

Humana Health Plan, Inc.

<http://feds.humana.com>

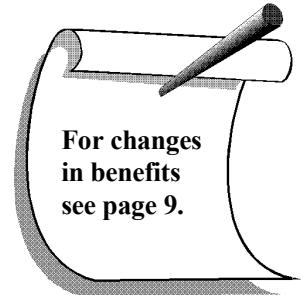


2004

A Health Maintenance Organization

Serving: The Kansas City metropolitan area

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



Enrollment codes for this plan:

High Option

MS1 Self Only

MS2 Self and Family

Standard Option

MS4 Self Only

MS5 Self and Family

Authorized for distribution by the:



**United States
Office of Personnel Management**

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



RI 73-054



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.

Table of Contents

Introduction	4
Plain Language	4
Stop Health Care Fraud!	4-5
Preventing medical mistakes	5-6
Section 1. Facts about this HMO plan	7-8
How we pay providers	7
Who provides my health care?	7
Your Rights	7
Service Area	8
Section 2. How we change for 2004	9
Program-wide changes	9
Changes to this Plan	9
Section 3. How you get care	10-12
Identification cards	10
Where you get covered care	10
• Plan providers	10
• Plan facilities	10
What you must do to get covered care	10-11
• Primary care	10
• Specialty care	10-11
• Hospital care	11
Circumstances beyond our control	12
Services requiring our prior approval	12
Section 4. Your costs for covered services	13
• Copayments	13
• Deductible	13
• Coinsurance	13
Your catastrophic protection out-of-pocket maximum	13
Section 5. Benefits	14-42
Overview	14
(a) Medical services and supplies provided by physicians and other health care professionals	15-23
(b) Surgical and anesthesia services provided by physicians and other health care professionals	24-28
(c) Services provided by a hospital or other facility, and ambulance services	29-32
(d) Emergency services/accidents	33-34
(e) Mental health and substance abuse benefits	35-36
(f) Prescription drug benefits	37-39
(g) Special features	40
• Flexible benefits option	
• Services for deaf and hearing impaired	

• High risk pregnancies	
• Centers of excellence	
• 24-hour nurse line	
(h) Dental benefits.....	41
(i) Non-FEHB benefits available to Plan members	42
Section 6. General exclusions – things we don't cover	43
Section 7. Filing a claim for covered services	44
Section 8. The disputed claims process	45-46
Section 9. Coordinating benefits with other coverage	47-51
When you have other health coverage	47
• What is Medicare?.....	47
• Should I enroll in Medicare?	47-49
• Medicare + Choice	50
• TRICARE and CHAMPVA	50
• Workers' Compensation	51
• Medicaid.....	51
• Other Government agencies	51
• When others are responsible for injuries	51
Section 10. Definitions of terms we use in this brochure	52-53
Section 11. FEHB facts	54-57
Coverage information	54-55
• No pre-existing condition limitation	54
• Where you can get information about enrolling in the FEHB Program	54
• Types of coverage available for you and your family	54
• Children's Equity Act	54-55
• When benefits and premiums start	55
• When you retire.....	55
When you lose benefits.....	55-57
• When FEHB coverage ends	55
• Spouse equity coverage.....	56
• Temporary Continuation of Coverage (TCC)	56
• Converting to individual coverage	56
• Getting a Certificate of Group Health Plan Coverage	56-57
Two new Federal Programs complement FEHB benefits.....	58-61
The Federal Flexible Spending Account Program – <i>FSAFEDS</i>	58-61
The Federal Long Term Care Insurance Program.....	61
Index	62
Summary of benefits.....	63-64
Rates	Back cover

- 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.

Service Area

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

The **Kansas** counties of Johnson, Leavenworth, Miami and Wyandotte and the **Missouri** counties of Bates, Buchanan, Carroll, Cass, Clay, Henry, Jackson, Johnson, Lafayette, Platte and Ray.

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

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

Section 2. How we change for 2004

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

Program-wide changes

- We 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 58-61.
- We added information regarding Preventing medical mistakes. See pages 5-6.
- We added information regarding enrolling in Medicare. See pages 47-48.
- We revised the Medicare Primary Payer Chart. See page 49.

Changes to this Plan

- Your share of the High Option non-Postal premium will increase by 40.1% for Self Only and 31% for Self and Family.
- Your share of the Standard Option non-Postal premium will increase by 50.1% for Self Only and 43% for Self and Family.

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 or write to us at 10450 Holmes, Kansas City, MO 64131. You may also request replacement cards through our website at feds.humana.com.

Where you get covered care

You get care from “Plan providers” and “Plan facilities.” You will only pay copayments and you will not have to file claims.

- **Plan providers**

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

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

It depends on the type of care you need. First, you and each family member must choose a primary care physician. This decision is important since your primary care physician provides or arranges for most of your health care. You may choose your primary care physician from our Provider Directory or our website, or you may call us for assistance.

- **Primary care**

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

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

- **Specialty care**

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

- OB/GYN providers for your annual well-woman exam

- Another doctor your primary care physician has designated to provide patient care when he or she is not available.

Here are other things you should know about specialty care:

- If you need to see a specialist frequently because of a chronic, complex, or serious medical condition, your primary care physician will develop a treatment plan that allows you to see your specialist for a certain number of visits without additional referrals. Your primary care physician will use our criteria when creating your treatment plan (the physician may have to get an authorization or approval beforehand).
- If you are seeing a specialist when you enroll in our Plan, talk to your primary care physician. Your primary care physician will decide what treatment you need. If he or she decides to refer you to a specialist, ask if you can see your current specialist. If your current specialist does not participate with us, you must receive treatment from a specialist who does. Generally, we will not pay for you to see a specialist who does not participate with our Plan.
- If you are seeing a specialist and your specialist leaves the Plan, call your primary care physician, who will arrange for you to see another specialist. You may receive services from your current specialist until we can make arrangements for you to see someone else.
- If you have a chronic or disabling condition and lose access to your specialist because we:
 - terminate our contract with your specialist for other than cause; or
 - drop out of the Federal Employees Health Benefits (FEHB) Program and you enroll in another FEHB Plan; or
 - reduce our service area and you enroll in another FEHB Plan;
 you may be able to continue seeing your specialist for up to 90 days after you receive notice of the change. Contact us or, if we drop out of the program, contact your new plan.

