

# Humana CoverageFirst

<http://feds.humana.com>

## 2008

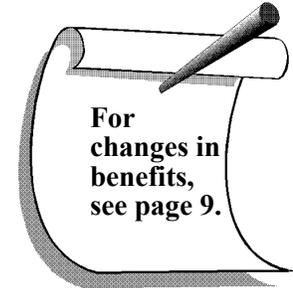
### A Consumer Driven Individual Practice Plan

Serving:

The following metropolitan areas – Phoenix and Tucson , Arizona; Colorado Springs and Denver, Colorado; Daytona, Jacksonville, Orlando, Pensacola/Ft. Walton, Tampa, and South Florida; Atlanta and Macon, Georgia; Chicago, Illinois; Indianapolis, Indiana; Kansas City, Kansas/Missouri; Lexington, Kentucky; Baton Rouge and New Orleans, Louisiana; Detroit, Grand Rapids and most of Michigan; Cincinnati, Ohio; Memphis and Nashville, Tennessee; Austin, Corpus Christi, Dallas, Houston and San Antonio, Texas; and Milwaukee, Wisconsin

Enrollment in this plan is limited:

You must live or work in our geographic service area to enroll. See pages 7 - 8 for details.



<p><b>Phoenix, Tucson, AZ:</b>  <b>DB1</b> Self Only  <b>DB2</b> Self and Family  <b>Colorado Springs, CO:</b>  <b>FC1</b> Self Only  <b>FC2</b> Self and Family  <b>Denver, CO:</b>  <b>7T1</b> Self Only  <b>7T2</b> Self and Family  <b>Daytona, FL:</b>  <b>DL1</b> Self Only  <b>DL2</b> Self and Family  <b>Jacksonville, FL:</b>  <b>MQ1</b> Self Only  <b>MQ2</b> Self and Family  <b>Orlando, FL:</b>  <b>YG1</b> Self Only  <b>YG2</b> Self and Family  <b>Pensacola/Ft. Walton, FL:</b>  <b>BP1</b> Self Only  <b>BP2</b> Self and Family  <b>South Florida:</b>  <b>QP1</b> Self Only  <b>QP2</b> Self and Family</p>	<p><b>Tampa, FL:</b>  <b>MJ1</b> Self Only  <b>MJ2</b> Self and Family  <b>Atlanta, GA:</b>  <b>AD1</b> Self Only  <b>AD2</b> Self and Family  <b>Macon, GA:</b>  <b>LM1</b> Self Only  <b>LM2</b> Self and Family  <b>Chicago, IL:</b>  <b>MW1</b> Self Only  <b>MW2</b> Self and Family  <b>Indianapolis, IN:</b>  <b>HZ1</b> Self Only  <b>HZ2</b> Self and Family  <b>Kansas City, KS/MO:</b>  <b>PH1</b> Self Only  <b>PH2</b> Self and Family  <b>Lexington, KY:</b>  <b>6N1</b> Self Only  <b>6N2</b> Self and Family</p>	<p><b>Baton Rouge, LA:</b>  <b>9L1</b> Self Only  <b>9L2</b> Self and Family  <b>New Orleans, LA:</b>  <b>9J1</b> Self Only  <b>9J2</b> Self and Family  <b>Detroit, MI:</b>  <b>BW1</b> Self Only  <b>BW2</b> Self and Family  <b>Grand Rapids, MI:</b>  <b>GT1</b> Self Only  <b>GT2</b> Self and Family  <b>Most of MI:</b>  <b>FT1</b> Self Only  <b>FT2</b> Self and Family  <b>Cincinnati, OH:</b>  <b>L81</b> Self Only  <b>L82</b> Self and Family  <b>Memphis, TN:</b>  <b>L61</b> Self Only  <b>L62</b> Self and Family</p>	<p><b>Nashville, TN:</b>  <b>BT1</b> Self Only  <b>BT2</b> Self and Family  <b>Austin, TX:</b>  <b>TV1</b> Self Only  <b>TV2</b> Self and Family  <b>Corpus Christi, TX:</b>  <b>TP1</b> Self Only  <b>TP2</b> Self and Family  <b>Dallas/Ft. Worth, TX:</b>  <b>T81</b> Self Only  <b>T82</b> Self and Family  <b>Houston, TX:</b>  <b>T21</b> Self Only  <b>T22</b> Self and Family  <b>San Antonio, TX:</b>  <b>TU1</b> Self Only  <b>TU2</b> Self and Family  <b>Milwaukee, WI:</b>  <b>FB1</b> Self Only  <b>FB2</b> Self and Family</p>
---	--	---	---

Authorized for distribution by the:



**United States  
Office of Personnel Management**

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

**Important Notice from Humana About  
Our Prescription Drug Coverage and Medicare**

OPM has determined that Humana's prescription drug coverage is, on average, expected to pay out as much as the standard Medicare prescription drug coverage will pay for all plan participants and is considered Creditable Coverage. Thus you do not need to enroll in Medicare Part D and pay extra for prescription drug benefit coverage. If you decide to enroll in Medicare Part D later, you will not have to pay a penalty for late enrollment as long as you keep your FEHB coverage.

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

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

---

**Please be advised**

---

If you lose or drop your FEHB coverage and go 63 days or longer without prescription drug coverage that's at least as good as Medicare's prescription drug coverage, your monthly premium will go up at least 1% per month for every month that you did not have that coverage. For example, if you go 19 months without Medicare Part D prescription drug coverage, your premium will always be at least 19% higher than what many other people pay. You'll have to pay this higher premium as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the next Annual Coordinated Election Period (November 15<sup>th</sup> through December 31<sup>st</sup>) to enroll in Medicare Part D.

**Medicare's Low Income Benefits**

*For people with limited income and resources, extra help paying for a Medicare prescription drug plan is available. Information regarding this program is available through the Social Security Administration (SSA) online at [www.socialsecurity.gov](http://www.socialsecurity.gov), or call the SSA at 1-800-772-1213 (TTY 1-800-325-0778).*

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

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

---

## Table of Contents

---

Introduction .....	3
Plain Language.....	3
Stop Health Care Fraud! .....	3
Preventing medical mistakes.....	4
Section 1. Facts about this Consumer Driven Health Plan .....	6
How we pay providers .....	0
Your Rights .....	0
Service Area.....	0
Section 2. How we change for 2008 .....	9
Changes to this Plan.....	0
Section 3. How you get care .....	11
Identification cards.....	11
Where you get covered care.....	11
• Plan providers .....	0
• Plan facilities .....	0
What you must do to get covered care.....	11
• Specialty care.....	0
• Hospital care.....	0
Circumstances beyond our control.....	12
Services requiring our prior approval .....	12
Section 4. Your costs for covered services.....	13
Copayments.....	14
Deductible .....	14
Coinsurance.....	15
Differences between our allowance and the bill .....	15
Your catastrophic protection out-of-pocket maximum .....	15
Section 5. Benefits .....	16
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
Section 9. Coordinating benefits with other coverage .....	47
When you have other health coverage .....	47
What is Medicare? .....	47
• Should I enroll in Medicare? .....	47
• The Original Medicare Plan (Part A or Part B).....	48
• Medicare Advantage (Part C) .....	48
• Medicare prescription drug coverage (Part D) .....	49
TRICARE and CHAMPVA .....	51
Workers’ Compensation .....	51
Medicaid.....	51
When other Government agencies are responsible for your care .....	51
When others are responsible for injuries.....	51
When you have Federal Employees Dental and Vision Insurance Plan (FEDVIP) coverage .....	51
Section 10. Definitions of terms we use in this brochure .....	52
Section 11. FEHB Facts .....	54
Coverage information .....	0

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
When benefits and premiums start.....	55
When you retire.....	55
When you lose benefits.....	0
When FEHB coverage ends .....	55
Upon divorce.....	56
Temporary Continuation of Coverage (TCC) .....	56
Converting to individual coverage.....	56
Getting a Certificate of Group Health Plan Coverage .....	56
Section 12. Three Federal Programs complement FEHB benefits .....	57
The Federal Flexible Spending Account Program – FSAFEDS .....	0
The Federal Long Term Care Insurance Program.....	0
The Federal Employees Dental and Vision Insurance Program - FEDVIP .....	0
Index.....	59
2008 Summary of benefits for the Consumer Driven Health Plan .....	62
2008 Rate Information for Humana .....	63

---

## Introduction

---

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

Humana Inc.  
500 West Main  
Louisville, KY 40201

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

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

OPM negotiates benefits and rates with each plan annually. Benefit changes are effective January 1, 2008, and changes are summarized on pages 10 - 11. Rates are shown at the end of this brochure.

---

## Plain Language

---

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

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

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

---

## Stop Health Care Fraud!

---

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

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

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

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

- Carefully review explanations of benefits (EOBs) statements 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.

- Bring the actual medicines or give your doctor and pharmacist a list of all the medicines that you take, including non-prescription (over-the-counter) medicines.
- Tell them about any drug allergies you have.
- Ask about any risks or side effects of the medication and what to avoid while taking it. Be sure to write down what your doctor or pharmacist says.

- Make sure your medicine is what the doctor ordered. Ask the pharmacist about your medicine if it looks different than you expected.
- Read the label and patient package insert when you get your medicine, including all warnings and instructions.
- Know how to use your medicine. Especially note the times and conditions when your medicine should and should not be taken.
- Contact your doctor or pharmacist if you have any questions.

**3. Get the results of any test or procedure.**

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

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

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

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

- Make sure you, your doctor, and your surgeon all agree on exactly what will be done during the operation.
- Ask your doctor, "Who will manage my care when I am in the hospital?"
- Ask your surgeon:

Exactly what will you be doing?

About how long will it take?

What will happen after surgery?

How can I expect to feel during recovery.

- Tell the surgeon, anesthesiologist, and nurses about any allergies, bad reactions to anesthesia, and any medications you are taking.

Visit these Web sites for more information about patient safety:

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

---

## Section 1. Facts about this Consumer Driven Health Plan

---

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

### **When you use Participating Providers**

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

The Plan pays the first \$1000 of covered medical services for each person enrolled. We call this your benefit allowance. While using the \$1000 benefit allowance you are only responsible for the applicable copayments. You do not have to submit receipts for reimbursement. The benefit allowance can only be used to pay for covered medical services from participating providers. Any benefit allowance that remains at the end of the Plan year cannot be “rolled over” or “cashed out.”

The following services do not reduce your \$1000 benefit allowance:

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

Once you spend your entire \$1000 benefit allowance, you pay for medical services until you meet the deductible. The amount the plan deducts from your allowance for a particular service is based on the price Humana has negotiated with the health care provider. After you meet the deductible, the Plan pays for most or all of the covered services that you receive.

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

### **When you use Non-Participating Providers**

When you use a non-participating provider, we will pay benefits at a lower level and you will pay a larger share of the costs. Since non-participating providers have not agreed to accept discounted or negotiated fees as payment in full, they may balance bill you for charges in excess of the allowable amount. You will be responsible for charges in excess of the allowable amount in addition to any applicable deductible or coinsurance. Any amount that you pay to a non-participating provider in excess of your coinsurance (percentage of the allowable fee) will not apply to your out of pocket limit or deductible.

### **How we pay providers**

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

**Non-Participating Providers:** For services rendered by non-participating physicians, the dollar amount of the deductible or benefit percentage is calculated based on a reimbursement schedule established by us and agreed to by your employer. When using a non-participating physician, you are also responsible for any charges that exceed this reimbursement schedule and non-covered services.

