrients and food supplements even if a physician prescribes or administers them* • *drugs obtained at a non-Plan pharmacy except for out of area emergencies* • *drugs to enhance athletic performance* • *smoking cessation drugs and medications, including nicotine patches* • *any drug used for the purpose of weight control* • *prescriptions that are to be taken by or administered to the member in whole or part, while a patient in a hospital, skilled nursing facility, convalescent hospital, inpatient facility or other facility where drugs are ordinarily provided by the facility on an inpatient basis* • *medical supplies such as dressings and antiseptics*	*All charges*

Section 5 (g). Special Features

Feature	Description
Services for deaf and hearing impaired	Humana offers telecommunication devices for the deaf (TDD) and Teletype (TTY) phone lines for the hearing impaired. Call 1-800-432-7482 to access the service.
High risk pregnancies	HumanaBeginnings is an outreach program that provides high-risk plan members support and educational materials so care can be actively managed during pregnancy.
Centers of excellence for transplants/heart surgery/etc.	Members can use any facility that is within Humana's contracted National Transplant Network. This network has over 35 transplant facilities located in more than 20 states.
Smoking cessation	HumanaHealth offers a telephonic smoking cessation program called "Ready to Quit". Members can call 1-888-QUIT-123 or 1-888-784-8123.
24-hour nurse line	For any of your health concerns, 24 hours a day, 7 days a week, you may call HumanaFirst® at 1-800-622-9529 and talk with a registered nurse who will discuss treatment options and answer your health questions.

Section 5 (h). Dental benefits

IMPORTANT

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

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan dentists must provide or arrange your care.
- We cover hospitalization for dental procedures only when a nondental physical impairment exists which makes hospitalization necessary to safeguard the health of the patient; 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.

IMPORTANT

Accidental injury benefit	You pay
We cover restorative services and supplies necessary to promptly repair (but not replace) sound natural teeth. The need for these services must result from an accidental injury.	Nothing

Dental benefits
We have no other dental benefits.

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

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

Expanded dental benefits

- **DEN-988**
  - Additional premium of $92.75 per member per year.
  - Diagnostic and most preventive services provided at no charge when received from participating general dentists. Other services including restorative care, endodontics, periodontics, prosthodontics, oral surgery, as provided by participating general dentists, are offered at copayments listed in the separate plan description. When you receive services from a participating specialist, you will receive a 20% discount off of their charges.
  - Administered by HumanaDental 1-800-955-0782

CREDIT CARD PAYMENT NOW AVAILABLE.
See application for details.

- **DEN-997**
  - All dental services at discounted fees as listed in the separate plan description. Services available from general dentist only.
  - No additional premium required; no application to complete.
  - Administered by HumanaDental 1-800-720-9548.

Vision care

- **VIS-920**
  - Examinations, glasses and contact lenses are available after copayments.
  - No additional premium required.

- **Vision One Discount Program**
  - Discounts available at participating providers for eye exams, frames and lenses. (see separate plan description on how to locate a provider nearest you).
  - Mail Order Contact Lens Replacement Program
  - Vision Correction (LASIK or PRK) for less than $1,000 per eye. (see separate Plan description on how to receive the discount)
  - No additional premium required.

Contact us for additional information concerning specific benefits, exclusions, limitations, eligible providers and other provisions of each of the above coverages.

Medicare prepaid plan enrollment – This plan offers Medicare recipients the opportunity to enroll in the Plan through Medicare. As indicated on page 45, annuitants and former spouses with FEHB coverage and Medicare Part B may elect to drop their FEHB coverage and enroll in a Medicare prepaid plan when one is available in their area. They may then later reenroll in the FEHB program. Most Federal annuitants have Medicare Part A. Those without Medicare Part A may join this Medicare prepaid plan, but will probably have to pay for hospital coverage in addition to the Part B premium. Before you join the plan, ask whether the plan covers hospital benefits and, if so, what you will have to pay. Contact your retirement system for information on dropping your FEHB enrollment and changing to a Medicare prepaid plan. Contact us at 1-888-393-6765 for information on the Medicare prepaid plan and the cost of that enrollment.