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

• Hospital care

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

If you are in the hospital when your enrollment in our Plan begins, call our customer service department immediately at 1-800/4HUMANA. 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 primary care physician has authority to refer you for most services. For certain services, however, your physician must obtain approval from us. Before giving approval, we consider if the service is covered, medically necessary, and follows generally accepted medical practice.

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

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

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

Section 4. Your costs for covered services

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

- **Copayments**

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

Example: When you see your primary care physician you pay a copayment of \$10 per office visit under the High Option and \$15 under the Standard Option.

- **Deductible**

We do not have a deductible.

- **Coinsurance**

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

Example: In our plan, you pay 50% of our allowance for infertility services.

Your catastrophic protection out-of-pocket maximum for copayments

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

- Prescription drugs

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

Section 5. Benefits – OVERVIEW

(See page 9 for how our benefits changed this year and pages 63-64 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 at our website at feds.humana.com.

(a) Medical services and supplies provided by physicians and other health care professionals	15-23
•Diagnostic and treatment services	•Speech therapy
•Lab, x-ray, and other diagnostic tests	•Hearing services (testing, treatment, and supplies)
•Preventive care, adult	•Vision services (testing, treatment, and supplies)
•Preventive care, children	•Foot care
•Maternity care	•Orthopedic and prosthetic devices
•Family planning	•Durable medical equipment (DME)
•Infertility services	•Home health services
•Allergy care	•Chiropractic
•Treatment therapies	•Alternative treatments
•Physical, occupational and cardiac therapies	•Educational classes and programs
(b) Surgical and anesthesia services provided by physicians and other health care professionals.....	24-28
•Surgical procedures	•Oral and maxillofacial surgery
•Reconstructive surgery	•Organ/tissue transplants
	•Anesthesia
(c) Services provided by a hospital or other facility, and ambulance services.....	29-32
•Inpatient hospital	•Extended care benefits/skilled nursing care facility benefits
•Outpatient hospital or ambulatory surgical center	•Hospice care
	•Ambulance
(d) Emergency services/accidents	33-34
•Medical emergency	•Ambulance
(e) Mental health and substance abuse benefits	35-36
(f) Prescription drug benefits.....	37-39
(g) Special features.....	40
• Flexible benefits option	
• Services for deaf and hearing impaired	
• High risk pregnancies	
• Centers of excellence	
• 24-hour nurse line	
(h) Dental benefits.....	41
(i) Non-FEHB benefits available to Plan members	42
Summary of benefits.....	63-64

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

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

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

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Benefit Description	You pay	
	Standard Option	High Option
Diagnostic and treatment services		
Professional services of physicians <ul style="list-style-type: none"> • In physician’s office • In an urgent care center • Office medical consultations • Second surgical opinion • At home 	\$15 per office visit for your primary care physician \$25 per office visit to a specialist	\$10 per office visit for your primary care physician \$20 per office visit to a specialist
<ul style="list-style-type: none"> • During a hospital stay • In a skilled nursing facility 	Nothing	Nothing
Lab, x-ray and other diagnostic tests		
Such as: <ul style="list-style-type: none"> • Blood tests • Urinalysis • Non-routine pap tests • Pathology • X-rays • Non-routine Mammograms • CAT Scans/MRI • Ultrasound • Electrocardiogram and EEG 	Nothing	Nothing

Preventive care, adult	You pay – Standard Option	You pay – High Option
<p>Routine screenings, such as:</p> <ul style="list-style-type: none"> • 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: <ul style="list-style-type: none"> – Sigmoidoscopy, screening – every five years starting at age 50; or – Colonoscopy – once every ten years at age 50; or – Double contrast barium enema (DCBE) – once every five to ten years at age 50. • Chlamydial infection screening • Routine Prostate Specific Antigen (PSA) test – one annually for men age 40 and older • Routine pap test – one annually <p>Note: The office visit is covered if pap test is received on the same day; see <i>Diagnostic and treatment services</i>, above.</p>	Nothing	Nothing
<p>Routine mammogram – covered for women age 35 and older, as follows:</p> <ul style="list-style-type: none"> • From age 35 through 39, one during this five year period • From age 40 through 64, one every calendar year • At age 65 and older, one every two consecutive calendar years • When prescribed by the doctor as medically necessary to diagnose or treat illness 	Nothing	Nothing
<p><i>Not covered: Physical exams and immunizations required for obtaining or continuing employment or insurance, attending schools or camp, or travel.</i></p>	<i>All charges</i>	<i>All charges</i>
<p>Routine immunizations, limited to:</p> <ul style="list-style-type: none"> • Tetanus-diphtheria (Td) booster – once every 10 years, ages 19 and over (except as provided for under Childhood immunizations) • Influenzal vaccines, annually • Pneumococcal vaccine, age 65 and over 	Nothing	Nothing

Preventive care, children	You pay – Standard Option	You pay – High Option
<ul style="list-style-type: none"> • Childhood immunizations recommended by the American Academy of Pediatrics 	Nothing	Nothing
<ul style="list-style-type: none"> • Well-child care charges for routine examinations (including comprehensive history), immunizations and care (under age 22) 	Nothing	Nothing
<ul style="list-style-type: none"> • Examinations, such as: <ul style="list-style-type: none"> – Eye exams through age 17 to determine the need for vision correction – Ear exams through age 17 to determine the need for hearing correction – Examinations done on the day of immunizations (through age 22) 	\$15 per office visit for your primary care physician \$25 per office visit to a specialist	\$10 per office visit for your primary care physician \$20 per office visit to a specialist
Maternity care		
Complete maternity (obstetrical) care, such as: <ul style="list-style-type: none"> • Prenatal care • Delivery • Postnatal care Note: Here are some things to keep in mind: <ul style="list-style-type: none"> • 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 Section 5(c) and Section 5(b). 	\$15 per office visit for your primary care physician \$25 per office visit to a specialist No copayment for other pre-natal and post-natal visits	\$10 per office visit for your primary care physician \$20 per office visit to a specialist No copayment for other pre-natal and post-natal visits
<i>Not covered: Routine sonograms to determine fetal age, size or sex</i>	<i>All charges</i>	<i>All charges</i>