### **Catastrophic protection**

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

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

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

## **Your rights**

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

- Nationally, Humana has been in the health care business since 1961.
- Humana is a for profit corporation which is publicly traded on the New York Stock Exchange (NYSE).

If you want more information about us, call 1-800-4/HUMANA. You may also contact us by visiting our website at [feds.humana.com](http://feds.humana.com).

## **Your medical and claims records are confidential**

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

## **Service Area**

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

**Arizona, Phoenix, Tucson** – Enrollment code **DB** – Maricopa, Pinal, and Pima counties.

**Colorado, Colorado Springs** – Enrollment code **FC** – El Paso County.

**Colorado, Denver** – Enrollment code **7T** – Adams, Arapahoe, Boulder, Broomfield, Denver, Douglas Jefferson, and Larimer counties.

**Florida, Daytona** – Enrollment code **DL** – Flagler and Volusia counties.

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

**Florida, Orlando** – Enrollment code **YG** – Lake, Orange, Osceola, and Seminole counties.

**Florida, Pensacola/Ft. Walton** – Enrollment code **BP** – Santa Rosa, Escambia, Walton and Okaloosa counties.

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

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

**Georgia, Atlanta** – Enrollment code **AD** – Barrow, Barton, Cherokee, Clayton, Cobb, Coweta, DeKalb, Douglas, Fayette, Forsyth, Fulton, Gwinett, Hall, Newton, Paulding, Rockdale, Spalding and Walton counties.

**Georgia, Macon** – Enrollment code **LM** – Jones, Bibb, Twiggs and Houston counties.

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

**Indiana, Indianapolis** – Enrollment code **HZ** – Boone, Hamilton, Hancock, Hendricks, Johnson, Madison, Marion, Morgan and Shelby counties.

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

**Kentucky, Lexington** – Enrollment code **6N** – Anderson, Bath, Bourbon, Boyle, Bracken, Clark, Estill, Fayette, Fleming, Franklin, Garrard, Harrison, Jessamine, Madison, Menifee, Mercer, Montgomery, Nicholas, Owen, Powell, Robertson, Scott and Woodford counties.

**Louisiana, Baton Rouge** – Enrollment code **9L** – Ascension, Assumption, East Baton Rouge, East Feliciana, Iberville, Livingston, Pointe Coupee, Saint Helena, West Baton Rouge, and West Feliciana.

**Louisiana, New Orleans** – Enrollment code **9J** – Jefferson, Lafourche, Orleans, Plaquemines, Saint Bernard, Saint Charles, Saint James, Saint John the Baptist, Saint Mary, Saint Tammany, Tangipahoa, Terrebonne, and Washington.

**Michigan, Detroit** – Enrollment code **BW** – Macomb, Oakland, St. Clair and Wayne counties.

**Michigan, Grand Rapids** – Enrollment code **GT** – Allegan, Kent, Muskegon and Ottawa counties.

**Michigan, most of** – Enrollment code **FT** – Alcona, Alger, Alpena, Antrim, Arenac, Baraga, Barry, Bay, Benzie, Berrien, Branch, Calhoun, Cass, Cheboygan, Chippewa, Clinton, Delta, Dickinson, Eaton, Emmet, Genesee, Gogebic, Grand Traverse, Gratiot, Hillsdale, Houghton, Huron, Ingham, Ionia, Iosco, Iron, Jackson, Kalamazoo, Kalkaska, Keweenaw, Lake, Lapeer, Leelanau, Lenawee, Livingston, Luce, Mackinac, Manistee, Marquette, Mason, Mecosta, Menominee, Missaukee, Monroe, Montcalm, Montmorency, Newaygo, Oceana, Ogemaw, Ontonagon, Osceola, Oscoda, Otsego, Presque Isle, Roscommon, Saginaw, Sanilac, Schoolcraft, Shiawassee, St. Joseph, Tuscola, Van Buren, Washtenaw and Wexford counties.

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

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

**Tennessee, Nashville** – Enrollment code **BT** – Bedford, Cannon, Cheatham, Coffee, Davidson, DeKalb, Dickson, Franklin, Giles, Lewis, Macon, Montgomery, Moore, Robertson, Rutherford, Smith, Sumner, Trousdale, Williamson and Wilson counties.

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

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

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

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

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

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

---

## Section 2. How we change for 2008

---

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

### Changes to this Plan

- United States Postal Service non-law enforcement career employees may now be covered either by Postal Category 1 or Postal Category 2 premium rates. (See page XX.)
- Enrollment code **DB** - Your share of the non-postal premium will increase for Self Only and increase for Self and Family. (See page 67.)
- Enrollment code **7T** - Your share of the non-postal premium will increase for Self Only and increase for Self and Family. (See page 67.)
- Enrollment code **MQ** - Your share of the non-postal premium will increase for Self Only and increase for Self and Family. (See page 67.)
- Enrollment code **YG** - Your share of the non-postal premium will increase for Self Only and increase for Self and Family. (See page 67.)
- Enrollment code **QP** - Your share of the non-postal premium will decrease for Self Only and decrease for Self and Family. (See page 67.)
- Enrollment code **MJ** - Your share of the non-postal premium will decrease for Self Only and decrease for Self and Family. (See page 68.)
- Enrollment code **MW** - Your share of the non-postal premium will increase for Self Only and increase for Self and Family. (See page 68.)
- Enrollment code **PH** - Your share of the non-postal premium will increase for Self Only and increase for Self and Family. (See page 68.)
- Enrollment code **6N** - Your share of the non-postal premium will increase for Self Only and increase for Self and Family. (See page 68.)
- Enrollment code **9L** - Your share of the non-postal premium will increase for Self Only and increase for Self and Family. (See page 68.)
- Enrollment code **9J** - Your share of the non-postal premium will increase for Self Only and increase for Self and Family. (See page 69.)
- Enrollment code **L8** - Your share of the non-postal premium will increase for Self Only and increase for Self and Family. (See page 69.)
- Enrollment code **L6** - Your share of the non-postal premium will increase for Self Only and increase for Self and Family. (See page 69.)
- Enrollment code **TV** - Your share of the non-postal premium will increase for Self Only and increase for Self and Family. (See page 70.)
- Enrollment code **TP** - Your share of the non-postal premium will increase for Self Only and increase for Self and Family. (See page 70.)
- Enrollment code **T8** - Your share of the non-postal premium will increase for Self Only and increase for Self and Family. (See page 70.)
- Enrollment code **T2** - Your share of the non-postal premium will increase for Self Only and increase for Self and Family. (See page 70.)

- Enrollment code **TU** - Your share of the non-postal premium will increase for Self Only and increase for Self and Family. (See page 70.)
- Enrollment code **FB** - Your share of the non-postal premium will increase for Self Only and increase for Self and Family. (See page 70.)
- Enrollment code **AD** - Your share of the non-postal premium will increase for Self Only and increase for Self and Family. (See page 68.)
- Enrollment code **BW** - Your share of the non-postal premium will increase for Self Only and increase for Self and Family. (See page 69.)
- Enrollment code **GT** - Your share of the non-postal premium will increase for Self Only and increase for Self and Family. (See page 69.)
- Enrollment code **HZ** - Your share of the non-postal premium will increase for Self Only and increase for Self and Family. (See page 68.)
- Enrollment code **LM** - Your share of the non-postal premium will increase for Self Only and increase for Self and Family. (See page 68.)
- Enrollment code **BT** - Your share of the non-postal premium will increase for Self Only and increase for Self and Family. (See page 69.)
- Enrollment code **FC** - Your share of the non-postal premium will increase for Self Only and increase for Self and Family. (See page 67.)
- Enrollment code **DL** - Your share of the non-postal premium will increase for Self Only and increase for Self and Family. (See page 67.)
- Enrollment code **FT** - Your share of the non-postal premium will increase for Self Only and increase for Self and Family. (See page 69.)
- Enrollment code **BP** - Your share of the non-postal premium will increase for Self Only and increase for Self and Family. (See page 67.)

**Benefit changes to all enrollment codes**

- Your Outpatient Hospital/Ambulatory Surgical Center copay will increase from a \$100 copay to a \$150 copay. (See page 33.)
- Your Outpatient Hospital Services such as: MRI, MRA, CAT, PET, and SPECT, both at a Hospital and Free Standing Facility will increase from a \$50 copay to a \$100 copay. (See page 33.)
- Your outpatient non-surgical, such as: Laboratory tests, mammograms, and x-rays will increase from a \$0 copay, to a \$50 copay. (See page 33.)
- Your treatment therapies will increase from a \$0 copay to a \$35 copay. (See page 33.)

**Service Area Expansions**

- Our service area expansion in Arizona includes Tucson and the county of Pima, Enrollment Code DB. (See page 8.)
- Our service area expansion in Kansas includes Lawrence and the county of Douglas, Enrollment Code PH. (See page 8.)

---

## Section 3. How you get care

---

<b>Identification cards</b>	<p>We will send you an identification (ID) card when you enroll. You should carry your ID card with you at all times. You must show it whenever you receive services from a Plan provider, or fill a prescription at a Plan pharmacy. Until you receive your ID card, use your copy of the Health Benefits Election Form, SF-2809, your health benefits enrollment confirmation (for annuitants), or your electronic enrollment system (such as Employee Express) confirmation letter.</p> <p>If you do not receive your ID card within 30 days after the effective date of your enrollment, or if you need replacement cards, call us at 1-800/4HUMANA or 1-800/448-6262. You may also request replacement cards through our Web site at <a href="http://feds.humana.com">feds.humana.com</a>.</p>
<b>Where you get covered care</b>	<p>You can get care from any “Plan provider” or “Plan facility.” You will only pay copayments, deductibles, and/or coinsurance, and you will not have to file claims. You can also get care from non-Plan providers, but it will cost you more.</p>
<ul style="list-style-type: none"><li>• <b>Plan providers</b></li></ul>	<p>Plan providers are physicians and other health care professionals in our service area that we contract with to provide covered services to our members. We credential Plan providers according to national standards.</p> <p>We list Plan providers in the provider directory, which we update periodically. The list is also on our Web site at <a href="http://feds.humana.com">feds.humana.com</a>.</p>
<ul style="list-style-type: none"><li>• <b>Plan facilities</b></li></ul>	<p>Plan facilities are hospitals and other facilities in our service area that we contract with to provide covered services to our members. We list these in the provider directory, which we update periodically. The list is also on our Web site at <a href="http://feds.humana.com">feds.humana.com</a>.</p>
<b>What you must do to get covered care</b>	<p>You do not have to select a primary care physician and may self refer. To obtain the highest level of coverage, however, a member must seek care from a participating provider. Some care requires you or your provider to obtain prior authorization.</p>
<ul style="list-style-type: none"><li>• <b>Specialty care</b></li></ul>	<p>Here are things you should know about specialty care:</p> <p>If you have a chronic and disabling condition and lose access to your specialist because we:</p> <ul style="list-style-type: none"><li>• Terminate our contract with your specialist for other than cause; or</li><li>• Drop out of the Federal Employees Health Benefits (FEHB) Program and you enroll in another FEHB program Plan,</li></ul> <p>you may be able to continue seeing your specialist for up to 90 days after you receive notice of the change. Contact us, or if we drop out of the Program, contact your new plan.</p> <p>If you are in the second or third trimester of pregnancy and you lose access to your specialist based on the above circumstances, you can continue to see your specialist until the end of your postpartum care and continue to receive participating provider benefits, even if it is beyond the 90 days.</p>
<ul style="list-style-type: none"><li>• <b>Hospital care</b></li></ul>	<p>Your Plan primary care physician or specialist will make necessary hospital arrangements and supervise your care. This includes admission to a skilled nursing or other type of facility.</p>
<ul style="list-style-type: none"><li>• <b>If you are hospitalized when your enrollment begins</b></li></ul>	<p>We pay for covered services from the effective date of your enrollment. However, if you are in the hospital when your enrollment in our Plan begins, call our customer service department immediately at 800- 426- 2173. If you are new to the FEHB Program, we will arrange for you to receive care and provide benefits for your covered services while you are in the hospital beginning on the effective date of your coverage.</p>

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

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

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

**Circumstances beyond our control**

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

**Services requiring our prior approval**

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

You must obtain preauthorization for the following services and supplies:

- Organ/tissue transplants
- All elective medical and surgical hospitalizations (Including Inpatient Hospice)
- Non emergent admissions for mental health, skilled nursing ,acute rehabilitation facilities and long term acute care facilities
- MRI , MRA, PET, CT Scan, SPECT Scan and Nuclear stress test.
- Uvulopalatopharyngoplasty (UPPP)
- Surgical treatment for morbid obesity
- All durable medical equipment (DME) over \$750
- Home health care services (Including Home Hospice)
- Infertility testing and treatment
- Sclerotherapy and Surgical Treatment for Varicose Vein
- Some prescription drugs
- All surgeries which may be considered plastic or cosmetic surgery
- AICD, Automatic Implantable Cardioverter Defibrillators
- Oral surgeries
- Ventricular assist devices
- Facet Injections
- Hyperbaric Therapy
- Outpatient Therapy Services for Physical, Occupational and Speech

Services requiring prior approval may change. Please check our web site for the most current list. The Prior Authorization phone number is on the member ID card.

