Humana CoverageFirst

http://feds.humana.com

HUMANA®

2004

A Consumer Driven Individual Practice Plan

Serving: The following metropolitan areas - Phoenix, Arizona; Jacksonville, Tampa, and South Florida; Chicago, Illinois; Kansas City, Kansas/Missouri; Louisville, Kentucky; Cincinnati, Ohio; Memphis, Tennessee; Austin, Corpus Christi, Dallas, Houston and San Antonio, Texas; and Milwaukee, Wisconsin

Who may enroll in this Plan: You must live or work in our geographic service area to enroll. See page 8 for details.

Enrollment codes for **Phoenix, AZ**:
- **DB1** Self Only
- **DB2** Self and Family

Enrollment codes for **Jacksonville, FL**:
- **MQ1** Self Only
- **MQ2** Self and Family

Enrollment codes for **Tampa, FL**:
- **MJ1** Self Only
- **MJ2** Self and Family

Enrollment codes for **South Florida**:
- **QP1** Self Only
- **QP2** Self and Family

Enrollment codes for **Chicago, IL**:
- **MW1** Self Only
- **MW2** Self and Family

Enrollment codes for **Kansas City, KS/MO**:
- **PH1** Self Only
- **PH2** Self and Family

Enrollment codes for **Louisville, KY**:
- **BM1** Self Only
- **BM2** Self and Family

Enrollment codes for **Cincinnati/Dayton, OH**:
- **L81** Self Only
- **L82** Self and Family

Enrollment codes for **Memphis, TN**:
- **L61** Self Only
- **L62** Self and Family

Enrollment codes for **Austin, TX**:
- **TV1** Self Only
- **TV2** Self and Family

Enrollment codes for **Corpus Christi, TX**:
- **TP1** Self Only
- **TP2** Self and Family

Enrollment codes for **Dallas/Ft. Worth, TX**:
- **T81** Self Only
- **T82** Self and Family

Enrollment codes for **Houston, TX**:
- **T21** Self Only
- **T22** Self and Family

Enrollment codes for **San Antonio, TX**:
- **TU1** Self Only
- **TU2** Self and Family

Enrollment codes for **Milwaukee, WI**:
- **FB1** Self Only
- **FB2** Self and Family

Special notice: This Plan is offered for the first time under the Federal Employees Health Benefits Program during the 2003 Open Season.

Authorized for distribution by the:

United States
Office of Personnel Management

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

FEHB
Federal Employees
Health Benefits Program

RI 73-829

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

OFFICE OF THE DIRECTOR

Dear Federal Employees Health Benefits Program Participant:

I am pleased to present this 2004 Federal Employees Health Benefits (FEHB) Program plan brochure. The brochure describes the benefits this plan offers you for 2004. Because benefits vary from year to year, you should review your plan's brochure every Open Season - especially Section 2, which explains how the plan changed.

It takes a lot of information to help a consumer make wise healthcare decisions. The information in this brochure, our FEHB Guide, and our web-based resources, make it easier than ever to get information about plans, to compare benefits and to read customer service satisfaction ratings for the national and local plans that may be of interest. Just click on www.opm.gov/insure!

The FEHB Program continues to be an enviable national model that offers exceptional choice, and uses private-sector competition to keep costs reasonable, ensure high-quality care, and spur innovation. The Program, which began in 1960, is sound and has stood the test of time. It enjoys one of the highest levels of customer satisfaction of any healthcare program in the country.

I continue to take aggressive steps to keep the FEHB Program on the cutting edge of employer-sponsored health benefits. We demand cost-effective quality care from our FEHB carriers and we have encouraged Federal agencies and departments to pay the full FEHB health benefit premium for their employees called to active duty in the Reserve and National Guard so they can continue FEHB coverage for themselves and their families. Our carriers have also responded to my request to help our members to be prepared by making additional supplies of medications available for emergencies as well as call-up situations and you can help by getting an Emergency Preparedness Guide at www.opm.gov. OPM's *HealthierFeds* campaign is another way the carriers are working with us to ensure Federal employees and retirees are informed on healthy living and best-treatment strategies. You can help to contain healthcare costs and keep premiums down by living a healthy life style.

Open Season is your opportunity to review your choices and to become an educated consumer to meet your healthcare needs. Use this brochure, the FEHB Guide, and the web resources to make your choice an informed one. Finally, if you know someone interested in Federal employment, refer them to www.usajobs.opm.gov.

Sincerely,

Kay Cole James
Director

Notice of the Office of Personnel Management's

Privacy Practices

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

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

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

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

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

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

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

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

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

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

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

information that you authorized OPM to release, or that was given out for law enforcement purposes or to pay for your health care or a disputed claim.

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

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

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

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

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

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

Table of Contents

Introduction

This brochure describes the benefits of Humana CoverageFirst, under our contract (CS 2887) with the Office of Personnel Management (OPM), as authorized by the Federal Employees Health Benefits law. This plan is underwritten by Humana Health Plan Inc., Humana Health Insurance Company of Florida, Inc., and Humana Insurance Company. The address for CoverageFirst administrative offices is:

Humana Inc.
500 West Main
Louisville, KY 40201

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

If you are enrolled in this Plan, you are entitled to the benefits described in this brochure. If you are enrolled 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, 2004, unless those benefits are also shown in this brochure.

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

Plain Language

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

- Except for necessary technical terms, we use common words. For instance, "you" means the enrollee or family member; "we" means Humana CoverageFirst.
- 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 e-mail OPM at fehbpwebcomments@opm.gov. You may also write to OPM at the Office of Personnel Management, Insurance Services Program, Program Planning & Evaluation Group, 1900 E Street, NW, Washington, DC 20415-3650.

Stop Health Care Fraud!

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

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

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

- Be wary of giving your plan identification (ID) number over the telephone or to people you do not know, except to your doctor, other provider, or authorized plan or OPM representative.
- Let only the appropriate medical professionals review your medical record or recommend services.

- Avoid using health care providers who say that an item or service is not usually covered, but they know how to bill us to get it paid.
- Carefully review explanations of benefits (EOBs) that you receive from us.
- Do not ask your doctor to make false entries on certificates, bills or records in order to get us to pay for an item or service.
- If you suspect that a provider has charged you for services you did not receive, billed you twice for the same service, or misrepresented any information, do the following:
    - Call the provider and ask for an explanation. There may be an error.
    - If the provider does not resolve the matter, call us at 1-800/4HUMANA and explain the situation.
    - If we do not resolve the issue:

CALL – THE HEALTH CARE FRAUD HOTLINE

202-418-3300

OR WRITE TO:

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

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

Preventing Medical Mistakes

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

1. **Ask questions if you have doubts or concerns.**
    - Ask questions and make sure you understand the answers.
    - Choose a doctor with whom you feel comfortable talking.
    - Take a relative or friend with you to help you ask questions and understand answers.
2. **Keep and bring a list of all the medicines you take.**
    - Give your doctor and pharmacist a list of all the medicines that you take, including non-prescription medicines.
    - Tell them about any drug allergies you have.

- Ask about side effects and what to avoid while taking the medicine.
- Read the label when you get your medicine, including all warnings.
- Make sure your medicine is what the doctor ordered and know how to use it.
- Ask the pharmacist about your medicine if it looks different than you expected.

3. **Get the results of any test or procedure.**
   - Ask when and how you will get the results of tests or procedures.
   - Don't assume the results are fine if you do not get them when expected, be it in person, by phone, or by mail.
   - Call your doctor and ask for your results.
   - Ask what the results mean for your care.
4. **Talk to your doctor about which hospital is best for your health needs.**
   - Ask your doctor about which hospital has the best care and results for your condition if you have more than one hospital to choose from to get the health care you need.
   - Be sure you understand the instructions you get about follow-up care when you leave the hospital.
5. **Make sure you understand what will happen if you need surgery.**
   - Make sure you, your doctor, and your surgeon all agree on exactly what will be done during the operation.
   - Ask your doctor, "Who will manage my care when I am in the hospital?"
   - Ask your surgeon:
     Exactly what will you be doing?
     About how long will it take?
     What will happen after surgery?
     How can I expect to feel during recovery?
   - Tell the surgeon, anesthesiologist, and nurses about any allergies, bad reaction to anesthesia, and any medications you are taking.