Family planning	You pay - Standard Option	You pay - High Option
<p>A range of voluntary family planning services, limited to:</p> <ul style="list-style-type: none"> • Voluntary sterilization; see Section 5(b) • Surgically implanted contraceptives (such as Norplant) • Contraceptive devices • Injectable contraceptive drugs (such as Depo Provera) • Intrauterine devices (IUD's) • Diaphragms <p>Note: We cover oral contraceptive drugs covered under prescription drug benefits. See Section 5(f).</p>	Nothing	Nothing
<i>Not covered: Reversal of voluntary surgical sterilization</i>	<i>All charges</i>	<i>All charges</i>
Infertility services		
<ul style="list-style-type: none"> • Diagnosis and treatment of infertility 	\$25 per office visit	\$20 per office visit
<ul style="list-style-type: none"> • Artificial insemination: <ul style="list-style-type: none"> – intravaginal insemination (IVI) – intracervical insemination (ICI) – intrauterine insemination (IUI) 	50% of charges	50% of charges
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Fertility drugs</i> • <i>Assisted reproductive technology (ART) procedures, such as:</i> <ul style="list-style-type: none"> – <i>in vitro fertilization</i> – <i>embryo transfer, gamete GIFT and zygote ZIFT</i> – <i>Zygote transfer</i> • <i>Services and supplies related to excluded ART procedures</i> • <i>Cost of donor sperm</i> • <i>Cost of donor egg</i> 	<i>All charges</i>	<i>All charges</i>
Allergy care		
<ul style="list-style-type: none"> • Allergy testing and treatment 	\$15 per office visit to your primary care physician \$25 per office visit to a specialist	\$10 per office visit to your primary care physician \$20 per office visit to a specialist
<ul style="list-style-type: none"> • Allergy serum • Allergy injections 	Nothing	Nothing
<i>Not covered: Provocative food testing and sublingual allergy desensitization</i>	<i>All charges</i>	<i>All charges</i>

Treatment therapies	You pay - Standard Option	You pay - High Option
<ul style="list-style-type: none"> • Chemotherapy and radiation therapy <p>Note: High dose chemotherapy in association with autologous bone marrow transplants is limited to those transplants listed under Organ/Tissue Transplants on page 27.</p> <ul style="list-style-type: none"> • Respiratory and inhalation therapy • Dialysis – hemodialysis and peritoneal dialysis • Intravenous (IV)/Infusion Therapy – Home IV and antibiotic therapy • Growth hormone therapy (GHT) <p>Note: Growth hormone is covered under the prescription drug benefit.</p> <p>Note: We will only cover Growth Hormone Therapy if the treatment is precertified and there is a laboratory confirmed diagnosis of Growth Hormone Deficiency. You will need to call the precertification telephone number on the back of your medical ID (identification) card. We will also ask that your physician submit information that establishes that the GHT is medically necessary. GHT must be authorized <u>before</u> you begin treatment.</p> <p>See <i>Services requiring our prior approval</i> in Section 3.</p>	<p>\$15 per visit to your primary care physician</p> <p>\$25 per visit to a specialist</p>	<p>\$10 per visit to your primary care physician</p> <p>\$20 per visit to a specialist</p>
Physical, occupational and cardiac therapies		
<ul style="list-style-type: none"> • Up to 60 treatments or two consecutive months per condition if significant improvement can be expected within two months. Includes the services of each of the following: <ul style="list-style-type: none"> – qualified physical therapists; and – occupational therapists. <p>Note: We only cover therapy to restore bodily function when there has been a total or partial loss of bodily function due to illness or injury. Occupational therapy is limited to services that assist the member to achieve and maintain self-care and improved functioning in other activities of daily living.</p>	<p>\$25 per outpatient visit</p> <p>Nothing per visit during covered inpatient admission.</p>	<p>\$20 per outpatient visit</p> <p>Nothing per visit during covered inpatient admission.</p>

Physical, occupational and cardiac therapies – continued on next page

Physical and occupational therapies (continued)	You pay - Standard Option	You pay - High Option
<ul style="list-style-type: none"> • Cardiac rehabilitation following a heart transplant, bypass surgery or a myocardial infarction, is provided for up to two months. 	\$25 per office visit	\$20 per office visit
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • Long-term rehabilitative therapy • Exercise programs 	<i>All charges.</i>	<i>All charges</i>
Speech therapy		
<ul style="list-style-type: none"> • Speech therapy provided by speech therapists 	\$25 per outpatient visit Nothing per visit during covered inpatient admission.	\$20 per outpatient visit Nothing per visit during covered inpatient admission.
Hearing services (testing, treatment, and supplies)		
<ul style="list-style-type: none"> • Hearing tests, including audiograms • Hearing testing for children through age 17 (see <i>Preventive care, children</i>) 	\$15 per office visit to your primary care physician \$25 per office visit to a specialist	\$10 per office visit to your primary care physician \$20 per office visit to a specialist
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • Hearing aids, testing and examinations for them 	<i>All charges.</i>	<i>All charges.</i>
Vision services (testing, treatment, and supplies)		
<ul style="list-style-type: none"> • One pair of eyeglasses or contact lenses to correct an impairment directly caused by accidental ocular injury or intraocular surgery (such as for cataracts) 	Nothing	Nothing
<ul style="list-style-type: none"> • Diagnosis and treatment of diseases of the eye. • Screening eye exam to determine the need for vision correction for children through age 17 (see <i>Preventive care</i>) 	\$15 per office visit to your primary care physician \$25 per office visit to a specialist	\$10 per office visit to your primary care physician \$20 per office visit to a specialist
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • Eyeglasses or contact lenses and, examinations for them, except as shown above • Eye exercises and orthoptics • Radial keratotomy and other refractive surgery 	<i>All charges</i>	<i>All charges</i>