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

## Section 4. Your costs for covered services

Each covered member under Humana CoverageFirst has a \$1000 benefit allowance to use for participating provider services. This allowance can be used for medical and mental health benefits before a deductible must be met. For expenses applied to the \$1000 benefit allowance, your only out-of-pocket costs are copayments.

Once your \$1000 benefit allowance is used, you pay all of your medical expenses until you satisfy your deductible. Your costs are based on Humana’s contracted rates. The following services do not apply to the benefit allowance or the deductible:

- **Prescription drugs and preventive care services** – You pay only the copayments (or the coinsurance for tier four drugs)
- **Routine physician office visits** – You pay only the copayments, even if your benefit allowance has been depleted. The copayment covers services billed as an office visit or consultation. Other services provided in the physician’s office, such as lab work or X-rays, are subject to the deductible.

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

**Here are some examples of how Humana CoverageFirst works:**

### Example 1

In January a member sees a specialist for a preventive Well Woman exam. Her physician prescribes a drug which she receives from a participating pharmacy.

In May she becomes ill and sees her primary care physician. Her physician sends her to the hospital for lab work and x-rays.

<b>Date of Service</b>	<b>Service – Participating Provider</b>	<b>Cost of Service</b>	<b>YOU PAY</b>	<b>Applied to Benefit Allowance</b>	<b>Plan pays</b>
January	Specialist Office Visit – Preventive *	\$150	\$35	\$0	\$115
January	Prescription Drug – Level 1 *	\$75	\$10	\$0	\$65
May	Primary Care Office Visit – Routine Care	\$100	\$20	\$80	\$0
May	Outpatient – Lab and X-ray	\$350	\$50	\$300	\$0
	<b>Totals</b>	<b>\$675</b>	<b>\$115</b>	<b>\$380</b>	<b>\$180</b>

In this example, \$380 was applied to the member’s benefit allowance, leaving a balance of \$620 for the remainder of the year.

\* Preventive care and prescription drugs do not reduce the benefit allowance or deductible`

**Example 2**

In March a member sees a specialist about a sports related injury. In April he has out patient surgery, followed by physical therapy.

In June he has a follow up visit with the specialist.

<b>Date of Service</b>	<b>Service- Participating Providers</b>	<b>Cost of Service</b>	<b>YOU PAY</b>	<b>Applied to Benefit allowance</b>	<b>Applied to Deductible</b>	<b>Plan pays</b>
March	Specialist office visit	\$135	\$35	\$100	\$0	\$0
April	Out Patient surgery – Facility	\$1050	\$150	\$900	\$0	\$0
April	Physicians Charges	\$2000	\$0	\$ 0	\$1000	\$1000
May	Physical Therapy (5 visits )	\$450	\$0	\$0	\$0	\$450
June	Specialist office Visit	\$125	\$35	\$0	\$0	\$90
	<b>Totals</b>	<b>\$3760</b>	<b>\$220</b>	<b>\$1000</b>	<b>\$1000</b>	<b>\$1540</b>

In this example, the member uses his benefit allowance and also meets his \$1000 deductible. For the remainder of the year, he will only be responsible for copayments.

**Copayments**

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

Copayments apply, even after you meet your deductible.

Example: When you see a participating Family Practice physician you will pay a \$20 copayment. When you have outpatient surgery at a participating facility, you will pay a \$150 copayment. Copayments do not reduce your \$1000 benefit allowance or count towards the deductible.

**Cost-sharing**

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

**Deductible**

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

Participating providers – If you use participating providers, you do not have to meet a deductible until your \$1000 benefit allowance is depleted. The calendar year individual deductible is \$1,000. Under a family enrollment, the deductible is \$2,000.

Non-participating providers – If you use non-participating providers, the \$1000 benefit allowance does not apply. Before benefits are payable, the calendar year deductible of \$3,000 per person must be met. The deductible for family coverage is \$6,000. Deductible and out-of-pocket limits for participating and non-participating benefits are calculated separately.

**Coinsurance**

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

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

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

**Differences between our allowance and the bill**

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

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

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

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

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

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

**Carryover**

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

**When Government facilities bill us**

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

**Section 5. Benefits**

This benefits section is divided into subsections. Please read the important things you should keep in mind at the beginning of each section. Read the General Exclusions in Section 6; they apply to the benefits in the following subsections. Also read pages 10-11 to see how we changed this year.

Section 5(a). Medical services and supplies provided by physicians and other health care professionals.....18

- Diagnostic and treatment services.....18
- Lab, X-ray and other diagnostic tests.....18
- Preventive care, adult.....19
- Preventive care, children.....20
- Maternity care .....20
- Family planning .....21
- Infertility services .....21
- Allergy care.....21
- Treatment therapies.....22
- Physical, occupational and cardiac therapies.....22
- Speech therapy.....23
- Hearing services (testing, treatment, and supplies).....23
- Vision services (testing, treatment, and supplies).....23
- Foot care.....23
- Orthopedic and prosthetic devices .....24
- Durable medical equipment (DME).....24
- Home health services .....25
- Chiropractic.....25
- Alternative treatments .....25
- Educational classes and programs.....25

Section 5(b). Surgical and anesthesia services provided by physicians and other health care professionals .....26

- Surgical procedures.....26
- Reconstructive surgery.....27
- Oral and maxillofacial surgery.....28
- Organ/tissue transplants .....28
- Anesthesia .....30

Section 5(c). Services provided by a hospital or other facility, and ambulance services .....31

- Inpatient hospital.....31
- Outpatient hospital or ambulatory surgical center .....32
- Extended care benefits/Skilled nursing care facility benefits .....32
- Hospice care.....33
- Ambulance .....33

Section 5(d). Emergency services/accidents .....34

- Emergency services.....34
- Ambulance .....35

Section 5(e). Mental health and substance abuse benefits .....36

- Mental health and substance abuse benefits .....36

Section 5(f). Prescription drug benefits .....38

- Covered medications and supplies.....39

Section 5(g). Dental benefits.....40

- Accidental injury benefit.....40
- Dental benefits .....40

Section 5(h). Special features.....41  
    Personal Nurse® .....41  
    HumanaFirst.....41  
    MyHumana.....41  
    HumanaBeginnings®.....41  
    Disease management.....41  
    Transplant management.....41  
    Case management.....41  
    Services for deaf and hearing impaired.....41  
    Infertility benefits.....41  
    Hearing benefits.....41  
    Autism.....41  
    Chiropractic.....41  
2008 Summary of benefits for the Consumer Driven Health Plan .....62

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

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

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- A facility copay applies to services that appear in this section but are performed in an ambulatory surgical center or the outpatient department of a hospital.
- Copays apply, even after you meet your deductible.
- The calendar year deductible is:

Participating providers – You do not have to meet a deductible until your \$1000 benefit allowance is depleted. The calendar year deductible is \$1,000 for self and \$2,000 for self and family.

Non-participating providers – The \$1000 benefit allowance does not apply. The calendar year deductible is \$3,000 for self and \$6,000 for self and family.

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

Benefit Description	You pay
<b>Note: The calendar year deductible applies to almost all benefits in this Section. We say “(No deductible)” when it does not apply.</b>	
<b>Diagnostic and treatment services</b>	
Professional services of physicians <ul style="list-style-type: none"> <li>• In physician’s office</li> <li>• Office medical consultations</li> <li>• At home</li> <li>• Second surgical opinion</li> </ul>	Participating: \$20 per office visit to a primary care physician; \$35 per office visit to a specialist (no deductible)  Non-participating: 30% of our plan allowance and any difference between our allowance and the billed amount
<ul style="list-style-type: none"> <li>• In an urgent care center</li> </ul>	Participating: \$35 copay (no deductible)  Non-participating: 30% of our plan allowance and any difference between our allowance and the billed amount
<ul style="list-style-type: none"> <li>• During a hospital stay</li> <li>• In a skilled nursing facility</li> </ul>	Participating: Nothing after deductible  Non-participating: 30% of our plan allowance and any difference between our allowance and the billed amount
<b>Lab, X-ray and other diagnostic tests</b>	
Tests, such as: <ul style="list-style-type: none"> <li>• Blood tests</li> <li>• Urinalysis</li> <li>• Non-routine Pap tests</li> <li>• Pathology</li> <li>• X-rays</li> <li>• Non-routine mammograms</li> </ul>	Participating: Nothing after deductible  Non-participating: 30% of our plan allowance and any difference between our allowance and the billed amount

*Lab, X-ray and other diagnostic tests - continued on next page*

Benefit Description	You pay
<b>Lab, X-ray and other diagnostic tests (cont.)</b>	
<ul style="list-style-type: none"> <li>• CAT Scans/MRI (See <i>Services requiring our prior approval</i> in Section 3).</li> <li>• Ultrasound</li> <li>• Electrocardiogram and EEG</li> </ul>	<p>Participating: Nothing after deductible</p> <p>Non-participating: 30% of our plan allowance and any difference between our allowance and the billed amount</p>
<b>Preventive care, adult</b>	
<p>When receiving these services from a participating provider, it is not necessary to first meet your deductible. The cost of the services does not apply toward your \$1000 benefit allowance. You only have to pay your copayment.</p> <p>Annual routine physical,</p> <p>Routine screenings, such as:</p> <ul style="list-style-type: none"> <li>• A fasting lipoprotein profile (total cholesterol, LDL, HDL, and triglycerides) – once every five years for adults 20 or over; and</li> <li>• Colorectal Cancer Screening, including <ul style="list-style-type: none"> <li>- Fecal occult blood test</li> <li>- Sigmoidoscopy, screening – every five years starting at age 50; or</li> <li>- Double contrast barium enema – once every five to ten years starting at age 50; or</li> <li>- Colonoscopy screening – once every ten years starting at age 50.</li> </ul> </li> <li>• Bone density testing for women age 35 and older</li> <li>• Chlamydial infection screening</li> <li>• Routine Prostate Specific Antigen (PSA) test – one annually for men age 40 and older</li> <li>• Routine Pap test – one annually</li> </ul> <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> <p>Routine mammogram – covered for women age 35 and older, as follows:</p> <ul style="list-style-type: none"> <li>• From age 35 through 39, one during this five year period</li> <li>• From age 40 through 64, one every calendar year</li> <li>• At age 65 and older, one every two consecutive calendar years</li> <li>• When prescribed by the doctor as medically necessary to diagnose or treat illness</li> </ul> <p>Adult routine immunizations endorsed by the Centers for Disease Control and Prevention (CDC).</p>	<p>Participating: \$20 per office visit to a primary care physician; \$35 per office visit to a specialist (no deductible)</p> <p>Non-participating: 30% of our plan allowance and any difference between our allowance and the billed amount</p>
<p><i>Not covered: Physical exams and immunizations required for obtaining or continuing employment or insurance, attending schools or camp, or travel.</i></p>	<p><i>All charges</i></p>