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

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

We do not cover the following:

- Care by non-Plan providers except for authorized referrals or emergencies (see Emergency Benefits);
- Services, drugs, or supplies you receive while you are not enrolled in this Plan;
- Services, drugs, or supplies that are not medically necessary;
- Services, drugs, or supplies not required according to accepted standards of medical, dental, or psychiatric practice;
- Experimental or investigational procedures, treatments, drugs or devices;
- Services, drugs, or supplies related to abortions, except when the life of the mother would be endangered if the fetus were carried to term;
- Services, drugs, or supplies related to sex transformations; or
- Services, drugs, or supplies you receive from a provider or facility barred from the FEHB Program.

Section 7. Filing a claim for covered services

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

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

Medical 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. Facilities will file on the UB-92 form. For claims questions and assistance, call us at 1-800/426-2173.

When you must file a claim – such as for out-of-area care – 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: **Humana Medical Plan, Inc.**
P.O. Box 14602
Lexington, Kentucky 40512-4602

Deadline for filing your claim

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

When we need more information

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

Section 8. The disputed claims process

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

Step	Description
1	Ask us in writing to reconsider our initial decision. You must: (a) Write to us within 6 months from the date of our decision; and (b) Send your request to us at: Humana Medical Plan, Inc., P.O. Box 19080F, Jacksonville, FL 32245-9080; and (c) Include a statement about why you believe our initial decision was wrong, based on specific benefit provisions in this brochure; and (d) Include copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms.
2	We have 30 days from the date we receive your request to: (a) Pay the claim (or, if applicable, arrange for the health care provider to give you the care); or (b) Write to you and maintain our denial – go to step 4; or (c) Ask you or your provider for more information. If we ask your provider, we will send you a copy of our request – go to step 3.
3	You or your provider must send the information so that we receive it within 60 days of our request. We will then decide within 30 more days. If we do not receive the information within 60 days, we will decide within 30 days of the date the information was due. We will base our decision on the information we already have. We will write to you with our decision.
4	If you do not agree with our decision, you may ask OPM to review it. You must write to OPM within: • 90 days after the date of our letter upholding our initial decision; or • 120 days after you first wrote to us – if we did not answer that request in some way within 30 days; or • 120 days after we asked for additional information. Write to OPM at: Office of Personnel Management, Office of Insurance Programs, Contracts Division 3, 1900 E Street, NW, Washington, DC 20415-3630.

The disputed claims process – Continued on next page

Step	Description

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 different claims, you must clearly identify which documents apply to which claim.

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

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

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

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

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

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

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

(a) We haven't responded yet to your initial request for care or preauthorization/prior approval, then call us at 1-800/426-2173 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 can call OPM's Health Benefits Contracts Division 3 at 202/606-0737 between 8 a.m. and 5 p.m. eastern time.

Section 9. Coordinating benefits with other coverage

When you have other health coverage

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

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

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

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

• What is Medicare?

Medicare is a Health Insurance Program for:

- People 65 years of age and older.
- Some people with disabilities, under 65 years of age.
- People with end-stage renal disease (permanent kidney failure requiring dialysis or a transplant).

Medicare has two parts:

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

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

• The Original Medicare Plan (Part A or Part B)

The Original Medicare Plan (Original Medicare) is available everywhere in the United States. It is the way everyone used to get Medicare benefits and it is the way most people get their Medicare Part A and Part B benefits now. You may go to any doctor, specialist, or hospital that accepts Medicare. The Original Medicare Plan pays its share and you pay your share. Some things are not covered under Original Medicare, like prescription drugs.

When you are enrolled in Original Medicare along with this Plan, you still need to follow the rules in this brochure for us to cover your care. Your care must continue to be authorized by your Plan PCP.