Foot care	You pay - Standard Option	You pay - High Option
<ul style="list-style-type: none"> • Routine foot care when you are under active treatment for a metabolic or peripheral vascular disease, such as diabetes. <p>See <i>Orthopedic and prosthetic devices</i> for information on podiatric shoe inserts.</p>	<p>\$15 per office visit to your primary care physician</p> <p>\$25 per office visit to a specialist</p>	<p>\$10 per office visit to your primary care physician</p> <p>\$20 per office visit to a specialist</p>
<p><i>Not covered, podiatric services:</i></p> <ul style="list-style-type: none"> • <i>Cutting, trimming or removal of corns, calluses, or the free edge of toenails, and similar routine treatment of conditions of the foot, except as stated above</i> • <i>Treatment of weak, strained or flat feet or bunions or spurs; and of any instability, imbalance or subluxation of the foot (unless the treatment is by open cutting surgery)</i> 	<p><i>All charges.</i></p>	<p><i>All charges.</i></p>
Orthopedic and prosthetic devices		
<ul style="list-style-type: none"> • Artificial limbs • Externally worn breast prostheses and surgical bras, including necessary replacements, following a mastectomy • Specialized braces • Artificial eyes • Internal prosthetic devices, such as artificial joints. 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. 	<p>Nothing</p>	<p>Nothing</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Foot orthotics</i> • <i>Dental prosthesis</i> • <i>Orthopedic braces</i> • <i>Orthopedic and corrective shoes</i> • <i>Arch supports</i> • <i>Heel pads and heel cups</i> • <i>Lumbosacral supports</i> • <i>Corsets, trusses, elastic stockings, support hose, and other supportive devices</i> • <i>Prosthetic replacements unless required by growth or change in medical condition or incorrect initial placement</i> 	<p><i>All charges</i></p>	<p><i>All charges</i></p>

Durable medical equipment (DME)	You pay - Standard Option	You pay - High Option
<p>Rental or purchase, at our option, including repair and adjustment, of durable medical equipment prescribed by your Plan physician, such as dialysis equipment.</p> <p>Under this benefit, we also cover:</p> <ul style="list-style-type: none"> • Hospital beds • Wheelchairs 	Nothing	Nothing
<ul style="list-style-type: none"> • Oxygen 	\$25 per month	\$25 per month
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Equipment such as exercise equipment, air cleaners, heating pads or lights, bed lifts</i> 	<i>All charges</i>	<i>All charges</i>
Home health services		
<ul style="list-style-type: none"> • Home health care ordered by a Plan physician and provided by a registered nurse (R.N.), licensed practical nurse (L.P.N.), licensed vocational nurse (L.V.N.), or home health aide. • Services include oxygen therapy, intravenous therapy and medications. 	Nothing	Nothing
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Nursing care requested by, or for the convenience of, the patient or the patient's family</i> • <i>Home care primarily for personal assistance that does not include a medical component and is not diagnostic, therapeutic, or rehabilitative.</i> 	<i>All charges</i>	<i>All charges</i>

Chiropractic	You pay - Standard Option	You pay - High Option
<ul style="list-style-type: none"> • Manipulation of the spine and extremities; • Adjunctive procedures such as ultrasound, electrical muscle stimulation, vibratory therapy, and cold pack application. 	\$25 per office visit	\$20 per office visit
Alternative treatments		
No benefit	<i>All charges</i>	<i>All charges</i>
Educational classes and programs		
<ul style="list-style-type: none"> • Smoking cessation - Up to \$100 for one (1) smoking cessation program per member per lifetime. 	Nothing	Nothing
<ul style="list-style-type: none"> • Primary care visits for smoking cessation. 	\$15 per office visit	\$10 per office visit
<ul style="list-style-type: none"> • Diabetes self management training 	\$15 per office visit to your primary care physician \$25 per office visit to a specialist	\$10 per office visit to your primary care physician \$20 per office visit to a specialist

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

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

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

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Benefit Description	You pay	
Surgical procedures	Standard Option	High Option
<p>A comprehensive range of services, such as:</p> <ul style="list-style-type: none"> • Operative procedures • Treatment of fractures, including casting • Normal pre- and post-operative care by the surgeon • Endoscopy procedures • Biopsy procedures • Removal of tumors and cysts • Correction of congenital anomalies (See <i>Reconstructive surgery</i>) • 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) – <i>Orthopedic and prosthetic devices</i> for device coverage information. • Voluntary sterilization (e.g., Tubal ligation, Vasectomy) • Treatment of burns <p>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.</p>	<p>Nothing for inpatient</p> <p>\$15 per office visit to your primary care physician</p> <p>\$25 per office visit to a specialist</p>	<p>Nothing for inpatient</p> <p>\$10 per office visit to your primary care physician</p> <p>\$20 per office visit to a specialist</p>

Surgical procedures – continued on next page

Surgical procedures (continued)	You pay – Standard Option	You pay – High Option
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>reversal of voluntary sterilization</i> 	<i>All charges</i>	<i>All charges</i>
Reconstructive surgery		
<ul style="list-style-type: none"> • Surgery to correct a functional defect • Surgery to correct a condition caused by injury or illness if: <ul style="list-style-type: none"> – the condition produced a major effect on the member’s appearance and – the condition can reasonably be expected to be corrected by such surgery • Surgery to correct a condition that existed at or from birth and is a significant deviation from the common form or norm. Examples of congenital anomalies are: protruding ear deformities; cleft lip; cleft palate; birth marks; webbed fingers; and webbed toes. • All stages of breast reconstruction surgery following a mastectomy, such as: <ul style="list-style-type: none"> – surgery to produce a symmetrical appearance on the other breast; – treatment of any physical complications, such as lymphedemas; – breast prostheses and surgical bras and replacements (see <i>Prosthetic devices</i>) <p>Note: If you need a mastectomy, you may choose to have the procedure performed on an inpatient basis and remain in the hospital up to 48 hours after the procedure.</p>	<p>Nothing for inpatient</p> <p>\$15 per office visit to your primary care physician</p> <p>\$25 per office visit to a specialist</p>	<p>Nothing for inpatient</p> <p>\$10 per office visit to your primary care physician</p> <p>\$20 per office visit to a specialist</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Cosmetic surgery – any surgical procedure (or any portion of a procedure) performed primarily to improve physical appearance through change in bodily form, except repair of accidental injury</i> • <i>Surgeries related to sex transformation</i> 	<i>All charges</i>	<i>All charges</i>