Want more information on patient safety?

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

Section 1. Facts about this plan

This Plan is a Consumer Driven Individual Practice Plan. This Plan allows you to choose your own physicians, hospitals and other health care providers. Members can use Participating Providers or Non Participating Providers and no referrals are necessary.

When you use Participating Providers

When you use participating providers, you receive the highest level of benefits, with less out of pocket expenses. You will not have to submit claim forms. You pay only the copayments, coinsurance, and deductibles described in this brochure.

The Plan pays the first $500 of covered medical services for each person enrolled. We call this your benefit allowance. While using the $500 benefit allowance you are only responsible for the applicable copayments. You do not have to submit receipts for reimbursement. The benefit allowance can only be used to pay for covered medical services from participating providers. Any benefit allowance that remains at the end of the Plan year cannot be "rolled over" or "cashed out."

The following services do not reduce your $500 benefit allowance:

> **Preventive Care** services are separate and do not apply toward the benefit allowance. Your copayments are the only out of pocket costs for these covered benefits. The costs of the services are not subject to the deductible.
>
> **Prescription Drug** copayments do not apply toward your benefit allowance. You are responsible only for any applicable copayments or coinsurance when you use a participating provider. You do not have to satisfy a deductible.

Once your expenses reach the $500 benefit allowance, you pay for medical services until you meet the deductible. After you meet the deductible, the Plan pays for most or all of the covered services that you receive. Your payments and the Plan's payments are based on Humana CoverageFirst's contracted rates.

Routine physician office visit benefits are excluded from the deductible. You will only be responsible for the applicable copayment throughout the plan year, even if your benefit allowance has been depleted. The copayment covers services billed as an office visit or consultation. Other services provided in the physician's office, such as lab work, X-rays and surgery, are still subject to the deductible.

When you use Non-Participating Providers

When you use a non-participating provider, we will pay benefits at a lower level and you will pay a larger share of the costs. Since non-participating providers have not agreed to accept discounted or negotiated fees as payment in full, they may balance bill you for charges in excess of the allowable amount. You will be responsible for charges in excess of the allowable amount in addition to any applicable deductible or coinsurance. Any amount that you pay to a non-participating provider in excess of your coinsurance (percentage of the allowable fee) will not apply to your out of pocket limit or deductible. There is no benefit allowance when you use non-participating providers.

How we pay providers

Participating Providers: We contract with physicians, health care facilities, or other health care professionals to provide the benefits in this brochure. These plan providers accept a negotiated payment from us based on a maximum allowable fee schedule. They will not bill you and you will not have to file claim forms. You will only be responsible for your copayments, coinsurance and deductibles.

Non-Participating Providers: Humana uses the maximum allowable fee schedule agreed to by us and network physicians. The schedules are based on a percentage of the Health Insurance Association of America (HIAA) fee schedule.

You will be responsible for any difference between the amount non-participating providers charge and our allowance, in addition to the applicable coinsurance and copayment amounts. Any amount that you pay to the provider in excess of the allowed amount will not apply to your out of pocket maximum deductible.

Your Rights

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

- Medical case management is a special Humana program that coordinates the provision of care and the management of benefits 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 subscribes to preventive care guidelines based on the United States Preventive Health Task Force and subscribes to their Healthy People 2010 goals. Our Patterns of Preventive 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.
- 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 1-800/448-6262. You may also contact us by visiting our website at feds.humana.com.

Service Area

To enroll in this plan you must live or work in our service areas. This is where our providers practice.

Arizona, Phoenix – Enrollment code **DB** - Maricopa County

Florida, Jacksonville – Enrollment code **MQ** - Nassau, Duval, Clay, St. John's, Alachua, Bradford, Union, Baker, Columbia, and Putnam counties.

Florida, Tampa – Enrollment code **MJ** - Pinellas, Hillsborough, Polk, Manatee, Sarasota, Pasco, Hernando, and Citrus counties.

Florida, South Florida – Enrollment code **QP** - Dade, Broward, Palm Beach, Martin, St. Lucie, Indian River, and Okeechobee counties.

Illinois, Chicago – Enrollment code **MW** - The Illinois counties of McHenry, Lake, Kane, DuPage, Cook, Will, Kendall and Kankakee. The Indiana counties of Lake, Porter, and LaPorte.

Kansas/Missouri, Kansas City – Enrollment code **PH** - The Missouri counties of Carroll, Lafayette, Johnson, Henry, Ray, Bates, Cass, Jackson, Clay and Platte. The Kansas counties of Miami, Johnson, Leavenworth and Wyandotte.

Kentucky, Louisville – Enrollment code **BM** - The Kentucky counties of Jefferson, Oldham, Henry, Trimble, Carroll, Shelby, Spencer, Bullitt, Nelson, Washington, Marion, Green, Taylor, Hart, Larue, Hardin, Meade, Breckinridge, Grayson, Barren, Metcalfe, Monroe, Allen, Warren, Simpson, Edmonson, Butler, Logan, Daviess, and Hancock. The Indiana counties of Harrison, Floyd, Clark, Washington, Scott, and Jefferson.

Ohio, Cincinnati – Enrollment code **L8** - The Ohio counties of Hamilton, Clermont, Brown, Adams, Butler, Warren, Clinton, Greene, Montgomery, Preble, Miami, Clark, and Champaign. The Kentucky counties of Boone, Kenton, Campbell, Pendleton, Grant, and Gallatin.

Tennessee, Memphis – Enrollment code **L6** - Dyer, Fayette, Gibson, Haywood, Lauderdale, Shelby, and Tipton counties.

Texas, Austin – Enrollment code **TV** - Bosque, Hamilton, Coryell, Lampasas, McLennan, Limestone, Robertson, Bell, Falls, Milam, Burleson, Lee, Bastrop, Caldwell, Hays, Travis, Williamson, and Burnet counties.

Texas, Corpus Christi – Ennrollment code **TP** - DeWitt, Victoria, Goliad, Bee, Live Oak, Refugio, San Patricio, Nueces, Jim Wells, Duval, Kleberg, Brooks, Kenedy, Jim Hogg, Zapata, Starr, Hidalgo, Willacy, and Cameron counties.

Texas, Dallas – Enrollment code **T8** - Collin, Dallas, Denton, Ellis, Hood, Hunt, Johnson, Kaufman, Parker, Rockwall, Tarrant, Grayson, Navarro, Hill, Somervell, Wise, and Cooke counties

Texas, Houston – Enrollment code **T2** - Madison, Grimes, Washington, Austin, Montgomery, Harris, Liberty, Hardin, Chambers, Jefferson, Orange, Galveston, Brazoria, Fort Bend, Wharton, Colorado, Waller, and Fayette counties.

Texas, San Antonio – Enrollment code **TU** - Blanco, Kendall, Comal, Guadalupe, Gonzales, Wilson, Karnes, Atascosa, Frio, Medina, Uvalde, Bandera, Webb, and Bexar counties.

Wisconsin, Milwaukee – Enrollment code **FB** - Dodge, Green, Jefferson, Kenosha, Milwaukee, Ozaukee, Racine, Rock, Walworth, Washington, Waukesha, Fond du Lac, Manitowoc, and Sheboygan counties.

Section 2. We are a new plan

This Plan is new to the FEHB Program. We are being offered for the first time during the 2003 open season.

Program-wide changes

- We added information regarding two new Federal Programs that complement FEHB benefits, the Federal Flexible Spending Account Program – FSAFEDS, and the Federal Long Term Care Insurance Program. See pages 56-59.
- We added information regarding Preventing medial mistakes. See pages 5-6.
- We added information regarding enrolling in Medicare. See pages 45-46.
- We revised the Medicare Primary Payer Chart. See page 47.