Benefit Description	You pay
<b>Preventive care, children</b>	
<p>When receiving these services from a participating provider, it is not necessary to first meet your deductible. The cost of the services does not apply toward your \$1000 benefit allowance. You only have to pay your copayment.</p> <ul style="list-style-type: none"> <li>• Childhood immunizations recommended by the American Academy of Pediatrics</li> <li>• Well-child care charges for routine examinations, immunizations and care (up to age 22)</li> <li>• Examinations, such as: <ul style="list-style-type: none"> <li>- Eye exams through age 17 to determine the need for vision correction</li> <li>- Ear exams through age 17 to determine the need for hearing correction</li> <li>- Examinations done on the day of immunizations (up to age 22)</li> </ul> </li> </ul>	<p>Participating: \$20 per office visit to a primary care physician; \$35 per office visit to a specialist (no deductible)</p> <p>Non-participating: 30% of our plan allowance and any difference between our allowance and the billed amount</p>
<b>Maternity care</b>	
<p>Complete maternity (obstetrical) care, such as:</p> <ul style="list-style-type: none"> <li>• Prenatal care</li> <li>• Delivery</li> <li>• Postnatal care</li> </ul> <p>Note: Here are some things to keep in mind:</p> <ul style="list-style-type: none"> <li>• You do not need to precertify your normal delivery; see page 13 for other circumstances, such as extended stays for you or your baby.</li> <li>• You may remain in the hospital up to 48 hours after a regular delivery and 96 hours after a cesarean delivery. We will extend your inpatient stay for you or your baby if medically necessary.</li> <li>• We cover routine nursery care of the newborn child during the covered portion of the mother’s maternity stay. We will cover other care of an infant who requires non-routine treatment only if we cover the infant under a Self and Family enrollment. Surgical benefits, not maternity benefits, apply to circumcision.</li> <li>• We pay hospitalization and surgeon services (delivery) the same as for illness and injury. See Hospital benefits (Section 5c) and Surgery benefits (Section 5b).</li> </ul>	<p>Participating: \$20 per office visit to a primary care physician; \$35 per office visit to a specialist (no deductible)</p> <p>Copay applies to first visit only</p> <p>Non-participating: 30% of our plan allowance and any difference between our allowance and the billed amount</p>
<p><i>Not covered: Routine sonograms to determine fetal age, size or sex</i></p>	<p><i>All charges</i></p>

Benefit Description	You pay
<b>Family planning</b>	
<p>A range of voluntary family planning services, limited to:</p> <ul style="list-style-type: none"> <li>• Surgically implanted contraceptives</li> <li>• Injectable contraceptive drugs (such as Depo Provera)</li> <li>• Intrauterine devices (IUDs)</li> <li>• Diaphragms</li> <li>• Voluntary sterilization (See <i>Surgical procedures</i>, Section 5b)</li> </ul> <p>Note: We cover oral contraceptives under the prescription drug benefit.</p>	<p>Participating: Nothing after deductible</p> <p>Non-participating: 30% of our plan allowance and any difference between our allowance and the billed amount</p>
<i>Not covered: Reversal of voluntary surgical sterilization</i>	<i>All charges</i>
<b>Infertility services</b>	
<p>Diagnosis and treatment of infertility, such as:</p> <ul style="list-style-type: none"> <li>• Artificial insemination: <ul style="list-style-type: none"> <li>- intravaginal insemination (IVI)</li> <li>- intracervical insemination (ICI)</li> <li>- intrauterine insemination (IUI)</li> </ul> </li> <li>• Fertility drugs</li> </ul> <p>Note: We cover injectable fertility drugs under medical benefits and oral fertility drugs under the prescription drug benefit.</p>	<p>Participating: 50% of charges</p> <p>Non-participating: 50% up to \$5,000 limit per plan year, of our plan allowance and any difference between our allowance and the billed amount</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• <i>Assisted reproductive technology (ART) procedures, such as:</i> <ul style="list-style-type: none"> <li>- <i>in vitro fertilization</i></li> <li>- <i>embryo transfer, gamete intra-fallopian transfer (GIFT) and zygote intra-fallopian transfer (ZIFT)</i></li> </ul> </li> <li>• <i>Services and supplies related to excluded ART procedures</i></li> <li>• <i>Cost of donor sperm</i></li> <li>• <i>Cost of donor egg</i></li> </ul>	<i>All charges</i>
<b>Allergy care</b>	
<ul style="list-style-type: none"> <li>• Testing and treatment</li> </ul>	<p>Participating: \$20 per office visit to a primary care physician; \$35 per office visit to a specialist (no deductible when received in physician's office)</p> <p>Non-participating: 30% of our plan allowance and any difference between our allowance and the billed amount</p>
<ul style="list-style-type: none"> <li>• Allergy injection</li> </ul>	<p>Participating: \$5 copay per visit (no deductible)</p> <p>Non-participating: 30% of our plan allowance and any difference between our allowance and the billed amount</p>

*Allergy care - continued on next page*

Benefit Description	You pay
<b>Allergy care (cont.)</b>	
<ul style="list-style-type: none"> <li>Allergy serum</li> </ul>	Participating: Nothing  Non-participating: 30% of our plan allowance and any difference between our allowance and the billed amount
<i>Not covered: Provocative food testing and sublingual allergy desensitization</i>	<i>All charges</i>
<b>Treatment therapies</b>	
<ul style="list-style-type: none"> <li>Chemotherapy and radiation therapy</li> </ul> <p>Note: High dose chemotherapy in association with autologous bone marrow transplants is limited to those transplants listed under <i>Organ/Tissue Transplants</i> on page 30.</p> <ul style="list-style-type: none"> <li>Respiratory and inhalation therapy</li> <li>Dialysis – hemodialysis and peritoneal dialysis</li> <li>Intravenous (IV)/Infusion Therapy – Home IV and antibiotic therapy (See <i>Services requiring our prior approval</i> in Section 3).</li> <li>Growth hormone therapy</li> </ul> <p>Note: Growth hormone therapy is covered under the Prescription drug benefit and is subject to preauthorization and notification requirements</p>	Participating: \$35 copay per visit  Non-participating: 30% of our plan allowance and any difference between our allowance and the billed amount
<b>Physical, occupational and cardiac therapies</b>	
<p>60 visits per condition per year for the services of each of the following:</p> <ul style="list-style-type: none"> <li>qualified physical therapists; and</li> <li>occupational therapists.</li> </ul> <p>Note: We only cover therapy to restore bodily function when there has been a total or partial loss of bodily function due to illness or injury.</p> <p>Cardiac rehabilitation following a heart transplant, bypass surgery or a myocardial infarction, is provided.</p> <p>See <i>Services requiring our prior approval</i> in Section 3</p>	Participating: Nothing after deductible  Non-participating: 30% of our plan allowance and any difference between our allowance and the billed amount
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li><i>Long-term rehabilitative therapy</i></li> <li><i>Exercise programs</i></li> </ul>	<i>All charges</i>

Benefit Description	You pay
<b>Speech therapy</b>	
<ul style="list-style-type: none"> <li>60 visits per year</li> </ul> <p>See <i>Services requiring our prior approval</i> in Section 3</p>	<p>Participating: Nothing after deductible</p> <p>Non-participating: 30% of our plan allowance and any difference between our allowance and the billed amount</p>
<b>Hearing services (testing, treatment, and supplies)</b>	
<ul style="list-style-type: none"> <li>First hearing aid and testing only when necessitated by accidental injury</li> <li>Hearing testing for children through age 17 (see <i>Preventive care, children</i>)</li> </ul>	<p>Participating: Nothing after deductible</p> <p>Non-participating: 30% of our plan allowance and any difference between our allowance and the billed amount</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>All other hearing testing</li> <li>Hearing aids, testing and examinations for them</li> </ul>	<p><i>All charges</i></p>
<b>Vision services (testing, treatment, and supplies)</b>	
<ul style="list-style-type: none"> <li>Diagnosis and treatment of diseases of the eye</li> <li>Eye exam to determine the need for vision correction for children through age 17 (see <i>Preventive care, children</i>)</li> </ul>	<p>Participating: \$20 per office visit to a primary care physician; \$35 per office visit to a specialist (no deductible)</p> <p>Non-participating: 30% of our plan allowance and any difference between our allowance and the billed amount</p>
<ul style="list-style-type: none"> <li>One pair of eyeglasses or contact lenses to correct an impairment directly caused by accidental ocular injury or intraocular surgery (such as for cataracts)</li> </ul>	<p>Participating: Nothing after deductible</p> <p>Non-participating: 30% of our plan allowance and any difference between our allowance and the billed amount</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>Eyeglasses or contact lenses except as shown above</li> <li>Eye exercises and orthoptics</li> <li>Radial keratotomy and other refractive surgery</li> </ul>	<p><i>All charges</i></p>
<b>Foot care</b>	
<ul style="list-style-type: none"> <li>Routine foot care when you are under active treatment for a metabolic or peripheral vascular disease, such as diabetes. See <i>Orthopedic and prosthetic devices</i> for information on podiatric shoe inserts.</li> </ul>	<p>Participating: \$20 per office visit to a primary care physician; \$35 per office visit to a specialist (no deductible)</p> <p>Non-participating: 30% of our plan allowance and any difference between our allowance and the billed amount</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>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</li> <li>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)</li> </ul>	<p><i>All charges</i></p>

Benefit Description	You pay
<b>Orthopedic and prosthetic devices</b>	
<ul style="list-style-type: none"> <li>• Artificial limbs and eyes; stump hose</li> <li>• Externally worn breast prostheses and surgical bras, including necessary replacements, following a mastectomy</li> <li>• Internal prosthetic devices, such as artificial joints, pacemakers, cochlear implants, and surgically implanted breast implant following mastectomy. Note: See Section 5(b) for coverage of the surgery to insert the device.</li> <li>• Corrective orthopedic appliances for non-dental treatment of temporomandibular joint (TMJ) pain dysfunction syndrome.</li> </ul>	<p>Participating: Nothing, after deductible</p> <p>Non-participating: 30% of our plan allowance and any difference between our allowance and the billed amount</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• <i>Foot orthotics</i></li> <li>• <i>Orthopedic and corrective shoes</i></li> <li>• <i>Arch supports</i></li> <li>• <i>Heel pads and heel cups</i></li> <li>• <i>Lumbosacral supports</i></li> <li>• <i>Corsets, trusses, elastic stockings, support hose, and other supportive devices</i></li> <li>• <i>Prosthetic replacements provided less than 3 years after the last one we covered</i></li> </ul>	<p><i>All charges</i></p>
<b>Durable medical equipment (DME)</b>	
<p>We cover rental or purchase of durable medical equipment, at our option, including repair and adjustment. Covered items include:</p> <ul style="list-style-type: none"> <li>• Oxygen;</li> <li>• Dialysis equipment;</li> <li>• Hospital beds;</li> <li>• Wheelchairs;</li> <li>• Crutches;</li> <li>• Walkers;</li> <li>• Blood glucose monitors; and</li> <li>• Insulin pumps.</li> </ul> <p>Note: Items over \$750, See <i>Services requiring our prior approval</i> in Section 3.</p>	<p>Participating: Nothing, after deductible</p> <p>Non-participating: 30% of our plan allowance and any difference between our allowance and the billed amount</p>
<p><i>Not covered: Equipment such as exercise equipment, air cleaners</i></p>	<p><i>All charges</i></p>