Oral and maxillofacial surgery	You pay – Standard Option	You pay – High Option
<p>Oral surgical procedures, limited to:</p> <ul style="list-style-type: none"> • Reduction of fractures of the jaws or facial bones; • Surgical correction of cleft lip, cleft palate or severe functional malocclusion; • Removal of stones from salivary ducts; • Excision of leukoplakia or malignancies; • Excision of cysts and incision of abscesses when done as independent procedures; and • Other surgical procedures that do not involve the teeth or their supporting structures. 	<p>Nothing for inpatient</p> <p>\$15 per office visit to your primary care physician</p> <p>\$25 per office visit to a specialist</p>	<p>Nothing for inpatient</p> <p>\$10 per office visit to your primary care physician</p> <p>\$20 per office visit to a specialist</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Oral implants and transplants</i> • <i>Procedures that involve the teeth or their supporting structures (such as the periodontal membrane, gingiva, and alveolar bone)</i> • <i>Dental care involved in the treatment of temporomandibular joint (TMJ) pain dysfunction syndrome</i> 	<p><i>All charges</i></p>	<p><i>All charges</i></p>

Organ/tissue transplants	You pay – Standard Option	You pay – High Option
<p>Limited to:</p> <ul style="list-style-type: none"> • Cornea • Heart • Lung: Single-Double • Heart/Lung • Kidney • Kidney/Pancreas • Liver • Pancreas • Allogeneic (donor) bone marrow transplants • Autologous bone marrow transplants (autologous stem cell and peripheral stem cell support) for the following conditions: acute lymphocytic or non-lymphocytic leukemia; advanced Hodgkin’s lymphoma; advanced non-Hodgkin’s lymphoma; advanced neuroblastoma; breast cancer; multiple myeloma; epithelial ovarian cancer; Wiskott-Aldrich syndrome; severe combined immunodeficiency syndrome; aplastic anemia; ewings sarcoma; and testicular, mediastinal, retroperitoneal and ovarian germ cell tumors. • Intestinal transplants (small intestine) and the small intestine with the liver or small intestine with multiple organs such as the liver, stomach, and pancreas. <p>Humana has a National Transplant Network with over 35 facilities within 20 states.</p> <p>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.</p> <p>Note: We cover related medical and hospital expenses of the donor when we cover the recipient. Donor expenses are covered subject to coordination of benefits with any coverage the donor may have. All transplants must be precertified.</p>	Nothing	Nothing
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Donor screening tests and donor search expenses, except those performed for the actual donor</i> • <i>Implants of artificial organs</i> • <i>Transplants not listed as covered</i> 	<i>All charges</i>	<i>All charges</i>

Anesthesia	You pay – Standard Option	You pay – High Option
Professional services provided in – <ul style="list-style-type: none"> • Hospital (inpatient) • Hospital outpatient department • Skilled nursing facility • Ambulatory surgical center • Office 	Nothing	Nothing

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

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Here are some important things to remember about these benefits:

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

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Benefit Description	You pay	
Inpatient hospital	Standard Option	High Option
Room and board, such as <ul style="list-style-type: none"> • Semiprivate, intensive care or cardiac care accommodations; • Private accommodations when medically necessary; • General nursing care; • Private duty nursing when Plan doctor determines it is medically necessary; and • Meals and special diets. Note: If you want a private room when it is not medically necessary, you pay the additional charge above the semiprivate room rate.	\$250 copayment per day for the first three days per admission	\$100 copayment per day for the first three days per admission

Inpatient hospital services – continued on next page

Inpatient hospital (continued)	You pay – Standard Option	You pay – High Option
<p>Other hospital services and supplies, such as:</p> <ul style="list-style-type: none"> • Operating, recovery, maternity, and other treatment rooms • Prescribed drugs and medicines • Diagnostic laboratory tests and x-rays • Administration of blood, blood plasma, and other biologicals • Blood and blood components if not 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 	Nothing	Nothing
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Cost of blood and blood components if replaced</i> • <i>Non-covered facilities, such as nursing homes and schools</i> • <i>Personal comfort items, such as telephone, television, barber services, guest meals and beds</i> 	<i>All charges</i>	<i>All charges</i>

Outpatient hospital or ambulatory surgical center	You pay – Standard Option	You pay – High Option
Outpatient surgery <ul style="list-style-type: none"> • Operating, recovery, and other treatment rooms • Prescribed drugs and medicines • Laboratory tests, x-rays, and pathology services • Administration of blood, blood plasma, and other biologicals • Blood and blood components if not replaced • Dressings, casts, and sterile tray services • Medical supplies, including oxygen • Anesthetics and anesthesia service 	\$200 copay per occurrence	\$100 copay per occurrence
<ul style="list-style-type: none"> • Pre-surgical testing 	Nothing	Nothing
Other hospital outpatient services, such as: <ul style="list-style-type: none"> • Laboratory tests and x-rays 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.	\$100 copay per occurrence	\$50 copay per occurrence
<i>Not covered: blood and blood components not replaced by the member</i>	<i>All charges</i>	<i>All charges</i>
Extended care benefits/skilled nursing care facility benefits		
Extended care benefit: Up to 100 days per calendar year, including <ul style="list-style-type: none"> • bed and board • general nursing care • drugs, biologicals, supplies and equipment provided by the facility Note: Coverage is provided when full-time skilled nursing care is necessary and confinement in a skilled nursing facility is medically appropriate as determined by a Plan doctor and approved by the Plan.	Nothing	Nothing
<i>Not covered: Custodial care, rest cures, domiciliary or convalescent care</i>	<i>All charges</i>	<i>All charges</i>

Hospice care	You pay – Standard Option	You pay – High Option
<ul style="list-style-type: none"> • Supportive and palliative care for a terminally ill member is covered in the home. Care must be arranged through our case management program. <p>Note: These services are provided under the direction of a Plan doctor who certifies that the patient is in the terminal stages of illness, with a life expectancy of approximately six months or less.</p>	Nothing	Nothing
<i>Not covered: Independent nursing, homemaker services</i>	<i>All charges</i>	<i>All charges</i>
Ambulance		
<ul style="list-style-type: none"> • Local professional ambulance service, when medically appropriate 	Nothing	Nothing

Section 5 (d). Emergency services/accidents

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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.
- 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.