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 1-800/4HUMANA or 1-800/448-6262. You may also request replacement cards through our website at feds.humana.com.

Where you get covered care

You can get care from any "Plan provider" or "Plan facility." You will only pay copayments, deductibles, and/or coinsurance, and you will not have to file claims. You can also get care from non-Plan providers, but it will cost you more.

- **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 feds.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 feds.humana.com.

What you must do to get covered care

You do not have to select a primary care physician and may self refer. To obtain the highest level of coverage, however, a member must seek care from a participating provider. Some care requires you or your provider to obtain prior authorization.

- **Specialty care**

Here are things you should know about specialty care:

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,

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

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

• Hospital care

If you are in the hospital when your enrollment in our Plan begins, call our customer service department immediately at 1-800/4 HUMANA or 1-800/448-6262. If you are new to the FEHB Program, we will arrange for you to receive care.

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

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

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

Circumstances beyond our control

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

Services requiring our prior approval

Your physician must obtain approval from us for certain services. We consider if the service is covered, medically necessary, and we follow generally accepted medical practice before we approve it.

You must obtain preauthorization for the following services and supplies:

- Non-emergent hospital, rehabilitation, skilled nursing and hospice facility admissions;
- Non-emergent admissions for mental health services and chemical dependency services;
- Hospice care programs;
- Transplant services;
- Durable medical equipment, prosthetics, and orthotics and diabetes equipment with a purchase price in excess of $750 per item.

You are responsible for alerting your health care provider to the preauthorization requirements. You or your provider must contact us by telephone, electronic mail, or in writing. If preauthorization is required but not obtained, benefits will be reduced by $500. This pre-authorization penalty will apply if you receive services from a non-participating provider.

Section 4. Your costs for covered services

Each covered member under Humana CoverageFirst has a $500 benefit allowance to use for participating provider services. This allowance can be used for medical and mental health benefits before a deductible must be reached. For expenses applied to the $500 benefit allowance, your only out-of-pocket costs are copayments.

Once your $500 benefit allowance is depleted, you pay 100% of your medical expenses until you satisfy your deductible. Your payments are based on Humana's contracted rates. The following services do not apply to the deductible:

- P**rescription drugs and preventive care services** – You pay only the copayments.
- R**outine physician office visits** – You pay only the copayments, even if your benefit allowance has been depleted. The copayment covers services billed as an office visit or consultation. Other services provided in the physician's office, such as lab work or X-rays, are subject to the deductible.

CoverageFirst pays most or all other covered expenses after you meet your deductible.

Here are some examples of how Humana CoverageFirst works:

Example 1

In January, member sees her primary care physician for a preventive care exam. Her physician orders a prescription drug which she receives from a participating pharmacy. Preventive care services and prescription drug costs do not reduce her $500 benefit allowance. In May, she becomes ill and sees her primary care physician. Her physician sends her to the hospital for lab work and x-rays.

Date of Service	Services – Provided by Participating Providers	Cost of Service	Member Copayment	Amount applied to CoverageFirst Benefit Allowance	Plan pays
January	Preventive Care Exam – Office Visit	$250	$20	$0	$230
January	Prescription Drug (Level 1)	$75	$10	$0	$65
May	Routine Care Exam - Office Visit	$100	$20	$80	$0
May	Routine Care - Outpatient Lab & X-ray	$350	$0	$350	$0
	Totals	$775	$50	$430	$295

In this example, benefit charges were $775. CoverageFirst paid $430, the member paid $50 and plan benefits paid $295. The member has a CoverageFirst benefit allowance of $70 remaining before the $1,500 individual deductible applies.

Example 2

In June, member has an accident, visits the emergency room and receives X-rays. He has outpatient surgery at a local hospital and five rehabilitation sessions. In August, member has a ruptured appendix, visits the emergency room and has surgery at a local hospital where he spends one night.

Date of Service	Services – Provided by Participating Providers	Cost of Service	Member Copayment	Amount applied to CoverageFirst Benefit Allowance	Member payment toward deductible	Plan pays
June	Emergency Room Visit & X-ray	$450	$100	$350	$0	$0
June	Outpatient Surgery	$1,600	$50	$150	$1,400	$0
June	5 Outpatient Physical Therapy Visits (Rehabilitation Sessions)	$250	$0	$0	$100	$150
August	Emergency Room Visit (Admitted as Inpatient)	$350	waived	$0	$0	$350
August	Inpatient Surgery and 1 day hospital stay	$5,500	$100	$0	$0	$5,400
	Totals	$8,150	$250	$500	$1,500	$5,900

In this example, the CoverageFirst allowance was used. The member was responsible for $250 in copayments and the $1,500 individual deductible. Services received in August were paid by the plan. The member was only responsible for the copayment.

Copayments

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

Example: When you see a participating Family Practice physician you will pay a $20 copayment. When you have outpatient surgery at a participating facility, you will pay a $50 copayment. Copayments do not reduce your $500 benefit allowance or count towards the deductible.

Deductible

A deductible is a fixed expense you must incur for certain covered services and supplies before we start paying benefits for them.

Participating providers – If you use participating providers, you do not have to meet a deductible until your $500 benefit allowance is depleted. The calendar year individual deductible is $1,500. Under a family enrollment, the deductible is $3,000.

Non-participating providers – If you use non-participating providers, the $500 benefit allowance does not apply. Before benefits are payable, the calendar year deductible of $3,000 per person must be met. The deductible for family coverage is $6,000. Deductible and out-of-pocket limits for participating and non-participating benefits are calculated separately.

Coinsurance

Coinsurance is the percentage of the Plan allowance that you must pay for your care. Coinsurance begins after you meet your deductible.

Participating providers – The infertility benefit has a 50% coinsurance. All other benefits on this Plan are covered services or the member responsibility is a copayment.

Non-participating providers – You pay a 30% coinsurance for an office visit with a physician.

Differences between our allowance and the bill

Participating providers – have agreed to accept a negotiated payment from us; you are only responsible for your copayments. You never have to pay the difference between the plan allowance and the billed amount.

Non-participating providers – You will be responsible for any difference between the amount non-participating providers charge and our allowance, in addition to the applicable coinsurance amounts.

Your catastrophic protection out-of-pocket maximum for coinsurance

Participating providers – There is no maximum out-of-pocket limit.

Non-participating providers - After your coinsurance totals $4,000 per person or $8,000 per family enrollment in any calendar year, you do not have to pay any more for covered services. The plan covers 100% of covered services. The maximum out-of-pocket expense limits exclude deductibles and expenses for covered organ transplants.

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

Section 5. Benefits – OVERVIEW

(See page 62 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 at 1-800/4HUMANA or 1-800/448-6262 or at our website at feds.humana.com.

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.
- The calendar year deductible is:

  Participating providers – You do not have to meet a deductible until your $500 benefit allowance is depleted. The calendar year deductible is $1,500 for self and $3,000 for self and family.