Benefit Description	You pay
<b>Home health services</b>	
<ul style="list-style-type: none"> <li>• 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.</li> <li>• Services include oxygen therapy, intravenous therapy and medications.</li> </ul> <p>See <i>Services requiring our prior approval</i> in Section 3</p>	<p>Participating: Nothing, after deductible</p> <p>Non-participating: 30% of our plan allowance and any difference between our allowance and the billed amount</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• Nursing care requested by, or for the convenience of, the patient or the patient’s family;</li> <li>• Home care primarily for personal assistance that does not include a medical component and is not diagnostic, therapeutic, or rehabilitative.</li> </ul>	<p><i>All charges</i></p>
<b>Chiropractic</b>	
<ul style="list-style-type: none"> <li>• Manipulation of the spine and extremities</li> <li>• Adjunctive procedures such as ultrasound, electrical muscle stimulation, vibratory therapy, and cold pack application</li> </ul>	<p>Participating: \$35 copay per office visit</p> <p>Non-participating: 30% of our plan allowance and any difference between our allowance and the billed amount</p>
<b>Alternative treatments</b>	
<p>No benefit</p>	<p><i>All charges</i></p>
<b>Educational classes and programs</b>	
<p>Coverage is limited to:</p> <ul style="list-style-type: none"> <li>• Diabetes self management training</li> </ul>	<p>Participating: \$20 copayment for primary care providers; \$35 copay for specialist (no deductible)</p> <p>Non-participating: 30% of our plan allowance and any difference between our allowance and the billed amount</p>
<ul style="list-style-type: none"> <li>• Smoking Cessation – Up to \$100 for one smoking cessation program per member per lifetime.</li> </ul>	<p>All costs over \$100</p>

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

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

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

Participating providers – The calendar year deductible is \$1,000 for self and \$2,000 for self and family.

Non-participating providers – The calendar year deductible is \$3,000 for self and \$6,000 for self and family.

- The calendar year deductible applies to almost all benefits in this section.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- The amounts listed below are for the charges billed by a physician or other health care professional for your surgical care. Look in Section 5(c) for charges associated with the facility (i.e. hospital, surgical center, etc.).
- **YOUR PHYSICIAN MUST GET PRECERTIFICATION FOR SOME SURGICAL PROCEDURES.** Please refer to the precertification information shown in Section 3 to be sure which services require precertification and identify which surgeries require precertification.

Benefit Description	You pay
<b>Note: The calendar year deductible applies to almost all benefits in this Section. We say “(No deductible)” when it does not apply.</b>	
<b>Surgical procedures</b>	
<p>A comprehensive range of services, such as:</p> <ul style="list-style-type: none"> <li>• Operative procedures</li> <li>• Treatment of fractures, including casting</li> <li>• Normal pre- and post-operative care by the surgeon</li> <li>• Correction of amblyopia and strabismus</li> <li>• Endoscopy procedures</li> <li>• Biopsy procedures</li> <li>• Removal of tumors and cysts</li> <li>• Correction of congenital anomalies (see <i>Reconstructive surgery</i>)</li> <li>• Surgical treatment for morbid obesity (bariatric surgery). Some of the requirements that must be met before surgery can be authorized are:               <ul style="list-style-type: none"> <li>- Patient is 18 years of age or older</li> <li>- Body Mass Index of <math>\geq 40</math>, or a Body Mass Index of <math>\geq 35</math> with associated comorbidity such as:                   <ul style="list-style-type: none"> <li>• Hypertension</li> <li>• Type two diabetes</li> <li>• Life-threatening cardiopulmonary problems</li> </ul> </li> </ul> </li> </ul>	<p>Participating: Nothing after deductible</p> <p>Non-participating: 30% of our plan allowance and any difference between our allowance and the billed amount</p>

*Surgical procedures - continued on next page*  
Consumer Driven Health Plan Section 5(b)

Benefit Description	You pay
<b>Surgical procedures (cont.)</b>	
<ul style="list-style-type: none"> <li>- Physician's documentation which indicates that you have had unsuccessful attempt(s) with nonoperative medically-supervised weight-reduction program(s)</li> <li>- To obtain network benefits, you must receive services at a participating bariatric Centers of Excellence.</li> <li>• Insertion of internal prosthetic devices. See Section 5(a) – <i>Orthopedic and prosthetic devices</i> for device coverage information</li> <li>• Treatment of burns</li> <li>• Voluntary sterilization (e.g., Tubal ligation, Vasectomy)</li> </ul> <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>Participating: Nothing after deductible</p> <p>Non-participating: 30% of our plan allowance and any difference between our allowance and the billed amount</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• <i>Reversal of voluntary sterilization</i></li> <li>• <i>Radial keratotomy and other refractive surgery</i></li> <li>• <i>Routine treatment of conditions of the foot: See Foot care in Section 5(a)</i></li> </ul>	<p><i>All charges</i></p>
<b>Reconstructive surgery</b>	
<ul style="list-style-type: none"> <li>• Surgery to correct a functional defect</li> <li>• Surgery to correct a condition caused by injury or illness if: <ul style="list-style-type: none"> <li>- the condition produced a major effect on the member's appearance and</li> <li>- the condition can reasonably be expected to be corrected by such surgery</li> </ul> </li> <li>• Surgery to correct a condition that existed at or from birth and that is a significant deviation from the common form or norm. Examples of congenital anomalies are: protruding ear deformities; cleft lip; cleft palate; birth marks; webbed fingers and webbed toes.</li> <li>• All stages of breast reconstruction surgery following a mastectomy, such as: <ul style="list-style-type: none"> <li>- surgery to produce a symmetrical appearance of breasts;</li> <li>- treatment of any physical complications, such as lymphedemas;</li> <li>- breast prostheses and surgical bras and replacements (see <i>Orthopedic and Prosthetic devices</i>)</li> </ul> </li> </ul> <p>Note: If you need a mastectomy, you may choose to have the procedure performed on an inpatient basis and remain in the hospital up to 48 hours after the procedure.</p>	<p>Participating: Nothing after deductible</p> <p>Non-participating: 30% of our plan allowance and any difference between our allowance and the billed amount</p>

Benefit Description	You pay
<b>Reconstructive surgery (cont.)</b>	
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• 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</li> <li>• Surgeries related to sex transformation</li> </ul>	<p><i>All charges</i></p>
<b>Oral and maxillofacial surgery</b>	
<p>Oral surgical procedures, limited to:</p> <ul style="list-style-type: none"> <li>• Reduction of fractures of the jaws or facial bones;</li> <li>• Surgical correction of cleft lip, cleft palate or severe functional malocclusion;</li> <li>• Removal of stones from salivary ducts;</li> <li>• Excision of leukoplakia or malignancies;</li> <li>• Excision of cysts and incision of abscesses when done as independent procedures; and</li> <li>• Other surgical procedures that do not involve the teeth or their supporting structures.</li> </ul>	<p>Participating: Nothing after deductible</p> <p>Non-participating: 30% of our plan allowance and any difference between our allowance and the billed amount</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• <i>Procedures that involve the teeth or their supporting structures (such as the periodontal membrane, gingiva, and alveolar bone)</i></li> <li>• <i>Oral implants and transplants</i></li> <li>• <i>Dental work related to treatment of temporomandibular joint syndrome (TMJ)</i></li> </ul>	<p><i>All charges</i></p>
<b>Organ/tissue transplants</b>	
<p>Solid organ transplants limited to:</p> <ul style="list-style-type: none"> <li>• Heart</li> <li>• Heart/Lung</li> <li>• Single, double lung</li> <li>• Kidney</li> <li>• Liver</li> <li>• Pancreas</li> </ul> <p>Autologous pancreas islet cell transplant (as an adjunct to total or near pancreatectomy) only for patients with chronic pancreatitis.</p> <ul style="list-style-type: none"> <li>• Intestinal transplants <ul style="list-style-type: none"> <li>- Small intestine</li> <li>- Small intestine with the liver</li> <li>- Small intestines with multiple organs, such as the liver, stomach and pancreas</li> </ul> </li> </ul>	<p>Participating: Nothing after deductible</p> <p>Non-participating: 30% of our plan allowance and any difference between our allowance and the billed amount</p> <p>Non-participating transplant services do not apply toward the maximum out-of-pocket expense limit.</p> <p>The total amount of benefits payable by us for covered organ transplant services received from non-network providers will not exceed the transplant non-network benefit level of \$35,000.</p>

*Organ/tissue transplants - continued on next page*

Benefit Description	You pay
<b>Organ/tissue transplants (cont.)</b>	
<p>Blood or marrow stem cell transplants limited to the stages of the following diagnoses: (The medical necessity limitation is considered satisfied for other tissue transplants if the patient meets the staging description.)</p> <ul style="list-style-type: none"> <li>• Allogeneic transplants for <ul style="list-style-type: none"> <li>- Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia</li> <li>- Advanced Hodgkin’s lymphoma</li> <li>- Advanced non-Hodgkin’s lymphoma</li> <li>- Chronic myelogenous leukemia</li> <li>- Severe combined immunodeficiency</li> <li>- Severe or very severe aplastic anemia</li> </ul> </li> <li>• Autologous transplants for <ul style="list-style-type: none"> <li>- Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia</li> <li>- Advanced Hodgkin’s lymphoma</li> <li>- Advanced non-Hodgkin’s lymphoma</li> <li>- Advanced neuroblastoma</li> </ul> </li> <li>• Autologous tandem transplants for recurrent germ cell tumors (including testicular cancer)</li> </ul> <p>Blood or marrow stem cell transplants for;</p> <ul style="list-style-type: none"> <li>• Autologous transplants for <ul style="list-style-type: none"> <li>- Multiple myeloma</li> <li>- Testicular, mediastinal, retroperitoneal, and ovarian germ cell tumors</li> <li>- Breast cancer</li> <li>- Epithelial ovarian cancer</li> </ul> </li> </ul> <p>Blood or marrow stem cell transplants covered only in a National Cancer Institute or National Institutes of Health approved clinical trial at a Plan-designed center of excellence and if approved by the Plan’s medical director in accordance with the Plan’s protocol.</p> <p>Benefits are available for Allogeneic and Autologous blood or marrow stem cell transplants utilizing a phase two or higher protocol.</p> <ul style="list-style-type: none"> <li>• National Transplant Program (NTP)-all services are determined and authorized through our transplant department, utilizing our National Transplant Network.</li> </ul> <p>Note: We cover related medical and hospital expenses of the donor when we cover the recipient.</p> <p>See <i>Services requiring our prior approval</i> in Section 3.</p>	<p>Participating: Nothing after deductible</p> <p>Non-participating: 30% of our plan allowance and any difference between our allowance and the billed amount</p> <p>Non-participating transplant services do not apply toward the maximum out-of-pocket expense limit.</p> <p>The total amount of benefits payable by us for covered organ transplant services received from non-network providers will not exceed the transplant non-network benefit level of \$35,000.</p>

*Organ/tissue transplants - continued on next page*

Benefit Description	You pay
<b>Organ/tissue transplants (cont.)</b>	
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• Donor screening tests and donor search expenses, except those performed for the actual donor</li> <li>• Implants of artificial organs</li> </ul>	<p><i>All charges</i></p>
<b>Anesthesia</b>	
<p>Professional services provided in –</p> <ul style="list-style-type: none"> <li>• Hospital (inpatient)</li> <li>• Hospital outpatient department</li> <li>• Skilled nursing facility</li> </ul>	<p>Participating: Nothing after deductible</p> <p>Non-participating: 30% of our plan allowance and any difference between our allowance and the billed amount</p>
<ul style="list-style-type: none"> <li>• Ambulatory surgical center</li> <li>• Office</li> </ul>	<p>Participating: Nothing after deductible</p> <p>Non-participating: 30% of our plan allowance and any difference between our allowance and the billed amount</p>
<p>Professional services provided in –</p> <ul style="list-style-type: none"> <li>• Office</li> </ul>	<p>Participating: Nothing if you receive these services during an office visit</p> <p>Non-participating: 30% of our plan allowance and any difference between our allowance and the billed amount</p>

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

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

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

Participating providers – You do not have to meet a deductible until your \$1000 benefit allowance is depleted. The calendar year deductible is \$1,000 for self and \$2,000 for self and family.