We will not waive any of our copayments or coinsurance.

Tell us if you or a family member is enrolled in Medicare Part A or B. Medicare will determine who is responsible for paying medical services and we will coordinate the payments. On occasion, you may need to file a Medicare claim form.

(Primary payer chart begins on next page.)

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

Primary Payer Chart		
A. When either you – or your covered spouse – are age 65 or over and …	**Then the primary payer is…**	
	Original Medicare	**This Plan**
1) Are an active employee with the Federal government (including when you or a family member are eligible for Medicare solely because of a disability),		✓
2) Are an annuitant,	✓	
3) Are a reemployed annuitant with the Federal government when… a) The position is excluded from FEHB,	✓	
b) Or the position is not excluded from FEHB (Ask your employing office which of these applies to you.)		✓
4) Are a Federal judge who retired under title 28, U.S.C., or a Tax Court judge who retired under Section 7447 of title 26, U.S.C. (or if your covered spouse is this type of judge),	✓	
5) Are enrolled in Part B only, regardless of your employment status,	✓ (for Part B services)	✓ (for other services)
6) Are a former Federal employee receiving Workers' Compensation and the Office of Workers' Compensation Programs has determined that you are unable to return to duty,	✓ (except for claims related to Workers' Compensation.)	
B. When you – or a covered family member – have Medicare based on end stage renal disease (ESRD) and…		
1) Are within the first 30 months of eligibility to receive Part A benefits solely because of ESRD,		✓
2) Have completed the 30-month ESRD coordination period and are still eligible for Medicare due to ESRD,	✓	
3) Become eligible for Medicare due to ESRD after Medicare became primary for you under another provision,	✓	
C. When you or a covered family member have FEHB and…		
1) Are eligible for Medicare based on disability, a) Are an annuitant, or	✓	
b) Are an active employee		✓
c) Are a former spouse of an annuitant, or	✓	
d) Are a former spouse of an active employee		✓

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

- When we are the primary payer, we process the claim first.
- When Original Medicare is the primary payer, Medicare processes your claim first. In most cases, your claims will be coordinated automatically and we will pay the balance of covered charges. You will not need to do anything. To find out if you need to do something about filing your claims, contact us at 1-800/426-2173.

We will not waive costs when you have the Original Medicare Plan – When Original Medicare is the primary payer, we will not waive out-of-pocket costs.

- **Medicare managed care plan**

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

This Plan and our Medicare managed care plan: You may enroll in our Medicare managed care plan and also remain enrolled in our FEHB plan. In this case, we do not waive any of our copayments, coinsurance, or deductibles for your FEHB coverage.

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

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

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

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

TRICARE

TRICARE is the health care program for eligible dependents of military persons, and retirees of the military. TRICARE includes the CHAMPUS program. If both TRICARE and this Plan cover you, we pay first. See your TRICARE Health Benefits Advisor if you have questions about TRICARE coverage.

Workers' Compensation

We do not cover services that:

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

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

Medicaid

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

When other Government agencies are responsible for your care

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

When others are responsible for injuries

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

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

Section 10. Definitions of terms we use in this brochure

Calendar year

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

Coinsurance

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

Copayment

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

Covered services

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

Custodial care

Services provided to you such as assistance with dressing, bathing, preparation and feeding of special diets, walking, supervision of medication which is ordinarily self-administered, getting in and out of bed, and maintaining continence and are not likely to improve your condition.

Durable Medical Equipment (DME)

Equipment recognized as such by Medicare Part B, that meets all of the following criteria:

- it can stand repeated use; and
- it is primarily and customarily used to serve a medical purpose rather than being primarily for comfort or convenience; and
- it is usually not useful to a person in the absence of Sickness or Injury; and
- it is appropriate for home use; and
- it is related to the patient's physical disorder; and the equipment must be used in the Member's home.