  Non-participating providers – The $500 benefit allowance does not apply. The calendar year deductible is $3,000 for self and $6,000 for self and family.
- Be sure to read Section 4, *Your costs for covered services,* for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

IMPORTANT

Benefit Description	You pay
NOTE: The calendar year deductible applies to almost all benefits in this section. We say "no deductible" when the deductible does not apply.	
Diagnostic and treatment services	
Professional services of physicians • In physician's office • Office medical consultations • Second surgical opinion	Participating: $20 per office visit to a primary care physician; $35 per office visit to a specialist (no deductible) Non-participating: 30% after deductible
• In an urgent care center	Participating: $35 copay (no deductible) Non-participating: 30% after deductible
• During a hospital stay • In a skilled nursing facility	Participating: Nothing after deductible Non-participating: 30% after deductible
• At home	Participating: $20 per office visit to a primary care physician; $35 per office visit to a specialist (no deductible) Non-participating: 30% after deductible

Lab, x-ray and other diagnostic tests	You pay
Tests, such as: • Blood tests • Urinalysis • Non-routine Pap tests • Pathology • X-rays • Non-routine Mammograms • CAT Scans/MRI • Ultrasound • Electrocardiogram and EEG	Participating: Nothing after deductible Non-participating: 30% after deductible
Preventive care, adult	
When receiving these services from a participating provider, it is not necessary to first meet your deductible. The cost of the services does not apply toward your $500 benefit allowance. You only have to pay your copayment. Routine screenings, such as: • A fasting lipoprotein profile (total cholesterol, LDL, HDL and triglycerides) once every five years for adults 20 or over; and. • Colorectal Cancer Screening, including Fecal occult blood test: – Sigmoidoscopy screening – every five years starting at age 50; or – Colonoscopy – once every 10 years at age 50; or – Double contrast barium enema (DCBE) – once every five to ten years at age 50. • Bone density testing for women age 35 and older • Chlamydial infection screening • Routine Prostate Specific Antigen (PSA) test – one annually for men age 40 and older • 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	Participating: $20 per office visit to a primary care physician; $35 per office visit to a specialist (no deductible) Non-participating: 30% after deductible

Preventive care, adult *(continued)*	**You pay**
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, ages 19 and over (except as provided for under *Preventive care, children)* • Influenza vaccines, annually • Pneumococcal vaccines, age 65 and older, or in the presence of high risk, chronic conditions	Participating: $20 per office visit to a primary care physician; $35 per office visit to a specialist (no deductible) Non-participating: 30% after deductible
Preventive care, children	
When receiving these services from a participating provider, it is not necessary to first meet your deductible. The cost of the services does not apply toward your $500 benefit allowance. You only have to pay your copayment. • Childhood immunizations recommended by the American Academy of Pediatrics • 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 (through age 22)	Participating: $20 per office visit to a primary care physician; $35 per office visit to a specialist (no deductible) Non-participating: 30% after deductible

Maternity care	You pay
Complete maternity (obstetrical) care, such as: • Prenatal care • Delivery • Postnatal care Note: Here are some things to keep in mind: • You do not need to precertify your normal delivery; see page 11 for other circumstances, such as extended stays for you or your baby. • You may remain in the hospital up to 48 hours after a regular delivery and 96 hours after a cesarean delivery. We will extend your inpatient stay if medically necessary. • We cover routine nursery care of the newborn child during the covered portion of the mother's maternity stay. We will cover other care of an infant who requires non-routine treatment only if we cover the infant under a Self and Family enrollment. • We pay hospitalization and surgeon services (delivery) the same as for illness and injury. See *Hospital benefits* (Section 5c) and *Surgery benefits* (Section 5b).	Participating: $20 per office visit to a primary care physician; $35 per office visit to a specialist (no deductible) Copay applies to first visit only Non-participating: 30% after deductible
Not covered: Routine sonograms to determine fetal age, size or sex	*All charges*
Family planning	
A range of voluntary family planning services, limited to: • Surgically implanted contraceptives (such as Norplant) • Injectable contraceptive drugs (such as Depo Provera) • Intrauterine devices (IUD's) • Diaphragms • Voluntary sterilization (See *Surgical Procedures*, Section 5b) Note: We cover oral contraceptives under the prescription drug benefit.	Participating: Nothing after deductible Non-participating: 30% after deductible
Not covered: Reversal of voluntary surgical sterilization, genetic counseling	*All charges*

Infertility services	You pay
Diagnosis and treatment of infertility, such as: • Artificial insemination: – *intravaginal insemination (IVI)* – *intracervical insemination (ICI)* – *intrauterine insemination (IUI)* • Fertility drugs Note: We cover injectable fertility drugs under medical benefits and oral fertility drugs under the prescription drug benefit.	Participating: 50% of charges after deductible Non-participating: 50% up to $5,000 limit per plan year, after deductible
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	Participating: $20 per office visit to a primary care physician; $35 per office visit to a specialist (no deductible when received in physician's office) Non-participating: 30% after deductible
• Allergy injection	Participating: $5 copay per visit (no deductible) Non-participating: 30% after deductible
• Allergy serum	Participating: Nothing Non-participating: 30% after deductible
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 28. • Respiratory and inhalation therapy • Dialysis – hemodialysis and peritoneal dialysis • Intravenous (IV)/Infusion therapy – Home IV and antibiotic therapy • Growth hormone therapy (GHT)	Participating: Nothing after deductible Non-participating: 30% after deductible
Physical, occupational and cardiac therapies	
• 60 visits per condition per year for the services of each of the following: – 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. • Cardiac rehabilitation following a heart transplant, bypass surgery or a myocardial infarction, is provided.	Participating: Nothing after deductible Non-participating: 30% after deductible
Not covered: • *Long-term rehabilitative therapy* • *Exercise programs*	*All charges*
Speech therapy	
• 60 visits per year	Participating: Nothing after deductible Non-participating: 30% after deductible

Hearing services (testing, treatment, and supplies)	You pay
• First hearing aid and testing only when necessitated by accidental injury • Hearing testing for children through age 17 (see *Preventive care, children*)	Participating: Nothing after deductible Non-participating: 30% after deductible
Not covered: • *All other hearing testing* • *Hearing aids, testing and examinations for them*	*All charges*
Vision services (testing, treatment, and supplies)	
• Diagnosis and treatment of diseases of the eye • Eye exam to determine the need for vision correction for children through age 17 (see *Preventive care, children*)	Participating: $20 per office visit to a primary care physician; $35 per office visit to a specialist (no deductible) Non-participating: 30% after deductible
• One pair of eyeglasses or contact lenses to correct an impairment directly caused by accidental ocular injury or intraocular surgery (such as for cataracts)	Participating: Nothing after deductible Non-participating: 30% after deductible
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.	Participating: $20 per office visit to a primary care physician; $35 per office visit to a specialist (no deductible) Non-participating: 30% after deductible
Not covered: • *Cutting, trimming or removal of corns, calluses, or the free edge of toenails, and similar routine treatment of conditions of the foot, except as stated above* • *Treatment of weak, strained or flat feet or bunions or spurs; and of any instability, imbalance or subluxation of the foot (unless the treatment is by open cutting surgery)*	*All charges*

Orthopedic and prosthetic devices	You pay
• Artificial limbs and eyes; stump hose • Externally worn breast prostheses and surgical bras, including necessary replacements, following a mastectomy • Internal prosthetic devices, such as artificial joints, pacemakers, cochlear implants, and surgically implanted breast implant following mastectomy. NOTE: See 5(b) for coverage of the surgery to insert the device. • Corrective orthopedic appliances for non-dental treatment of temporomandibular joint (TMJ) pain dysfunction syndrome.	Participating: Nothing, after deductible Non-participating: 30% after deductible
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 provided less than 3 years after the last one we covered*	*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 • Blood glucose monitors; and • Insulin pumps	Participating: Nothing, after deductible Non-participating: 30% after deductible
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 include oxygen therapy, intravenous therapy and medications.	Participating: Nothing, after deductible Non-participating: 30% after deductible
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.	Participating: $35 per office visit after deductible Non-participating: 30% after deductible
Alternative treatments	
• No benefit	All charges
Educational classes and programs	
Coverage is limited to: • Diabetes self management training	Participating: $20 copayment for primary care providers; $35 copay for specialist (no deductible) Non-participating: 30% after deductible
• Smoking cessation - Up to $100 for one smoking cessation program per member per lifetime, including all related expenses such as drugs.	All costs over $100

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.
- The calendar year deductible is:

  Participating providers – You do not have to meet a deductible until your $500 benefit allowance is depleted. The calendar year deductible is $1,500 for self and $3,000 for self and family.

  Non-participating providers – The $500 benefit allowance does not apply. The calendar year deductible is $3,000 for self and $6,000 for self and family.