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What is a medical emergency?

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

What to do in case of emergency:

Emergencies within our service area: If you are in an emergency situation, please call your primary care doctor. In extreme emergencies, if you are unable to contact your doctor, contact the local emergency system (e.g., the 911 telephone system) or go to the nearest hospital emergency room. Be sure to tell the emergency room personnel that you are a Plan member so they can notify the Plan. You or a family member must notify the Plan within 48 hours unless it was not reasonably possible to do so. It is your responsibility to ensure that the Plan has been timely notified.

If you need to be hospitalized, the Plan must be notified within 48 hours or on the first working day following your admission, unless it was not reasonably possible to notify the Plan within that time. If you are hospitalized in non-Plan facilities and a Plan doctor believes care can be better provided in a Plan hospital, you will be transferred when medically feasible with any ambulance charges covered in full.

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

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

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

If you need to be hospitalized, the Plan must be notified within 48 hours or on the first working day following your admission, unless it was not reasonably possible to notify the Plan within that time. If a Plan doctor believes care can be better provided in a Plan hospital, you will be transferred when medically feasible with any ambulance charges covered in full.

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

Emergency services/accidents – continued on next page

Benefit Description	You pay	
	Standard Option	High Option
Emergency within our service area		
<ul style="list-style-type: none"> • Emergency care at a doctor's office • Emergency care at an urgent care center 	\$15 per visit for your primary care physician \$25 per visit to a specialist	\$10 per visit for your primary care physician \$20 per visit to a specialist
<ul style="list-style-type: none"> • Emergency care as an outpatient at a hospital, including doctors' services 	\$75 per visit; if the emergency results in admission to a hospital the copay is waived	\$75 per visit; if the emergency results in admission to a hospital, the copay is waived
<i>Not covered: Elective care or non-emergency care</i>	<i>All charges</i>	<i>All charges</i>
Emergency outside our service area		
<ul style="list-style-type: none"> • Emergency care at a doctor's office • Emergency care at an urgent care center 	\$15 per visit for a primary care physician \$25 per visit to a specialist	\$10 per visit for a primary care physician \$20 per visit to a specialist
<ul style="list-style-type: none"> • Emergency care as an outpatient at a hospital, including doctors' services 	\$75 per visit; if the emergency results in admission to a hospital the copay is waived	\$75 per visit; if the emergency results in admission to a hospital, the copay is waived
<i>Not covered:</i> <ul style="list-style-type: none"> • <i>Elective care or non-emergency care</i> • <i>Emergency care provided outside the service area if the need for care could have been foreseen before leaving the service area</i> • <i>Medical and hospital costs resulting from a normal full-term delivery of a baby outside the service area</i> 	<i>All charges</i>	<i>All charges</i>
Ambulance		
<ul style="list-style-type: none"> • Professional ambulance service when ordered or authorized by a Plan doctor. See 5(c) for non-emergency service. <p>Note: Air ambulance is covered only when point of pick-up is inaccessible by land vehicle; or great distances or other obstacles are involved in getting a patient to the nearest hospital with appropriate facilities when prompt admission is essential</p>	Nothing	Nothing

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

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

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

All benefits are subject to the definitions, limitations, and exclusions in this brochure.

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

YOU MUST GET PREAUTHORIZATION OF THESE SERVICES.

See the instructions after the benefits description below.

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Benefit Description	You pay	
	Standard Option	High Option
Mental health and substance abuse benefits		
All diagnostic and treatment services recommended by a Plan provider and contained in a treatment plan that we approve. The treatment plan may include services, drugs, and supplies described elsewhere in this brochure. Note: Plan benefits are payable only when we determine the care is clinically appropriate to treat your condition and only when you receive the care as part of a treatment plan that we approve.	Your cost sharing responsibilities are no greater than for other illnesses or conditions.	Your cost sharing responsibilities are no greater than for other illnesses or conditions.
<ul style="list-style-type: none"> • Professional services, including individual or group therapy by providers such as psychiatrists, psychologists, or clinical social workers • Medication management 	\$25 per office visit	\$20 per office visit
<ul style="list-style-type: none"> • Diagnostic tests 	Nothing if you receive these services during your office visit; otherwise: \$25 per office visit	Nothing if you receive these services during your office visit; otherwise: \$20 per office visit

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

Mental health and substance abuse benefits <i>(continued)</i>	You pay – Standard Option	You pay – High Option
<ul style="list-style-type: none"> • Services provided by a hospital or other facility • Services in approved alternative care settings such as partial hospitalization, half-way house, residential treatment, full-day hospitalization, facility based intensive outpatient treatment <p>NOTE: Some services are considered to be partial hospitalization. Two partial hospitalization days will be considered one confinement day.</p>	<p>\$250 copayment per day for the first three days per admission</p> <p>\$100 copayment for outpatient services</p>	<p>\$100 copayment per day for the first three days per admission</p> <p>\$50 copayment for outpatient services</p>
<p><i>Not covered: Services we have not approved.</i></p> <p><i>Note: OPM will base its review of disputes about treatment plans on the treatment plan's clinical appropriateness. OPM will generally not order us to pay or provide one clinically appropriate treatment plan in favor of another.</i></p>	<p><i>All charges</i></p>	<p><i>All charges</i></p>

Preauthorization

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

- Please contact New Directions at 1-800/851-9536 to obtain Mental Health/Substance Abuse treatment services.

Limitation

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

Section 5 (f). Prescription drug benefits

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

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

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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 for the first three levels 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.