Experimental or investigational services

A drug, biological product, device, medical treatment, or procedure is determined to be experimental or investigational if reliable evidence shows it meets one of the following criteria:

- when applied to the circumstances of a particular patient is the subject of ongoing phase I, II or III clinical trials, or
- when applied to the circumstances of a particular patient is under study with written protocol to determine maximum tolerated dose, toxicity, safety, efficacy, or efficacy in comparison to conventional alternatives, or
- is being delivered or should be delivered subject to the approval and supervision of an Institutional Review Board as required and defined by the USFDA or Department of Health and Human Services
- is not generally accepted by the medical community

Reliable evidence means, but is not limited to, published reports and articles in authoritative medical scientific literature or regulations and other official actions and publications issued by the USFDA or the Department of Health and Human Services.

Medical necessity	Services necessary for the treatment or product that a licensed Physician or licensed healthcare provider would provide his or her patient for the purpose of diagnosing, treating a sickness, illness, disease or its symptoms.
Morbid Obesity	Morbid or clinically severe obesity correlated with a Body Mass Index (BMI) or 40k/m2 or with being 100 pounds over ideal body weight.
Oral Surgery	Procedures to correct diseases, injuries and defects of the jaw and mouth structures.
Participating Provider	A Hospital, Physician, or any other health services provider who has been designated to provide services to covered members under this plan.
Service Area	The geographic area where the Participating Provider services are available to covered members.
Transplant	Services for pre-transplant; the transplant including any chemotherapy, associated services and post-discharge services, and treatment of complications after transplant.
Us/We	Us and we refer to Humana Medical Plan, Inc.
You	You refers to the enrollee and each covered family member.

Section 11. FEHB facts

No pre-existing condition limitation

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

Where you can get information about enrolling in the FEHB Program

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

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

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

Types of coverage available for you and your family

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

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

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

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

When benefits and premiums start

The benefits in this brochure are effective on January 1. If you joined this Plan during Open Season, your coverage begins on the first day of your first pay period that starts on or after January 1. Annuitants coverage and premiums begin on January 1. If you joined at any other time during the year, your employing office will tell you the effective date of coverage.

Your medical and claims records are confidential

We will keep your medical and claims information confidential. Only the following will have access to it:

- OPM, this Plan, and subcontractors when they administer this contract;
- This Plan and appropriate third parties, such as other insurance plans and the Office of Workers' Compensation Programs (OWCP), when coordinating benefit payments and subrogating claims;
- Law enforcement officials when investigating and/or prosecuting alleged civil or criminal actions;
- OPM and the General Accounting Office when conducting audits;
- Individuals involved in bona fide medical research or education that does not disclose your identity; or
- OPM, when reviewing a disputed claim or defending litigation about a claim.

When you retire

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

When you lose benefits

- **When FEHB coverage ends**

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

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

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

- **Spouse equity coverage**

If you are divorced from a Federal employee or annuitant, you may not continue to get benefits under your former spouse's enrollment. But, you may be eligible for your own FEHB coverage under the spouse equity law. If you are recently divorced or are anticipating a divorce, contact your ex-spouse's employing or retirement office to get RI 70-5, the *Guide to Federal Employees Health Benefits Plans for Temporary Continuation of Coverage and Former Spouse Enrollees*, or other information about your coverage choices.

- **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 job, if you are a covered dependent child and you turn 22 or marry.

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

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

- **Converting to individual coverage**

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

- Your coverage under TCC or the spouse equity law ends. (If you canceled your coverage or did not pay your premium, you cannot convert);
- You decided not to receive coverage under TCC or the spouse equity 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 protectionsfor 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 indicate 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 FEHP Program. See also the FEHBP web site (www.opm.gov/insure/health): refer to the "TCC and HIPAA" frequently asked question. These highlight HIPAA rules, such as the requirement that Federal employees must exhaust any TCC eligibility as one condition for guaranteed access to individual health coverage under HIPAA, and have information about Federal and State agencies you can contact for more information.