  The calendar year deductible applies to almost all benefits in this section.
- Be sure to read Section 4, *Your costs for covered services* for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- The amounts listed below are for the charges billed by 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	You pay
Surgical procedures	
A comprehensive range of services, such as: • Operative procedures • Treatment of fractures, including casting • Normal pre- and post-operative care by the surgeon • Correction of amblyopia and strabismus • Endoscopy procedures • Biopsy procedures • Removal of tumors and cysts • 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 (e.g., Tubal ligation, Vasectomy) 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.	Participating: Nothing after deductible Non-participating: 30% after deductible

Surgical procedures *(continued)*	**You pay**
Not covered: • *Reversal of voluntary sterilization* • *Radial keratotomy and other refractive surgery*	*All charges*
Reconstructive surgery	
• 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 that 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.	Participating: Nothing after deductible Non-participating: 30% after deductible
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, limited to: • Reduction of fractures of the jaws or facial bones; • Surgical correction of cleft lip, cleft palate or severe functional malocclusion; • Removal of stones from salivary ducts; • Excision of leukoplakia or malignancies; • Excision of cysts and incision of abscesses when done as independent procedures; and • Other surgical procedures that do not involve the teeth or their supporting structures.	Participating: Nothing after deductible Non-participating: 30% after deductible
Not covered: • *Procedures that involve the teeth or their supporting structures (such as the periodontal membrane, gingiva, and alveolar bone)* • *Oral implants and transplants*	*All charges*

Organ/tissue transplants	You pay
Limited to: • Cornea • Heart • Heart/lung • Kidney • Kidney/Pancreas • Liver • Lung: Single - Double • Pancreas • Allogeneic (donor) bone marrow transplants • Autologous bone marrow transplants (autologous stem cell and peripheral stem cell support) for the following conditions: acute lymphocytic or non-lymphocytic leukemia; advanced Hodgkin's lymphoma; advanced non-Hodgkin's lymphoma; advanced neuroblastoma; breast cancer; multiple myeloma; epithelial ovarian cancer; and testicular, mediastinal, retroperitoneal and ovarian germ cell tumors. • Intestinal transplants (small intestine) and the small intestine with the liver or small intestine with multiple organs such as the liver, stomach, and pancreas. 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 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.	Participating: Nothing after deductible Non-participating: 30% after deductible Non-participating transplant services do not apply toward the maximum out-of-pocket expense limit
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) • Hospital outpatient department • Skilled nursing facility • Ambulatory surgical center	Participating: Nothing after deductible Non-participating: 30% after deductible
Professional services provided in – • Office	Participating: Nothing if you receive these services during an office visit Non-participating: 30% after deductible

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.
- 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 calendar year deductible is:

  Participating providers – You do not have to meet a deductible until your $500 benefit allowance is depleted. The calendar year deductible is $1,500 for self and $3,000 for self and family.

  Non-participating providers – The $500 benefit allowance does not apply. The calendar year deductible is $3,000 for self and $6,000 for self and family.

  The calendar year deductible applies to almost all benefits in this section.
- 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	You pay
Inpatient hospital	
Room and board, such as • Ward, semiprivate, or intensive care accommodations; • General nursing care; and • Meals and special diets. Note: If you want a private room when it is not medically necessary, you pay the additional charge above the semiprivate room rate.	Participating: $100 copayment per day for the first five days per admission, after deductible Non-participating: 30% after deductible

Inpatient hospital – continued on next page

Inpatient hospital *(continued)*	**You pay**
Other hospital services and supplies, such as: • Operating, recovery, maternity, and other treatment rooms • Prescribed drugs and medicines • Diagnostic laboratory tests and x-rays • Administration of blood and blood products • Blood or blood plasma, if not donated or replaced • Dressings, splints, casts, and sterile tray services • Medical supplies and equipment, including oxygen • Anesthetics, including nurse anesthetist services • Take-home items • Medical supplies, appliances, medical equipment, and any covered items billed by a hospital for use at home. (Note: calendar year deductible applies.)	Nothing after deductible
Not covered: • *Custodial care* • *Non-covered facilities, such as nursing homes, schools* • *Personal comfort items, such as telephone, television, barber services, guest meals and beds* • *Private nursing care*	*All charges*
Outpatient hospital or ambulatory surgical center	
• Operating, recovery, and other treatment rooms • Prescribed drugs and medicines • Diagnostic laboratory tests, x-rays, and pathology services • Administration of blood, blood plasma, and other biologicals • Blood and blood plasma if not donated or replaced • Pre-surgical testing • Dressings, casts, and sterile tray services • Medical supplies, including oxygen • Anesthetics and anesthesia service Note: We cover hospital services and supplies related to dental procedures when necessitated by a non-dental physical impairment. We do not cover the dental procedures.	Participating: $50 copay per visit after deductible Non-participating: 30% after deductible

Outpatient hospital or ambulatory surgical center *(continued)*	**You pay**
Outpatient non-surgical, such as: • Laboratory tests and x-rays	Participating: nothing, after deductible Non-participating: 30% after deductible
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 60 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.	Participating: nothing, after deductible Non-participating: 30% after deductible
Not covered: Custodial care	*All charges*
Hospice care	
Supportive and palliative care for a terminally ill member is covered in the home or hospice facility. Includes: • Inpatient and outpatient services and supplies Note: These services must be described in a Hospice Care program that has been approved by us.	Participating: nothing, after deductible Non-participating: 30% after deductible
Ambulance	
• Local professional ambulance service when medically appropriate.	Participating: nothing, after deductible Non-participating: 30% after deductible

Section 5 (d). Emergency services/accidents

IMPORTANT

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

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- The calendar year deductible is:

  Participating providers – You do not have to meet a deductible until your $500 benefit allowance is depleted. The calendar year deductible is $1,500 for self and $3,000 for self and family.

  Non-participating providers – The $500 benefit allowance does not apply. The calendar year deductible is $3,000 for self and $6,000 for self and family.
- Be sure to read Section 4, *Your costs for covered services* for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

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:

If a medical emergency requires that an insured person be admitted to a hospital, we must be advised by the hospital of the admission immediately. We will then review the medical necessity of the admission. If the insured person has been admitted to a non-participating hospital, and it has been determined that the insured person's condition has stabilized sufficiently to allow the insured person to be transferred safely to a participating hospital, we will request that the insured person and the insured person's physician approve the transfer. If the transfer is not approved, the non-participating hospital deductible and copayment amounts will be applied to the benefits payable for any days of hospital confinement beyond the date the insured person's medical emergency was stabilized.

Benefit Description	You pay
NOTE: The calendar year deductible applies to almost all benefits in this section. We say "no deductible"when the deductible does not apply.	
Emergency services	
• Emergency care at a doctor's office	Participating: $20 at a a primary care physician's office; $35 at a specialist's office (no deductible) Non-participating: 30% after deductible

Emergency services *(continued)*	**You pay**
• Emergency care at an urgent care center	Participating: $35 copayment (no deductible) Non-participating: 30% after deductible
• Emergency care as an outpatient or inpatient at a hospital, including doctors' services.	Participating: $100 copayment after deductible (Copayment waived if admitted; inpatient copayments apply) Non-participating: 30% after deductible
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 medically appropriate See 5(c) for non-emergency service.	Participating: Nothing after deductible Non-participating: 30% after deductible (If true medical emergency – benefit paid as participating)

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

IMPORTANT

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

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

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- The calendar year deductible is:
- Participating providers – You do not have to meet a deductible until your $500 benefit allowance is depleted. The calendar year deductible is $1,500 for self and $3,000 for self and family.
- Non-participating providers – The $500 benefit allowance does not apply. The calendar year deductible is $3,000 for self and $6,000 for self and family.
- Be sure to read Section 4, *Your costs for covered services* for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- **YOU MUST GET PREAUTHORIZATION OF THESE SERVICES.** See the instructions after the benefits description below.