Non-participating providers – The \$1000 benefit allowance does not apply. The calendar year deductible is \$3,000 for self and \$6,000 for self and family.

The calendar year deductible applies to almost all benefits in this section.

- The amounts listed below are for the charges billed by the facility (i.e., hospital or surgical center) or ambulance service for your surgery or care. Any costs associated with the professional charge (i.e., physicians, etc.) are in Sections 5(a) or (b).
- **YOUR PHYSICIAN MUST GET PRECERTIFICATION FOR HOSPITAL STAYS.** Please refer to Section 3 to be sure which services require precertification.

Benefit Description	You pay
<b>NOTE: The calendar year deductible applies to almost all benefits in this section. We say “no deductible” when the deductible does not apply.</b>	
<b>Inpatient hospital</b>	
Room and board, such as: <ul style="list-style-type: none"> <li>• Ward, semiprivate, or intensive care accommodations;</li> <li>• General nursing care; and</li> <li>• Meals and special diets.</li> </ul> Note: If you want a private room when it is not medically necessary, you pay the additional charge above the semiprivate room rate.	Participating: \$250 copayment per day for the first five days per admission  Non-participating: 30% of our plan allowance and any difference between our allowance and the billed amount
Other hospital services and supplies, such as: <ul style="list-style-type: none"> <li>• Operating, recovery, maternity, and other treatment rooms</li> <li>• Prescribed drugs and medicines</li> <li>• Diagnostic laboratory tests and X-rays</li> <li>• Dressings, splints, casts, and sterile tray services</li> <li>• Medical supplies and equipment, including oxygen</li> <li>• Anesthetics, including nurse anesthetist services</li> <li>• Take-home items</li> <li>• Medical supplies, appliances, medical equipment, and any covered items billed by a hospital for use at home.</li> </ul>	Nothing after deductible

Benefit Description	You pay
<b>Inpatient hospital (cont.)</b>	
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• Custodial care</li> <li>• Non-covered facilities, such as nursing homes, schools</li> <li>• Personal comfort items, such as telephone, television, barber services, guest meals and beds</li> <li>• Blood and blood components if not replaced</li> </ul>	<p><i>All charges</i></p>
<b>Outpatient hospital or ambulatory surgical center</b>	
<ul style="list-style-type: none"> <li>• Operating, recovery, and other treatment rooms</li> <li>• Prescribed drugs and medicines</li> <li>• Diagnostic laboratory tests, X-rays, and pathology services</li> <li>• Administration of blood, blood plasma, and other biologicals</li> <li>• Pre-surgical testing</li> <li>• Dressings, casts, and sterile tray services</li> <li>• Medical supplies, including oxygen</li> <li>• Anesthetics and anesthesia service</li> </ul> <p>Note: We cover hospital services and supplies related to dental procedures when necessitated by a non-dental physical impairment. We do not cover the dental procedures.</p>	<p>Participating: \$150 copay per visit</p> <p>Non-participating: 30% of our plan allowance and any difference between our allowance and the billed amount</p>
<p>Outpatient Hospital Services such as: MRI, MRA, CAT, PET, and SPECT both at a Hospital and Free Standing Facility.</p>	<p>Participating: \$100 copay</p> <p>Non-participating: 30 % of our plan allowance and any difference between our allowance and the billed amount</p>
<p>Outpatient non surgical, such as:</p> <ul style="list-style-type: none"> <li>• Laboratory tests, mammograms, and x-rays</li> </ul>	<p>Participating: \$50 copay</p> <p>Non-participating: 30% of our plan allowance and any difference between our allowance and the billed amount</p>
<p><i>Not covered: Blood and Blood components if not replaced by the member.</i></p>	<p><i>All charges</i></p>
<b>Extended care benefits/Skilled nursing care facility benefits</b>	
<p>Extended care benefit:</p> <p>Up to 60 days per calendar year, including:</p> <ul style="list-style-type: none"> <li>• Bed and board</li> <li>• General nursing care</li> <li>• Drugs, biologicals, supplies and equipment provided by the facility</li> </ul> <p>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.</p>	<p>Participating: Nothing after deductible</p> <p>Non-participating: 30% of our plan allowance and any difference between our allowance and the billed amount</p>
<p><i>Not covered: Custodial care</i></p>	<p><i>All charges</i></p>

Benefit Description	You pay
<b>Hospice care</b>	
<p>Supportive and palliative care for a terminally ill member is covered in the home or hospice facility. Includes:</p> <ul style="list-style-type: none"> <li>• Inpatient and outpatient services and supplies</li> </ul> <p>Note: These services must be described in a Hospice Care program that has been approved by us.</p> <p>See <i>Services requiring our prior approval</i> in Section 3</p>	<p>Participating: Nothing after deductible</p> <p>Non-participating: 30% of our plan allowance and any difference between our allowance and the billed amount</p>
<i>Not covered: Independent nursing; homemaker services</i>	<i>All charges</i>
<b>Ambulance</b>	
Local professional ambulance service when medically appropriate	<p>Participating: Nothing after deductible</p> <p>Non-participating: 30% of our plan allowance and any difference between our allowance and the billed amount</p>

## Section 5(d). Emergency services/accidents

**Important things to keep in mind about these benefits:**

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

Participating providers – You do not have to meet a deductible until your \$1000 benefit allowance is depleted. The calendar year deductible is \$1,000 for self and \$2,000 for self and family.

Non-participating providers – The \$1000 benefit allowance does not apply. The calendar year deductible is \$3,000 for self and \$6,000 for self and family.

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

**What is a medical emergency?**

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

**What to do in case of emergency:**

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

Benefit Description	You pay
<b>Note: The calendar year deductible applies to almost all benefits in this Section. We say “(No deductible)” when it does not apply.</b>	
<b>Emergency services</b>	
<ul style="list-style-type: none"> <li>• Emergency care at a doctor’s office</li> </ul>	Participating: \$20 at a primary care physician’s office; \$35 at a specialist’s office (no deductible)  Non-participating: 30% of our plan allowance and any difference between our allowance and the billed amount
<ul style="list-style-type: none"> <li>• Emergency care at an urgent care center</li> </ul>	Participating: \$35 copayment (no deductible)  Non-participating: 30% of our plan allowance and any difference between our allowance and the billed amount

*Emergency services - continued on next page*

Benefit Description	You pay
<b>Emergency services (cont.)</b>	
<ul style="list-style-type: none"> <li>Emergency care at a hospital, including doctors' services</li> </ul> <p>Note: If admitted, hospital copays apply. See Section 5(c) for <i>Inpatient Hospital Services</i></p>	<p>Participating: \$150 per visit; copay is waived if admitted</p> <p>Non-participating: 30% of our plan allowance and any difference between our allowance and the billed amount</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li><i>Elective care or non-emergency care</i></li> <li><i>Emergency care provided outside the service area if the need for care could have been foreseen before leaving the service area</i></li> <li><i>Medical and hospital costs resulting from a normal full-term delivery of a baby outside the service area</i></li> </ul>	<p><i>All charges</i></p>
<b>Ambulance</b>	
<p>Professional ambulance service when medically appropriate. See Section 5(c) for non-emergency service.</p>	<p>Participating: Nothing after deductible</p> <p>Non-participating: 30% of our plan allowance and any difference between our allowance and the billed amount (If true medical emergency – benefit paid as participating)</p>

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

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

**Important things to keep in mind about these benefits:**

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

Participating providers – You do not have to meet a deductible until your \$1000 benefit allowance is depleted. The calendar year deductible is \$1,000 for self and \$2,000 for self and family.

Non-participating providers – The \$1000 benefit allowance does not apply. The calendar year deductible is \$3,000 for self and \$6,000 for self and family.

- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- **YOU MUST GET PREAUTHORIZATION FOR THESE SERVICES.** See the instructions after the benefits description below.

Benefit Description	You pay
<p><b>Note: The calendar year deductible applies to almost all benefits in this Section. We say “(No deductible)” when it does not apply.</b></p>	
<p><b>Mental health and substance abuse benefits</b></p>	
<p>All diagnostic and treatment services recommended by a Plan provider and contained in a treatment plan that we approve. The treatment plan may include services, drugs, and supplies described elsewhere in this brochure.</p> <p>Note: Plan benefits are payable only when we determine the care is clinically appropriate to treat your condition and only when you receive the care as part of a treatment plan that we approve.</p>	<p>Your cost sharing responsibilities are no greater than for other illnesses or conditions.</p>
<ul style="list-style-type: none"> <li>• Professional services, including individual or group therapy by providers such as psychiatrists, psychologists, or clinical social workers</li> <li>• Medication management</li> </ul>	<p>Participating: \$35 per visit (no deductible)</p> <p>Non-participating: 30% of our plan allowance and any difference between our allowance and the billed amount</p>
<ul style="list-style-type: none"> <li>• Diagnostic tests</li> </ul>	<p>Participating: Nothing if you receive these services during an office visit; otherwise, nothing after deductible</p> <p>Non-participating: 30% of our plan allowance and any difference between our allowance and the billed amount</p>

*Mental health and substance abuse benefits - continued on next page*

Benefit Description	You pay
<b>Mental health and substance abuse benefits (cont.)</b>	
<ul style="list-style-type: none"> <li>• Services provided by a hospital or other facility</li> <li>• Services in approved alternative care settings such as partial hospitalization, full-day hospitalization, facility based intensive outpatient treatment</li> </ul>	<p>Participating: \$250 copay per day for the first five days per admission</p> <p>Non-participating: 30% of our plan allowance and any difference between our allowance and the billed amount</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>

**Preauthorization**

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

- Please contact the phone number on your identification card.

**Limitation**

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

---

## Section 5(f). Prescription drug benefits

---

### Important things to keep in mind about these benefits:

- We cover prescribed drugs and medications, as described in the chart beginning on the next page.
- Prescription copayments and coinsurance amounts do not apply to the benefit allowance or the deductibles when using participating pharmacies.
- 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.