Long Term Care Insurance Is Coming Later in 2002!

- Many FEHB enrollees think that their health plan and/or Medicare will cover their long-term care needs. Unfortunately, they are *WRONG*!
- How are YOU planning to pay for the future custodial or chronic care you may need?
- You should consider buying long-term care insurance.

The Office of Personnel Management (OPM) will sponsor a high-quality long term care insurance program effective in October 2002. As part of its educational effort, OPM asks you to consider these questions:

What is long term care (LTC) insurance?

- It's insurance to help pay for long term care services you may need if you can't take care of yourself because of an extended illness or injury, or an age-related disease such as Alzheimer's.
- LTC insurance can provide broad, flexible benefits for nursing home care, care in an assisted living facility, care in your home, adult day care, hospice care, and more. *LTC insurance can supplement care provided by family members, reducing the burden you place on them.*

I'm healthy. I won't need long term care. Or, will I?

- Welcome to the club!
- 76% of Americans believe they will never need long term care, but the facts are that about half of them will. And it's not just the old folks. About 40% of people needing long term care are under age 65. They may need chronic care due to a serious accident, a stroke, or developing multiple sclerosis, etc.
- We hope you will never need long term care, but everyone should have a plan just in case. *Many people now consider long term care insurance to be vital to their financial and retirement planing.*

Is long term care expensive?

- Yes, it can be very expensive. A year in a nursing home can exceed $50,000. Home care for only three 8- hour shifts a week can exceed $20,000 a year. And that's before inflation!
- Long term care can easily exhaust your savings. *Long term care insurance can protect your savings.*

But won't my FEHB plan, Medicare or Medicaid cover my long term care?

- Not FEHB. Look at the "*Not covered*" blocks in sections 5(a) and 5(c) of your FEHB brochure. Health plans don't cover custodial care or a stay in an assisted living facility or a continuing need for a home health aide to help you get in and out of bed and with other activities of daily living. Limited stays in skilled nursing facilities can be covered in some circumstances.
- Medicare only covers skilled nursing home care (the highest level of nursing care) after a hospitalization for those who are blind, age 65 or older or fully disabled. It also has a 100 day limit.
- Medicaid covers long term care for those who meet their state's poverty guidelines, but has restrictions on covered services and where they can be received. *Long term care insurance can provide choices of care and preserve your independence.*

When will I get more information on how to apply for this new insurance coverage?

- Employees will get more information from their agencies during the LTC open enrollment period in the late summer/early fall of 2002.
- Retirees will receive information at home.

How can I find out more about the program NOW?

- Our toll-free teleservice center will begin in mid-2002. In the meantime, you can learn more about the program on our web site at www.opm.gov/insure/ltc.

Index

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

Allergy care 17
Alternative treatment 22
Allogenetic (donor) bone marrow transplant……26
Ambulance..... 29 31
Anesthesia 26-28
Autologous bone marrow transplant 26
Blood and blood plasma 27-28
Blood glucose monitor 35
Breast cancer screening 14-15
Casts 27-28
Changes for 2002..... 8
Chemotherapy 18