IMPORTANT

Description	You pay
NOTE: The calendar year deductible applies to almost all benefits in this section. We say "no deductible"when the deductible does not apply.	
Mental health and substance abuse benefits	
All diagnostic and treatment services recommended by a Plan provider and contained in a treatment plan that we approve. The treatment plan may include services, drugs, and supplies described elsewhere in this brochure. Note: Plan benefits are payable only when we determine the care is clinically appropriate to treat your condition and only when you receive the care as part of a treatment plan that we approve.	Your cost sharing responsibilities are no greater than for other illnesses or conditions
• Professional services, including individual or group therapy by providers such as psychiatrists, psychologists, or clinical social workers • Medication management	Participating: $35 per visit (no deductible) Non-participating: 30% after deductible
• Diagnostic tests	Participating: Nothing if you receive these services during an office visit; otherwise: nothing after deductible. Non-participating: 30% after deductible

Mental health and substance abuse benefits *(continued)*	
• 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 NOTE: Two partial hospitalization days will be considered one confinement day.	Participating: $100 copay per day for the first five days per admission, after deductible Non-participating: 30% after deductible
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 the phone number on your identification card.

Limitation

We may limit your benefits if you do not obtain a 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.
- Prescription copayments and coinsurance amounts do not apply to the benefit allowance or the deductibles when using participating pharmacies.
- 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 the prescription?** A plan physician or licensed dentist must write the prescription.
- **Where can you 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.
- The **Rx4 Plan** allows members access to any drug that is used to treat a condition the medical plan covers. Thousands of drugs have been placed in levels based on their a) efficacy, b) safety, c) possible side effects, d) drug interactions, and e) cost compared to similar drugs. The levels are no longer based on a Drug List or formulary. New drugs are continually reviewed for level placement, dispensing limits and prior authorization requirements that represent the current clinical judgment of our Pharmacy and Therapeutics Committee.

  Level One contains the lowest copayment for - low-cost generic and brand-name drugs.

  Level Two copays are higher than Level One – this level covers higher cost generic and brand-name drugs.

  Level Three is made up of higher cost drugs, mostly brand names. These drugs may have generic or brand-name options on Levels One or Two.

  Level Four includes high technology drugs that are often newly approved by the U.S. Food and Drug Administration.

  Rx4's specific copayment amounts eliminate unexpected charges at the pharmacy, which means you won't have to calculate cost differentials when you choose brand-name drugs over generic equivalents. You can visit our web site at feds.humana.com to check the copayment for your prescription drug coverage before you get your prescription filled. You can also find out more about possible drug alternatives and the locations of participating pharmacies.

  With **Rx4** the member takes on more of the cost share for the drug. In return, members receive access to more drugs to treat their conditions and have more choices, along with their physicians, to decide which drug to take. Members receive letters offering guidance in changing medications to those with a lower copayment. We use internal data to identify members for whom a less expensive prescription drug option may be available. We communicate the information to the member to enable them, along with their physician, to make an informed choice regarding prescription drug copayment options.

- **What are the dispensing limits?** 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.

  If there is a national emergency or you are called to active military duty, you may call 1-800-448-6262. A representative will review criteria to determine whether you may obtain more than your normal dispensing amount.

- **Non-participating pharmacy coverage.** You may purchase prescribed medications from a non-participating pharmacy. You will pay for your prescriptions the following way:

  You pay 100% of the dispensing pharmacy charges
  You file a claim with Humana
  The claim is paid at 70% of charges, after the applicable copay.

Benefit Description	You pay
Covered medications and supplies	
We cover the following medications and supplies prescribed by a plan physician and obtained from a Plan pharmacy or through our mail order program: • Drugs and medicines that by Federal law of the United States require a physician's prescription for their purchase, except those listed as *Not covered*. • Insulin • 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 approved by us • Self administered injectable drugs • Oral fertility drugs. • Oral contraceptive drugs • Growth hormone • 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.	At participating pharmacies: $10 for Level One drugs $25 for Level Two drugs $50 for Level Three drugs 25% of the amount that the plan pays to the dispensing pharmacy for Level Four drugs The out of pocket maximum for Level Four drugs is $2,500 per member per calendar year 3 applicable copays for a 90-day supply of prescribed maintenance drugs, when ordered through our mail-order program At non-participating pharmacies: 30% of charges plus applicable copay
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
Flexible benefits option	Under the flexible benefits option, we determine the most effective way to provide services. • We may identify medically appropriate alternatives to traditional care and coordinate other benefits as a less costly alternative benefit. • Alternative benefits are subject to our ongoing review. • By approving an alternative benefit, we cannot guarantee you will get it in the future. • The decision to offer an alternative benefit is solely ours, and we may withdraw it at any time and resume regular contract benefits. • Our decision to offer or withdraw alternative benefits is not subject to OPM review under the disputed claims process.
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.
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. Call 1-888-847-9960.
Centers of excellence	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.
Infertility benefits	Illinois benefits comply with state mandates.

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; see Section 5 (c) for inpatient hospital benefits. We do not cover the dental procedure unless it is described below.
- Be sure to read Section 4, *Your costs for covered services,* for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

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.	Same as any other illness

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 catastrophic protection out-of-pocket maxim

Expanded dental benefits	Texas, Florida and Chicago area members: Please refer to enclosed materials for Dental Coverage information.
Complementary and Alternative Medicine	Complementary and Alternative Medicine (CAM) is a program offered to all Humana members, giving discounted access to supplemental health services. Through this program members will receive a discount of up to 30% on services by participating providers in the American WholeHealth Network. Alternative medicine is known for its focus on being healthy and preventing problems, not just treating illness and injury. To learn more about this program go to www.wholehealthmd.com/Humana.
Vision discount program	This Vision Discount Program is available to you through EYE-MED, which offers access to optometrists, ophthalmologists, and opticians. There are no claim forms to fill out and no waiting for reimbursement. The discount will be applied to your purchase. The discount card is enclosed in this packet. Call 1-866-392-6056 for the EYE-MED provider locator service.

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

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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:

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

Section 7. Filing a claim for covered services

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

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

Medical and hospital benefits

In most cases, providers and facilities file claims for you. Physicians must file on the form HCFA-1500, Health Insurance Claim Form. Facilities will file on the UB-92 form. For claims questions and assistance, call us at 1-800/4HUMANA or 1-800/448-6262.

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

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

Submit your claims to:

Humana Claims Office
P.O. Box 14601
Lexington, KY 40512-4601

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 Claims Office, Attn: Grievance & Appeals, P.O. Box 14601, Lexington, KY 40512-4601; 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: United States Office of Personnel Management, Insurance Services Programs, Health Insurance Group 3, 1900 E Street, NW, Washington, DC 20415-3630.

The disputed claims process – Continued on next page

The Disputed Claims Process ***(continued)***

Send OPM the following information:

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

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

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

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

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

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

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

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

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

(a) We haven't responded yet to your initial request for care or preauthorization/prior approval, then call us at 1-800/4HUMANA or 1-800/448-6262 and we will expedite our review; or

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

- If we expedite our review and maintain our denial, we will inform OPM so that they can give your claim expedited treatment too, or
- You may call OPM's Health Insurance Group 3 at 202/606-0737 between 8 a.m. and 5 p.m. eastern time.

Section 9. Coordinating benefits with other coverage

When you have other health coverage

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

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

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

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

What is Medicare?

Medicare is a Health Insurance Program for:

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

Medicare has two parts:

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

- **Should I enroll in Medicare?**

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

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

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

If you are eligible for Medicare, you may have choices in how you get your health care. Medicare + Choice 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. .

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

- When we are the primary payer, we process the claim first.
- When Original Medicare is the primary payer, Medicare processes your claim first. In most cases, your claims will be coordinated automatically and we will then provide secondary benefits for covered charges. You will not need to do anything. To find out if you need to do something to file your claim, contact us at 1-800/4HUMANA or 1-800/448-6262, or visit our web site: feds.humana.com.

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

(Primary payer chart begins on next page.)