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

- **Who can write your prescription.** A plan physician or licensed dentist must write the prescription.
- **Where you can obtain them.** You must fill the prescription at a plan pharmacy, or by mail for a prescribed maintenance medication. Maintenance medications are drugs that are generally prescribed for the treatment of long term chronic sicknesses or injuries.
- **The Rx4 Plan** allows members access to any drug that is used to treat a condition the medical plan covers. Thousands of drugs have been placed in levels based on their a) efficacy, b) safety, c) possible side effects, d) drug interactions, and e) cost compared to similar drugs. The levels are no longer based on a Drug List or formulary. New drugs are continually reviewed for level placement, dispensing limits and prior authorization requirements that represent the current clinical judgment of our Pharmacy and Therapeutics Committee.

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

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

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

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

**Rx4's** specific copayment amounts eliminate unexpected charges at the pharmacy, which means you won't have to calculate cost differentials when you choose brand-name drugs over generic equivalents. You can visit our web site at [feds.humana.com](http://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.

- **Prior Authorization** – Prior Authorization means the required prior approval from US for the coverage of Prescription drugs, medicines and medications, including the dosage, quantity and duration, as appropriate for the Member's diagnosis, age and sex. Certain Prescription drugs, medicines or medications may require Prior Authorization.
- **These are the dispensing limitations.** Prescription drugs dispensed at a Plan pharmacy will be dispensed for up to a 30-day supply. You may receive up to a 90-day supply of a prescribed maintenance medication through our mail-order program.

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

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

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

Benefit Description	You pay
<p><b>Note: The calendar year deductible applies to almost all benefits in this Section. We say "(No deductible)" when it does not apply.</b></p>	
<p><b>Covered medications and supplies</b></p>	
<p>We cover the following medications and supplies prescribed by a plan physician and obtained from a Plan pharmacy or through our mail order program:</p> <ul style="list-style-type: none"> <li>• Drugs and medicines that by Federal law of the United States require a physician’s prescription for their purchase, except those listed as <i>Not covered</i>.</li> <li>• Insulin</li> <li>• Disposable needles and syringes for the administration of covered medications</li> <li>• Diabetes supplies including testing agents, lancet devices, alcohol swabs, glucose elevating agents, insulin delivery devices and blood glucose monitors approved by us</li> <li>• Self administered injectable drugs</li> <li>• Oral fertility drugs</li> <li>• Oral contraceptive drugs</li> <li>• Growth hormone</li> <li>• Drugs for sexual dysfunction</li> </ul> <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>At participating pharmacies:</p> <p>\$10 for Level One drugs</p> <p>\$30 for Level Two drugs</p> <p>\$50 for Level Three drugs</p> <p>25% of the amount that the plan pays to the dispensing pharmacy for Level Four drugs</p> <p>The out of pocket maximum for Level Four drugs is \$2,500 per member per calendar year</p> <p>2 applicable copays for a 90-day supply of prescribed maintenance drugs, when ordered through our mail-order program</p> <p>At non-participating pharmacies:</p> <p>30% of charges plus applicable copay</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• <i>Drugs available without a prescription, or for which there is a non-prescription equivalent available</i></li> <li>• <i>Drugs and supplies for cosmetic purposes (such as Rogaine)</i></li> <li>• <i>Vitamins, fluoride, nutrients and food supplements even if a physician prescribes or administers them</i></li> <li>• <i>Drugs obtained at a non-Plan pharmacy except for out-of-area emergencies</i></li> <li>• <i>Drugs to enhance athletic performance</i></li> <li>• <i>Smoking cessation drugs and medications, including nicotine patches</i></li> <li>• <i>Any drug used for the purpose of weight control</i></li> <li>• <i>Medical supplies such as dressings and antiseptics</i></li> </ul>	<p><i>All charges</i></p>

## Section 5(g). Dental benefits

**Important things to keep in mind about these benefits:**

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary
- If you are enrolled in a Federal Employee Dental Vision Insurance Program (FEDVIP) Dental Plan, your FEHB Plan will be primary payer of any Benefit payments and your FEDVIP Plan is secondary to your FEHB Plan. See Section 9 Coordinating benefits with other coverage.
- Plan dentists must provide or arrange your care.
- We cover hospitalization for dental procedures only when a non-dental physical impairment exists which makes hospitalization necessary to safeguard the health of the patient. See Section 5(c) for inpatient hospital benefits. We do not cover the dental procedure unless it is described below.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

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

## Section 5(h). Special features

Feature	Description
<b>Personal Nurse<sup>®</sup></b>	The Personal Nurse is a registered nurse that partners with you throughout your course of membership, providing education, counseling, and motivation. The Personal Nurse supports you in understanding your condition or illness, resources that may help, and how to most effectively use your benefits – all in an effort to help you realize your health goals and live a healthier life. From clinical care coordination to health education to benefit guidance, the Personal Nurse is committed to helping you with your unique needs.
<b>HumanaFirst</b>	Registered nurses are available around the clock to answer health-related questions and to help you decide where to best seek treatment. These nurses can be of service when you are contemplating a trip to the ER for a sore elbow, taking a child with fever to the hospital in the middle of the night, or don't know if a reaction to a new medication is normal. Additionally, they can help with 'how-to' questions like how to properly change a bandage at home or how to use certain durable medical equipment.
<b>MyHumana</b>	<i>MyHumana</i> is your password-protected, personal home page on <a href="http://humana.com">humana.com</a> . You can log in anytime to look up your benefits, check the status of a claim, find participating providers, and more. <i>MyHumana</i> also has lots of resources to help you make health care decisions – such as prescription drug information, a health encyclopedia, and centers focused on managing specific conditions like diabetes and heart disease – as well as financial tools to help with budgeting for health care.
<b>HumanaBeginnings<sup>®</sup></b>	<i>HumanaBeginnings</i> is dedicated to helping Humana members make healthy decisions throughout pregnancy. The program combines personal contact with a registered nurse specially trained in pre-natal care and informative mailings to help you reach your goal of having a happy, healthy baby. While <i>HumanaBeginnings</i> looks to help those mothers with special needs, all expectant mothers are encouraged to register.
<b>Disease management</b>	To help you manage specific chronic conditions, Humana has developed an array of disease management programs. Humana offers programs for asthma, cancer, congestive heart failure, coronary artery disease, diabetes, kidney disease, neonatal intensive care, and 13 rare diseases including cystic fibrosis and Parkinson's disease – all designed to engage you in actively managing chronic, long-term conditions.
<b>Transplant management</b>	The dedicated Transplant Department provides effective ways for you and your family to manage the complex and emotional process of organ and tissue transplants. These specialists review coverage, coordinate benefits, facilitate services, and follow the transplant recipient's progress from initial referral through treatment and recovery.
<b>Case management</b>	Humana understands that facing major medical situations can be overwhelming with the complex information and decisions. Case Managers are there to help you navigate the health care system, coordinate necessary services, understand your health benefit coverage, and hopefully make things a little easier during a difficult time.
<b>Services for deaf and hearing impaired</b>	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.
<b>Infertility benefits</b>	Illinois benefits comply with state mandates.
<b>Hearing benefits</b>	Louisiana and Kentucky benefits comply with state mandates.
<b>Autism</b>	Kentucky benefits comply with state mandates.
<b>Chiropractic</b>	Kentucky and Florida benefits comply with state mandates.

---

## Non-FEHB benefits available to Plan members

---

The benefits on this page are not part of the FEHB contract or premium, and you cannot file an FEHB disputed claim about them. Fees you pay for these services do not count toward FEHB deductibles or catastrophic protection out-of-pocket maximums. These programs and materials are the responsibility of the Plan, and all appeals must follow their guidelines. For additional information contact us at, 1-800-4-HUMANA or visit the website at [feds.humana.com](http://feds.humana.com).

**Expanded Dental Benefits**

South Florida and Chicago area members

Please refer to our web site at [feds.humana.com](http://feds.humana.com) for availability of Dental Plan offerings.

**Complementary and Alternative Medicine**

A Complementary and Alternative Medicine section is provided within the Savings Center of *MyHumana*. Links are provided to several vendors such as American Whole Health, Dr. Weil's MyOptimum Health Plan, Holistic Primary Care, and Mind/Body Skills for Healing that have negotiated discounts with Humana members. These sites provide coupons and discounts for alternative medicine services such as chiropractic care, acupuncture, and massage therapy. In addition, there are savings on publications and health related products and services.

**EyeMed Vision Discount Program**

EyeMed offers access to ophthalmologists, optometrists, opticians and Lenscrafters. Receive discounts for eye exams, frames, and contacts lenses. There are no claim forms to file and no waiting for reimbursement. No premium is required.

To locate a provider go to the Savings Center section of *MyHumana* on our web site or call EyeMed at 1-866-392-6056.

**TruVision**

Discounts on traditional and custom LASIK procedures. To find a location call 1-877-580-2020.

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

---

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

---

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

We do not cover the following:

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

---

## Section 7. Filing a claim for covered services

---

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

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

### **Medical and hospital benefits**

In most cases, providers and facilities file claims for you. Physicians must file on the form HCFA-1500, Health Insurance Claim Form. Your facility 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 received outside the Plan’s service area – submit it on the HCFA-1500 or a claim form that includes the information shown below. Bills and receipts should be itemized and show:

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

**Submit your claims to: Humana Claims Office  
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 benefits for your claim if you do not respond.

---

## Section 8. The disputed claims process

---

Follow this Federal Employees Health Benefits Program disputed claims process if you disagree with our decision on your claim or request for services, drugs, or supplies – including a request for preauthorization/prior approval as required by Section 3:

Step	Description
<b>1</b>	<p>Ask us in writing to reconsider our initial decision. You must:</p> <ul style="list-style-type: none"><li>a) Write to us within 6 months from the date of our decision; and</li><li>b) Send your request to us at: Humana Claims Office, Attn: Grievance &amp; Appeals, P.O. Box 14601, Lexington, KY 40512-4601; and</li><li>c) Include a statement about why you believe our initial decision was wrong, based on specific benefit provisions in this brochure; and</li><li>d) Include copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms.</li></ul>
<b>2</b>	<p>We have 30 days from the date we receive your request to:</p> <ul style="list-style-type: none"><li>a) Pay the claim (or, if applicable, arrange for the health care provider to give you the care); or</li><li>b) Write to you and maintain our denial - go to step 4; or</li><li>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.</li></ul>
<b>3</b>	<p>You or your provider must send the information so that we receive it within 60 days of our request. We will then decide within 30 more days.</p> <p>If we do not receive the information within 60 days, we will decide within 30 days of the date the information was due. We will base our decision on the information we already have.</p> <p>We will write to you with our decision.</p>
<b>4</b>	<p>If you do not agree with our decision, you may ask OPM to review it.</p> <p>You must write to OPM within:</p> <ul style="list-style-type: none"><li>• 90 days after the date of our letter upholding our initial decision; or</li><li>• 120 days after you first wrote to us - if we did not answer that request in some way within 30 days; or</li><li>• 120 days after we asked for additional information.</li></ul> <p>Write to OPM at: United States Office of Personnel Management, Insurance Services Programs, Health Insurance Group 3, 1900 E Street, NW, Washington, DC 20415-3630.</p> <p>Send OPM the following information:</p> <ul style="list-style-type: none"><li>• A statement about why you believe our decision was wrong, based on specific benefit provisions in this brochure;</li><li>• Copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms;</li><li>• Copies of all letters you sent to us about the claim;</li><li>• Copies of all letters we sent to you about the claim; and</li><li>• Your daytime phone number and the best time to call.</li></ul> <p>Note: If you want OPM to review more than one claim, you must clearly identify which documents apply to which claim.</p>

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

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 1-800-523-0023 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 has coverage under any other health plan or has automobile insurance that pays health care expenses without regard to fault. This is called “double coverage.”