Chiropractic 22
Cholesterol tests 15
Claims..... 41
Coinsurance 12, 49
Colorectal cancer screening..... 15
Congenital anomalies 24
Contraceptive devices and drugs 17, 35
Coordination of benefits 44-48
Copayment..... 12, 49
Covered services..... 49
Covered providers 6, 9
Crutches..... 21
Definitions 49
Dental care..... 38
Diagnostic services..... 14, 27
Dialysis..... 18, 21
Disputed claims review 42-43
Donor expenses (transplants)..... 26
Dressings 27-28
Durable medical equipment (DME) 21
Effective date of enrollment..... 51
Emergency..... 30-31
Experimental or investigational.. 49
Eyeglasses 19-20
Family planning 17
Fecal occult blood test..... 15
Foot care..... 20
General Exclusions..... 40
Growth hormone therapy..... 18
Hearing services 19
Home health services..... 14, 21
Home nursing care..... 21
Hospital 27-28
Immunizations 15-16
Infertility..... 17
Inhospital physician care 14, 23
Inpatient Hospital Benefits 27-28
Insulin 35
Insulin pumps 21
Laboratory and pathological services 14, 27-28
Machine diagnostic tests..... 14, 27-28
Magnetic Resonance Imagings (MRIs) 14
Mail-order prescription drugs 34-35
Mammograms 14-15
Maternity Benefits 8-9, 15, 25
Medicaid 48
Medical necessity 50
Medicare 44-47
Mental Conditions/Substance Abuse Benefits 32-33
Newborn care..... 16
Non-FEHB Benefits 39
Nurse
  Licensed Practical Nurse 21
  Licensed Vocational Nurse..... 21
  Nurse Anesthetist..... 26
  Registered Nurse..... 21
Obstetrical care 10, 16
Occupational therapy 19
Office visits 14
Oral and maxillofacial surgery 25
Orthopedic devices 20-21
Out-of-pocket expenses 12
Outpatient facility care 28
Oxygen 27-28
Pap test 14-15
Physical examination 15-16
Physical therapy..... 19
Physician..... 9
Preventive care, adult 15
Preventive care, children 16
Prescription drugs 34-36
Preventive services 16
Prior approval 11
Prostate cancer screening..... 15
Prosthetic devices 20-21
Psychologist..... 32
Radiation therapy..... 18
Room and board..... 27-28
Second surgical opinion..... 14
Skilled nursing facility care 28
Smoking cessation 22
Speech therapy..... 19
Splints 27-28
Sterilization procedures 17
Subrogation..... 48
Substance abuse 32-33
Surgery..... 23-26
  • Anesthesia..... 26
  • Oral 25
  • Outpatient 23
  • Reconstructive 24
Syringes 35
Temporary continuation of coverage 52
Transplants..... 26
Treatment therapies 18
Vision services..... 19-20
Walkers..... 21
Well child care..... 16
Wheelchairs 21
Workers' compensation 48
X-rays 14, 27-28

NOTES:

Summary of benefits for Humana Medical Plan, Inc. – 2002

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

Benefits	You Pay	Page
Medical services provided by physicians:		
• Diagnostic and treatment services provided in the office	Office visit copay: $10 primary care; $10 specialist	14
Services provided by a hospital:		
• Inpatient	Nothing	27-28
• Outpatient	Nothing	28
Emergency benefits:		
• In-area	$50 per visit	31
• Out-of-area	25% of charges up to a $50 maximum per visit.	31
Mental health and substance abuse treatment	Regular cost sharing	32-33
Prescription drugs:		
• Generic listed drugs	$5 copay	35
• Brand name listed drugs	$20 copay	35
• Non listed drugs	$40 copay	35
• Maintenance drugs (90-day supply) when ordered through our mail-order program	3 applicable copays	35
Dental Care		
• Accidental injury benefit	Nothing	38
Vision Care	No benefit	20
Special features: *TDD and TTY phone lines; HumanaBeginnings; National Transplant Network; HumanaHealth and HumanaFirst®*		37
Out-of-pocket maximum	Nothing after $1,500/per person or $3,000/Family enrollment per year. Some costs do not count toward this maximum.	12

2002 Rate Information for
Humana Medical Plan, Inc.

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

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

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

		Non-Postal Premium				Postal Premium	
		Biweekly		Monthly		Biweekly	
Type of Enrollment	Code	Gov't Share	Your Share	Gov't Share	Your Share	USPS Share	Your Share
Self Only	EE1	$79.88	$26.62	$173.06	$57.69	$94.52	$11.98
Self and Family	EE2	$199.69	$66.56	$432.66	$144.22	$236.30	$29.95