Prescription drug benefits – continued on next page

Benefit Description	You pay	
Covered medications and supplies	Standard Option	High Option
<p>We cover the following medications and supplies prescribed by a Plan physician and obtained from a Plan pharmacy or through our mail order program:</p> <ul style="list-style-type: none"> • Drugs and medicines that by Federal law of the United States require a physician’s prescription for their purchase, except those listed as <i>Not covered</i>. • Insulin • Disposable needles and syringes for the administration of covered medications • Diabetic supplies including testing agents, lancet devices, alcohol swabs, glucose elevating agents, insulin delivery devices and blood glucose monitors. • Self administered injectable drugs • Oral contraceptive drugs • Growth hormones • Drugs for sexual dysfunction <p>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.</p>	<p>\$10 for Level One drugs \$25 for Level Two drugs \$45 for Level Three drugs 25% of the amount that the Plan pays to the dispensing pharmacy for Level Four drugs 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</p>	<p>\$5 for Level One drugs \$20 for Level Two drugs \$40 for Level Three drugs 25% of the amount that the Plan pays to the dispensing pharmacy for Level Four drugs 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</p>

Covered medications and supplies <i>(continued)</i>	You pay – Standard Option	You pay – High Option
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Drugs available without a prescription, or for which there is a non-prescription equivalent available</i> • <i>Drugs and supplies for cosmetic purposes (such as Rogaine)</i> • <i>Vitamins, fluoride, nutrients and food supplements even if a physician prescribes or administers them</i> • <i>Drugs obtained at a non-Plan pharmacy except for out of area emergencies</i> • <i>Drugs to enhance athletic performance</i> • <i>Smoking cessation drugs and medications, including nicotine patches</i> • <i>Any drug used for the purpose of weight control</i> • <i>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</i> • <i>Medical supplies such as dressings and antiseptics</i> • <i>Fertility drugs</i> 	<p><i>All charges</i></p>	<p><i>All charges</i></p>

Section 5 (g). Special Features

Feature	Description
Flexible benefits option	<p>Under the flexible benefits option, we determine the most effective way to provide services.</p> <ul style="list-style-type: none"> • We may identify medically appropriate alternatives to traditional care and coordinate other benefits as a less costly alternative benefit. • Alternative benefits are subject to our ongoing review. • By approving an alternative benefit, we cannot guarantee you will get it in the future. • The decision to offer an alternative benefit is solely ours, and we may withdraw it at any time and resume regular contract benefits. • Our decision to offer or withdraw alternative benefits is not subject to OPM review under the disputed claims process.
Services for deaf and hearing impaired	<p>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.</p>
High risk pregnancies	<p>HumanaBeginnings is an outreach program that provides high-risk plan members support and educational materials so care can be actively managed during pregnancy.</p>
Centers of excellence	<p>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.</p>
24-hour nurse line	<p>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.</p>

Section 5 (h). Dental benefits

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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.

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Accidental injury benefit	You pay – Standard Option	You pay – High Option
We cover restorative services and supplies necessary to promptly repair (but not replace) sound natural teeth. The need for these services must result from an accidental injury.	Nothing	Nothing
Dental benefits		
We have no other dental benefits.	<i>All charges</i>	<i>All charges</i>

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

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

We do not cover the following:

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

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 Health Plan, Inc.
P.O. Box 14601
Lexington, Kentucky 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	<p>Ask us in writing to reconsider our initial decision. You must:</p> <ul style="list-style-type: none">(a) Write to us within 6 months from the date of our decision; and(b) Send your request to us at: Humana Health Plan, Inc., P.O. Box 14604, Lexington, Kentucky 40512-4602; 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	<p>We have 30 days from the date we receive your request to:</p> <ul style="list-style-type: none">(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	<p>You or your provider must send the information so that we receive it within 60 days of our request. We will then decide within 30 more days.</p> <p>If we do not receive the information within 60 days, we will decide within 30 days of the date the information was due. We will base our decision on the information we already have.</p> <p>We will write to you with our decision.</p>
4	<p>If you do not agree with our decision, you may ask OPM to review it.</p> <p>You must write to OPM within:</p> <ul style="list-style-type: none">• 90 days after the date of our letter upholding our initial decision; or• 120 days after you first wrote to us – if we did not answer that request in some way within 30 days; or• 120 days after we asked for additional information. <p>Write to OPM at: United States Office of Personnel Management, Insurance Services Programs, Health Insurance Group 3, 1900 E Street, NW, Washington, DC 20415-3630.</p>

The disputed claims process – Continued on next page

Step	Description
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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 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 is the way most people get their Medicare Part A and Part B benefits now. You may go to any doctor, specialist, or hospital that accepts Medicare. The Original Medicare Plan pays its share and you pay your share. Some things are not covered under Original Medicare, like prescription drugs.

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

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 claims, contact us at 1-800/4HUMANA or at 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

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.
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.
Durable Medical Equipment (DME)	Equipment recognized as such by Medicare Part B, that meets all of the following criteria: <ul style="list-style-type: none">• 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	<p>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:</p> <ul style="list-style-type: none">• 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 <p>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.</p>

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.
Participating Provider	A Hospital, Physician, or any other health services provider who has been designated to provide services to covered members under this plan.
Service Area	The geographic area where the Participating Provider services are available to covered members.
Transplant	Services for pre-transplant; the transplant including any chemotherapy, associated services and post-discharge services, and treatment of complications after transplant.
Us/We	Us and we refer to Humana Health Plan, Inc.
You	You refers to the enrollee and each covered family member.

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.