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

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

* Unless you have FEHB coverage through your spouse who is an active employee

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

- **Medicare + Choice**

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

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

This Plan and our Medicare + Choice plan: You may enroll in our Medicare + Choice plan and also remain enrolled in our FEHB plan. [In this case, we do waive some cost-sharing for your FEHB coverage.] [In this case, we do not waive cost-sharing for your FEHB coverage.]

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

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

TRICARE and CHAMPVA

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

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

Workers' Compensation

We do not cover services that:

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

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

Medicaid

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

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

When other Government agencies are responsible for your care

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

When others are responsible for injuries

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

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

Section 10. Definitions of terms we use in this brochure

Calendar year

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

Coinsurance

Coinsurance is the percentage of our allowance that you must pay for your care. See page 13.

Consumer Driven Plan

A plan that gives greater control over your choices of health care expenditures. You decide what health care services will be reimbursed under the health plan benefit allowance. The benefit allowance is only used for participating providers. If you spend the entire benefit allowance before the end of the year, then you must satisfy your deductible before benefits are payable under the traditional type of insurance covered by your plan.

Copayment

A copayment is a fixed amount of money you pay when you receive covered services. See page 13.

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, which are not likely to improve your condition. Custodial care that lasts 90 days or more is sometimes known as long term care.

Deductible

A deductible is a fixed amount of covered expenses you must incur for certain covered services and supplies before we start paying benefits for those services. See page 13.

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

The determination as to whether a medical service is required to treat a condition, illness, or injury. In order to meet the standard of medical necessity the service must be consistent with symptoms, diagnosis, or treatment; consistent with good medical practice; and the most appropriate level of service that can be safely provided.

Morbid Obesity

Morbid or clinically severe obesity correlated with a Body Mass Index (BMI) of 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.

Out of Pocket

The out-of-pocket amount is the limit on total member copayments, deductibles, and coinsurance under a benefit contract.

Participating Provider

A hospital, physician, or any other health services provider who has been designated to provide services to covered members under this plan

Specialist

A specialist is a physician other than a family practitioner, general practitioner, internist or pediatrician.

Us/We

Us and we refer to Humana CoverageFirst

You

You refers to the enrollee and each covered family member.

Section 11. FEHB facts

Coverage information

No pre-existing condition limitation

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

Where you can get information about enrolling in the FEHB Program

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

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

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

Types of coverage available for you and your family

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

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

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

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

Children's Equity Act

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

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

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

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

When benefits and premiums start

The benefits in this brochure are effective 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. If you changed plans or plan options during Open Season and you receive care between January 1 and the effective date of coverage under your new plan or option, your claims will be paid according to the 2004 benefits of your old plan or option. However, if your old plan left the FEHB Program at the end of the year, you are covered under that plan's 2003 benefits until the effective date of your coverage with your new plan. Annuitants' coverage and premiums begin on January 1. If you joined at any other time during the year, your employing office will tell you the effective date of coverage.

When you retire

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

When you lose benefits

• When FEHB coverage ends

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

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

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

• Spouse equity coverage

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

• Temporary Continuation of Coverage (TCC)

If you leave Federal service, or if you lose coverage because you no longer qualify as 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, etc.

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

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

• Converting to individual coverage

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

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

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

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

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

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

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

Two new Federal Programs complement FEHB benefits

Important information

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

The Federal Flexible Spending Account Program – *FSAFEDS*

- **What is an FSA?**

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

There are two types of FSAs offered by the FSAFEDS Program:

Health Care Flexible Spending Account (HCFSA)

- Covers eligible health care expenses not reimbursed by this Plan, or any other medical, dental, or vision care plan you or your dependents may have.
- Eligible dependents for this account include anyone you claim on your Federal income tax return as a qualified dependent under the U.S. Internal Revenue Service (IRS) definition and/or with whom you jointly file your Federal income tax return, even if you don't have self and family health benefits coverage. ***Note:*** The IRS has a broader definition than that of a "family member" than is used under the FEHB Program to provide benefits by your FEHB Plan.
- The maximum amount that can be allotted for the HCFSA is $3,000 annually. The minimum amount is $250 annually.

Dependent Care Flexible Spending Account (DCFSA)

- Covers eligible dependent care expenses incurred so you can work, or if you are married, so you and your spouse can work, or your spouse can look for work or attend school full-time.
- Eligible dependents for this account include anyone you claim on your Federal income tax return as a qualified IRS dependent and/or with whom you jointly file your Federal income tax return.
- The maximum that can be allotted for the DCFSA is $5,000 annually. The minimum amount is $250 annually. ***Note:*** The IRS limits contributions to a Dependent Care FSA. For single taxpayers and taxpayers filing a joint return, the maximum is $5,000 per year. For taxpayers who file their taxes separately with a spouse, the maximum is $2,500 per year. The limit includes any child care subsidy you may receive.

- **Enroll during Open Season**

You **must make an election** to enroll in an FSA during the FEHB Open Season. Even if you enrolled during the initial Open Season for 2003, you must make a new election to continue participating in 2004. Enrollment is easy!

- Enroll online anytime during Open Season (November 10 through December 8, 2003) at **www.fsafeds.com.**
- Call the toll-free number 1-877-FSAFEDS (372-3337) Monday through Friday, from 9 a.m. until 9 p.m. eastern time and a FSAFEDS Benefit Counselor will help you enroll.

What is SHPS?

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

Who is eligible to enroll?

If you are a Federal employee eligible for FEHB – even if you're not enrolled in FEHB – you can choose to participate in either, or both, of the flexible spending accounts. If you are not eligible for FEHB, you are not eligible to enroll for a Health Care FSA. However, almost all Federal employees are eligible to enroll for the Dependent Care FSA. The only exception is intermittent (also called when actually employed [WAE]) employees expected to work less than 180 days during the year.

Note: FSAFEDS is the FSA Program established for all Executive Branch employees and Legislative Branch employees whose employers signed on. Under IRS law, FSAs are not available to annuitants. In addition, the U.S. Postal Service and the Judicial Branch, among others, are Federal agencies that have their own plans with slightly different rules, but the advantages of having an FSA are the same no matter what agency you work for.

- **How much should I contribute to my FSA?**

Plan carefully when deciding how much to contribute to an FSA. Because of the tax benefits of an FSA, the IRS places strict guidelines on them. You need to estimate how much you want to allocate to an FSA because current IRS regulations require you forfeit any funds remaining in your account(s) at the end of the FSA plan year. This is referred to as the "use-it-or-lose-it" rule. You will have until April 29, 2004 to submit claims for your eligible expenses incurred during 2003 if you enrolled in FSAFEDS when it was initially offered. You will have until April 30, 2005 to submit claims for your eligible expenses incurred from January 1 through December 31, 2004 if you elect FSAFEDS during this Open Season.

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

- **What can my HCFSA pay for?**

Every FEHB health plan includes cost sharing features, such as deductibles you must meet before the Plan provides benefits, coinsurance or copayments that you pay when you and the Plan share costs, and medical services and supplies that are not covered by the Plan and for which you must pay. These out-of-pocket costs are summarized on page 13 and detailed throughout this brochure. Your HCFSA will reimburse you for such costs when they are for tax deductible medical care for you and your dependents that is NOT covered by this FEHB Plan or any other coverage that you have.

Under this Plan, typical out-of-pocket expenses include deductibles, coinsurance and copayments for office visits, hospital services and prescription drugs.

The IRS governs expenses reimbursable by a HCFSA. See Publication 502 for a comprehensive list of tax-deductible medical expenses. **Note: While you will see insurance premiums listed in Publication 502, they are NOT a reimbursable expense for FSA purposes.** Publication 502 can be found on the IRS Web site at http://www.irs.gov/pub/irs-pdf/p502.pdf. If you do not see your service or expense listed in Publication 502, please call a FSAFEDS Benefit Counselor at 1-877-FSAFEDS (372-3337), who will be able to answer your specific questions.