Index

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

- Allergy care 18
- Alternative treatment 23
- Allogeneic (donor) bone marrow transplant.....27
- Ambulance..... 32, 34
- Anesthesia..... 28, 30, 31
- Autologous bone marrow transplant 27
- Blood and blood plasma 30, 31
- Breast cancer screening 15, 16
- Casts 30, 31
- Changes for 2004..... 9
- Chemotherapy..... 19
- Cholesterol tests..... 16
- Childbirth.....17
- Chiropractic 23
- Claims..... 44
- Colorectal cancer screening..... 16
- Congenital anomalies 25
- Contraceptive devices and drugs 18, 38
- Coordination of benefits 47-51
- Covered services..... 52
- Covered providers..... 7, 10, 53
- Definitions 52-53
- Dental care..... 41
- Diagnostic services... 15, 30, 31, 35
- Dialysis..... 19
- Disputed claims review 45-46
- Donor expenses (transplants)..... 27
- Dressings 30, 31
- Durable medical equipment (DME) 22, 52
- Effective date of enrollment 55
- Emergency 33-34
- Experimental or investigational .. 52
- Eyeglasses..... 20
- Family planning..... 18
- Fecal occult blood test 16
- Foot care 21
- General Exclusions..... 43
- Hearing services 20
- Home health services..... 15, 22
- Home nursing care..... 22
- Hormones 16
- Hospice care 32
- Hospital 11, 29-30
- Immunizations..... 16, 17
- Infertility..... 18
- Inhospital physician care . 15, 24-28
- Inpatient Hospital Benefits..... 11, 29-30
- Insulin 38
- Laboratory and pathological services 15, 30, 31
- Machine diagnostic tests..... 15
- Magnetic Resonance Imagings (MRIs) 15
- Mail-order prescription drugs 38
- Mammograms 15, 16
- Maternity Benefits 17
- Medicaid 51
- Medical necessity 53
- Medicare 47-50
- Members 7
- Mental Conditions/Substance Abuse Benefits..... 35-36
- Newborn care..... 17
- Non-FEHB Benefits..... 42
- Nurse Licensed Practical Nurse 22
- Licensed Vocational Nurse 22
- Nurse Anesthetist..... 30
- Registered Nurse..... 22, 40
- Obstetrical care..... 17
- Occupational therapy 19
- Office visits..... 15
- Oral and maxillofacial surgery 26
- Orthopedic devices 21
- Out-of-pocket expenses 13
- Outpatient facility care 31
- Oxygen 22, 30, 31
- Pap test 15, 16
- Physical examination..... 16, 17
- Physical therapy..... 19
- Physician..... 7, 10-11
- Preventive care, adult..... 16
- Preventive care, children 17
- Prescription drugs 37-39
- Preventive services 16, 17
- Prior approval 12
- Prostate cancer screening..... 16
- Prosthetic devices 21
- Psychologist..... 35
- Radiation therapy..... 19
- Room and board..... 29, 31
- Second surgical opinion..... 15
- Skilled nursing facility care 31
- Smoking cessation 23
- Speech therapy..... 20
- Splints 30
- Sterilization procedures 18, 24
- Subrogation..... 51
- Substance abuse 35-36
- Surgery..... 24-28
 - Anesthesia..... 28
 - Oral 26
 - Outpatient 31
 - Reconstructive 25
- Syringes 38
- Temporary Continuation of Coverage 56
- Transplants..... 27
- Treatment therapies..... 19
- Vision services..... 20
- Well child care..... 17
- Wheelchairs 22
- Workers' Compensation 51
- X-rays 15, 30, 31

Summary of benefits for Humana Health Plan, Inc. 2004 High Option

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

Benefits	You Pay	Page
Medical services provided by physicians: • Diagnostic and treatment services provided in the office.....	Office visit copay: \$10 primary care; \$20 specialist	15
Services provided by a hospital: • Inpatient.....	\$100 per day for the first three days per admission	29-30
• Outpatient -- surgical.....	\$100 per visit	31
• Outpatient – non-surgical	\$50 per visit	
Emergency benefits: • At a hospital.....	\$75 per visit	34
• At a doctor’s office or urgent care center	\$10 per visit – primary care; \$20 per visit - specialist	
Mental health and substance abuse treatment.....	Regular cost sharing	35-36
Prescription drugs: • Level One drugs	\$5 copay	38
• Level Two drugs.....	\$20 copay	
• Level Three drugs.....	\$40 copay	
• Level Four drugs	25% of charges	
• Maintenance drugs (90-day supply) when ordered through our mail-order program	3 applicable copays	
Dental care • Accidental injury benefit.....	Nothing	41
Vision care.....	No benefit	20
Special features: <i>Flexible Benefits Option; TDD and TTY phone lines; HumanaBeginnings; National Transplant Network; and HumanaFirst®</i>		40
Protection against catastrophic costs (your catastrophic protection out-of-pocket maximum	Nothing after \$2,500/per person or \$5,000/per family enrollment Some costs do not count toward this protection	13

Summary of benefits for Humana Health Plan, Inc. 2004 Standard Option

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

Benefits	You Pay	Page
Medical services provided by physicians: • Diagnostic and treatment services provided in the office.....	Office visit copay: \$15 primary care; \$25 specialist	14
Services provided by a hospital: • Inpatient.....	\$250 per day for the first three days per admission	28-29
• Outpatient – surgical.....	\$200 per visit	30
• Outpatient – non-surgical	\$100 per visit	
Emergency benefits: • In-area (at a hospital).....	\$75 per visit	33
• In-area (at a doctor’s office or urgent care center)	\$15 per visit	
• Out-of-area	\$25 per visit	
Mental health and substance abuse treatment.....	Regular cost sharing	34-35
Prescription drugs: • Level One drugs	\$10 copay	37
• Level Two drugs.....	\$25 copay	
• Level Three drugs.....	\$45 copay	
• Level Four drugs	25% of charges	
• Maintenance drugs (90-day supply) when ordered through our mail-order program	3 applicable copays	
Dental care • Accidental injury benefit.....	Nothing	40
Vision care.....	No benefit	19
Special features: <i>Flexible Benefits Option; TDD and TTY phone lines; HumanaBeginnings; National Transplant Network; and HumanaFirst®</i>		39
Out-of-pocket maximum	Nothing after \$2,500/per person or \$5,000/per family enrollment. Some costs do not count toward this protection.	12

2004 Rate Information for Humana Health Plan, Inc.

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

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

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

Type of Enrollment	Code	Non-Postal Premium				Postal Premium	
		Biweekly		Monthly		Biweekly	
		Gov't Share	Your Share	Gov't Share	Your Share	USPS Share	Your Share

Kansas City Area

High Option Self Only	MS1	\$121.40	\$49.31	\$263.03	\$106.84	\$143.32	\$27.39
High Option Self and Family	MS2	\$277.09	\$115.55	\$600.36	\$250.36	\$327.12	\$65.52
Standard Option Self Only	MS4	\$92.17	\$30.72	\$199.70	\$66.56	\$109.06	\$13.83
Standard Option Self and Family	MS5	\$211.98	\$70.66	\$459.29	\$153.10	\$250.84	\$31.80