- **Tax savings with an FSA**

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

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

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

- **Tax credits and deductions**

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

Health care expenses

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

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

Dependent care expenses

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

Visit www.fsafeds.com and download the Dependent Care Tax Credit Worksheet from the Quick Links box to help you determine what is best for your situation. You may also wish to consult a tax professional for more details.

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

Probably not. While there is an administrative fee of $4.00 per month for an HCFSA and 1.5% of the annual election for a DCFSA, most agencies have elected to pay these fees out of their share of employment tax savings. To be sure, check the FSAFEDS.com web site or call 1-877-FSAFEDS (372-3337). Also, remember that participating in FSAFEDS can cost you money if you don't spend your entire account balance by the end of the plan year and wind up forfeiting your end of year account balance, per the IRS "use-it-or-lose-it" rule.

- **Contact us**

To find out more or to enroll, please visit the **FSAFEDS Web site at www.fsafeds.com**, or contact SHPS by e-mail or by phone. SHPS Benefit Counselors are available from 9:00 a.m. until 9:00 p.m. eastern time, Monday through Friday.

- E-mail: fsafeds@shps.net
- Telephone: 1-877-FSAFEDS (372-3337)
- TTY: 1-800-952-0450 (for hearing impaired individual that would like to utilize a text messaging service)

The Federal Long Term Care Insurance Program

It's important protection

Here's why you should consider enrolling in the Federal long Term Care Insurance Program:

- **FEHB plans do not cover the cost of long term care.** Also called "custodial care," long term care is help you receive when you need assistance performing activities of daily living – such as bathing or dressing yourself. This need can strike anyone at any age and the cost of care can be substantial.
- **The Federal Long Term Care Insurance Program can help protect you from the potentially high cost of long term care.** This coverage gives you control over the type of care you receive and where you receive it. It can also help you remain independent, so you won't have to worry about being a burden to your loved ones.
- **It's to your advantage to apply sooner rather than later.** Long term care insurance is something you must apply for, and pass a medical screening (called underwriting) in order to be enrolled. Certain medical conditions will prevent some people from being approved for coverage. By applying while you're in good health, you could avoid the risk of having a change in health disqualify you from obtaining coverage. Also, the younger you are when you apply, the lower your premiums.
- **You don't have to wait for an open season to apply.** The Federal Long Term Care Insurance Program accepts applications from eligible persons at any time. You will have to complete a full underwriting application, which asks a number of questions about your health. However, if you are a new or newly eligible employee, you (and your spouse, if applicable) have a limited opportunity to apply using the abbreviated underwriting application, which asks fewer questions. If you marry, your new spouse will also have a limited opportunity to apply using abbreviated underwriting. Qualified relatives are also eligible to apply with full underwriting.

To find out more and to request an application

Call 1-800-LTC-FEDS (1-800-582-3337) (TTY 1-800-843-3557) or visit www.ltcfeds.com.

Index

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

NOTES:

Summary of benefits for Humana CoverageFirst – 2004

- **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.
- Members have a $500 benefit allowance to use before they must meet a deductible.

Benefits	You Pay	Page
Medical services provided by physicians:		
• Diagnostic and treatment services provided in the office	Office visit copay: $20 primary care; $35 specialist	16
Services provided by a hospital:		
• Inpatient	$100 copay per day for the first five days per admission, after deductible	29-30
• Outpatient – Surgery	$50 per visit, after deductible	30
• Outpatient – other services	Nothing, after deductible	31
Emergency benefits:		32-33
• At a doctor's office or urgent care center	$20 primary care; $35 specialist	
• At a hospital	$100 copay (waived if admitted; inpatient copay will apply)	
Mental health and substance abuse treatment	Regular cost sharing	34-35
Prescription drugs:		37
• Level One drugs	$10 copay	
• Level Two drugs	$25 copay	
• Level Three drugs	$50 copay	
• Level Four drugs	25% of the amount the plan pays	
• Maintenance drugs (90-day supply) when ordered through our mail-order program	3 applicable copays	
Dental Care		
• Accidental injury benefit only	Same as any other injury	39
Vision Care	No benefit	
Special features: *Flexible Benefits Option; TDD and TTY phone lines; HumanaBeginnings; National Transplant Network; and HumanaFirst®*		38
Protection against catastrophic costs (your catastrophic protection out-of-pocket maximum)	None	14

2004 Rate Information for
Humana CoverageFirst

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

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

Postal rates do not apply to non-career postal employees, postal retirees, or associate members of any postal employee organization 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
Arizona: Phoenix							
Self Only	DB1	$68.45	$22.82	$148.31	$49.44	$81.00	$10.27
Self and Family	DB2	$157.43	$52.48	$341.11	$113.70	$186.30	$23.61
Florida: Jacksonville							
Self Only	MQ1	$79.26	$26.42	$171.73	$57.24	$93.79	$11.89
Self and Family	MQ2	$182.30	$60.76	$394.97	$131.66	$215.72	$27.34
Florida: Tampa							
Self Only	MJ1	$75.66	$25.22	$163.93	$54.64	$89.53	$11.35
Self and Family	MJ2	$174.01	$58.00	$377.02	$125.67	$205.91	$26.10
Florida: South Florida							
Self Only	QP1	$72.06	$24.02	$156.13	$52.04	$85.27	$10.81
Self and Family	QP2	$165.73	$55.24	$359.08	$119.69	$196.11	$24.86
Illinois: Chicago							
Self Only	MW1	$57.65	$19.21	$124.90	$41.63	$68.21	$8.65
Self and Family	MW2	$132.58	$44.19	$287.25	$95.75	$156.88	$19.89

2004 Rate Information for Humana CoverageFirst *(continued)*

		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
Kansas/Missouri: Kansas City							
Self Only	PH1	$57.65	$19.21	$124.90	$41.63	$68.21	$8.65
Self and Family	PH2	$132.58	$44.19	$287.25	$95.75	$156.88	$19.89
Kentucky: Louisville							
Self Only	BM1	$86.46	$28.82	$187.33	$62.44	$102.31	$12.97
Self and Family	BM2	$198.87	$66.29	$430.88	$143.63	$235.33	$29.83
Ohio: Cincinnati/Dayton							
Self Only	L81	$72.06	$24.02	$156.13	$52.04	$85.27	$10.81
Self and Family	L82	$165.73	$55.24	$359.08	$119.69	$196.11	$24.86
Tennessee: Memphis							
Self Only	L61	$72.06	$24.02	$156.13	$52.04	$85.27	$10.81
Self and Family	L62	$165.73	$55.24	$359.08	$119.69	$196.11	$24.86
Texas: Austin							
Self Only	TV1	$79.26	$26.42	$171.73	$57.24	$93.79	$11.89
Self and Family	TV2	$182.30	$60.76	$394.97	$131.66	$215.72	$27.34
Texas: Corpus Christi							
Self Only	TP1	$75.66	$25.22	$163.93	$54.64	$89.53	$11.35
Self and Family	TP2	$174.01	$58.00	$377.02	$125.67	$205.91	$26.10
Texas: Dallas/Fort Worth							
Self Only	T81	$82.87	$27.62	$179.55	$59.85	$98.06	$12.43
Self and Family	T82	$190.58	$63.53	$412.93	$137.64	$225.52	$28.59

2004 Rate Information for Humana CoverageFirst *(continued)*

		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
Texas: Houston							
Self Only	T21	$86.46	$28.82	$187.33	$62.44	$102.31	$12.97
Self and Family	T22	$198.87	$66.29	$430.88	$143.63	$235.33	$29.83
Texas: San Antonio							
Self Only	TU1	$72.06	$24.02	$156.13	$52.04	$85.27	$10.81
Self and Family	TU2	$165.73	$55.24	$359.08	$119.69	$196.11	$24.86
Wisconsin: Milwaukee							
Self Only	FB1	$79.26	$26.42	$171.73	$57.24	$93.79	$11.89
Self and Family	FB2	$182.30	$60.76	$394.97	$131.66	$215.72	$27.34