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

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

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

### What is Medicare?

Medicare is a Health Insurance Program for:

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

Medicare has four parts:

- Part A (Hospital Insurance). Most people do not have to pay for Part A. If you or your spouse worked for at least 10 years in Medicare-covered employment, you should be able to qualify for premium-free Part A insurance. ( If you were a Federal employee at any time both before and during January 1983, you will receive credit for your Federal employment before January 1983). Otherwise, if you are age 65 or older, you may be able to buy it. Contact 1-800-MEDICARE for more information.
- Part B (Medical Insurance). Most people pay monthly for Part B. Generally, Part B premiums are withheld from your monthly Social Security check or your retirement check.
- Part C (Medicare Advantage). You can enroll in a Medicare Advantage plan to get your Medicare benefits. We offer a Medicare Advantage plan. Please review the information on coordinating benefits with Medicare Advantage plans on the next page.
- Part D (Medicare prescription drug coverage). There is a monthly premium for Part D coverage. If you have limited savings and a low income, you may be eligible for Medicare’s Low-Income Benefits. For people with limited income and resources, extra help in paying for a Medicare prescription drug plan is available. Information regarding this program is available through the Social Security Administration (SSA). For more information about this extra help, visit SSA online at [www.socialsecurity.gov](http://www.socialsecurity.gov), or call them at 1-800-772-1213 (TTY 1-800-325-0778). Before enrolling in Medicare Part D, please review the important disclosure notice from us about the FEHB prescription drug coverage and Medicare. The notice is on the first inside page of this brochure. The notice will give you guidance on enrolling in Medicare Part D.

- **Should I enroll in Medicare?**

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

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

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

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

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

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

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

If your Plan physician does not participate in Medicare, you will have to file a claim with Medicare.

**Claims process when you have the Original Medicare Plan** – You will probably not need to file a claim form when you have both our Plan and the Original Medicare Plan.

- When we are the primary payer, we process the claim first.
- When Original Medicare is the primary payer, Medicare processes your claim first. In most cases, your claim will be coordinated automatically and we will then provide secondary benefits for covered charges. To find out if you need to do something to file your claim, call us at 1-800-4HUMANA or 1-800-448-6262 or visit our website: [feds.humana.com](http://feds.humana.com).

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

- **Medicare Advantage (Part C)**

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

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

**This Plan and our Medicare Advantage plan:** You may enroll in our Medicare Advantage plan and also remain enrolled in our FEHB plan. We will still provide benefits when your Medicare Advantage plan is primary. We will not waive any of the copayments, coinsurance or deductibles. If you enroll in a Medicare Advantage plan, tell us. We will need to know whether you are in the Original Medicare plan or in a Medicare Advantage plan so we can correctly coordinate benefits with Medicare. For information about Medicare Advantage plans offered in your area call 1-866-836-5079.

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

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

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

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

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

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

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

**TRICARE and CHAMPVA**

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

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

**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.

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

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

---

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

---

<b>Calendar year</b>	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.
<b>Coinsurance</b>	Coinsurance is the percentage of our allowance that you must pay for your care. See page 15.
<b>Consumer Driven Plan</b>	A plan that gives greater control over your choices of health care expenditures. You decide what health care services will be reimbursed under the health plan benefit allowance. The benefit allowance is only used for participating providers. If you spend the entire benefit allowance before the end of the year, then you must satisfy your deductible before benefits are payable under the traditional type of insurance covered by your plan.
<b>Copayment</b>	A copayment is a fixed amount of money you pay when you receive covered services. See page 15.
<b>Cost-sharing</b>	Cost-sharing is the general term used to refer to your out-of-pocket costs (e.g. deductible, coinsurance, and copayments) for the covered care you receive.
<b>Covered services</b>	Care we provide benefits for, as described in this brochure.
<b>Custodial care</b>	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.
<b>Deductible</b>	A deductible is a fixed amount of covered expenses you must incur for certain covered services and supplies before we start paying benefits for those services. See page 15.
<b>Durable Medical Equipment (DME)</b>	Equipment recognized as such by Medicare Part B, that meets all of the following criteria: <ul style="list-style-type: none"><li>• it can stand repeated use; and</li><li>• it is primarily and customarily used to serve a medical purpose rather than being primarily for comfort or convenience; and</li><li>• it is usually not useful to a person in the absence of sickness or injury; and</li><li>• it is appropriate for home use; and</li><li>• it is related to the patient's physical disorder; and</li><li>• the equipment must be used in the member's home.</li></ul>
<b>Experimental or investigational services</b>	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: <ul style="list-style-type: none"><li>• when applied to the circumstances of a particular patient is the subject of ongoing phase I, II or III clinical trials, or</li><li>• 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</li><li>• 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</li><li>• is not generally accepted by the medical community</li></ul>

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

**Medical necessity**

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

**Morbid obesity**

Excess body weight in comparison to set standards. Obesity refers specifically to having an abnormal proportion of body fat. The primary classification of overweight and obesity is based on the assessment of Body Mass Index (BMI).

**Oral surgery**

Procedures to correct diseases, injuries and defects of the jaw and mouth structures.

**Out of pocket**

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

**Participating provider**

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

**Specialist**

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

**Us/We**

Us and We refer to Humana CoverageFirst

**You**

You refers to the enrollee and each covered family member.

---

## Section 11. FEHB Facts

---

### Coverage information

- **No pre-existing condition limitation**

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

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

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

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

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

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

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

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

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

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

Your employing or retirement office will **not** notify you when a family member is no longer eligible to receive benefits, nor will we. Please tell us immediately when family members are added or lose coverage for any reason, including your marriage, divorce, annulment, or when your child under age 22 turns 22 or has a change in marital status, divorce, or when your child under age 22 marries.

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

- **Children's Equity Act**

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

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

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

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

• **When benefits and premiums start**

The benefits in this brochure are effective January 1. If you joined this Plan during Open Season, your coverage begins on the first day of your first pay period that starts on or after January 1. If you changed plans or plan options during Open Season and you receive care between January 1 and the effective date of coverage under your new plan or option, your claims will be paid according to the 2008 benefits of your old plan or option. However, if your old plan left the FEHB Program at the end of the year, you are covered under that plan's 2007 benefits until the effective date of your coverage with your new plan. Annuitants' coverage and premiums begin on January 1. If you joined at any other time during the year, your employing office will tell you the effective date of coverage.

• **When you retire**

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

**When you lose benefits**

• **When FEHB coverage ends**

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

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

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

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

- **Upon divorce**

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

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

If you leave Federal service, or if you lose coverage because you no longer qualify as a family member, you may be eligible for Temporary Continuation of Coverage (TCC). For example, you can receive TCC if you are not able to continue your FEHB enrollment after you retire, if you lose your Federal job, if you are a covered dependent child and you turn 22 or marry, etc.

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

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

- **Converting to individual coverage**

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

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

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

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

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

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

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

---

## Section 12. Three Federal Programs complement FEHB benefits

---

### Important information

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

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

Second, the **Federal Flexible Spending Account (FSA) Program**, also known as **FSAFEDS**, lets you set aside pre-tax money to pay for health and dependent care expenses. The result can be a discount of 20% to more than 40% on services you routinely pay for out-of-pocket.

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

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

#### It's important protection

The Federal Long Term Care Insurance program (FLTCIP) can help you pay for the potentially high cost of long term care services, which are not covered by FEHB plans. Long term care is help you receive to perform activities of daily living – such as bathing or dressing yourself – or supervision you receive because of severe cognitive impairment. To qualify for coverage under the FLTCIP, you must apply and pass a medical screening (called underwriting). To request an Information Kit and application, call 1-800-LTC-FEDS (1-800-582-3337) (TTY 1-800-843-3557) or visit [www.ltcfeds.com](http://www.ltcfeds.com)

### The Federal Flexible Spending Account Program – *FSAFEDS*

#### What is an FSA?

It is a tax-favored benefit that allows you to set aside pre-tax money from your paychecks to pay for a variety of eligible expenses. **Annuitants are not eligible to enroll.**

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

- **Health Care FSA (HCFSA)** – Pays for eligible health care expenses (such as copayments, deductibles, over-the-counter medications and products, visions and dental expenses, and much more) for you and your dependents which are not covered or reimbursed by FEHBP or FEDVIP coverage or any other insurance.
- **Limited Expense Health Care FSA (LEX HCFSA)** – Designed for employees enrolled in or covered by a High Deductible Health Plan with a Health Savings Account. Eligible expenses are limited to dental and vision care expenses for you and your dependents, which are not covered or reimbursed, by FEHBP or FEDVIP coverage or any other insurance.
- **Dependent Care FSA (DCFSA)** – Pays for eligible dependent care expenses for you child(ren) under age 13 or for dependents unable to care for themselves that allow you (and your spouse if married) to work, look for work (as long as you have earned income for the year), or attend school full-time.

#### Where can I get more information about FSAFEDS?

Visit [www.FSAFEDS.com](http://www.FSAFEDS.com) or call an FSAFEDS Benefits Counselor toll-free at 1-877-FSAFEDS (1-877-372-3337), Monday through Friday, 9 a.m. until 9 p.m., Eastern Time. TTY: 1-800-952-0450.

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

### **Important Information**

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

### **Dental Insurance**

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

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

### **Vision Insurance**

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

### **Additional Information**

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

### **How do I enroll?**

You enroll on the Internet [www.BENEFEDS.com](http://www.BENEFEDS.com). For those without access to a computer, call 1-877-888-3337 (TTY number, 1-877-889-5680).

---

## Index

---

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

### **Accidental injury**

Ambulance  
Anesthesia  
Autologous bone marrow transplant

### **Biopsy**

Blood and blood plasma

### **Casts**

Catastrophic protection out-of-pocket maximum  
Chemotherapy  
Chiropractic  
Cholesterol tests  
Claims

### **Coinsurance**

Colorectal cancer screening  
Congenital anomalies  
Contraceptive drugs and devices  
Covered charges  
Crutches

### **Deductible**

Definitions  
Dental care  
Diagnostic services  
Dressings

### **Educational classes and programs**

Effective date of enrollment  
Emergency  
Experimental or investigational  
Eyeglasses

### **Family planning**

Fecal occult blood test  
Fraud

### **General exclusions**

#### **Home health services**

Hospital

#### **Immunizations**

Infertility  
Inpatient hospital benefits  
Insulin

#### **Magnetic Resonance Imagings (MRIs)**

Mammograms  
Maternity benefits  
Medicaid  
Medically necessary

#### **Medicare**

Medicare Advantage  
Original

#### **Members**

Associate  
Family  
Plan

#### **Mental Health/Substance Abuse Benefits**

#### **Newborn care**

Non-FEHB benefits  
Nurse  
Licensed Practical Nurse (LPN)  
Nurse Anesthetist (NA)

#### **Occupational therapy**

Ocular injury  
Office visits  
Oral and maxillofacial surgical  
Original  
Out-of-pocket expenses  
Oxygen

### **Pap test**

Physician  
Precertification  
Prescription drugs  
Preventive care, adult  
Preventive care, children  
Preventive services  
Prior approval  
Prosthetic devices  
Psychologist

### **Radiation therapy**

Room and board

### **Second surgical opinion**

Skilled nursing facility care  
Smoking cessation  
Social worker  
Splints  
Subrogation  
Surgery

Anesthesia  
Oral

Reconstructive

Syringes

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

Transplants  
Treatment therapies

### **Vision care**

Vision services

### **Wheelchairs**

Workers Compensation

### **X-rays**

---

## Notes

---

---

## Notes

---

## 2008 Summary of benefits for the Consumer Driven Health Plan

- **Do not rely on this chart alone.** All benefits are provided in full unless indicated and are subject to the definitions, limitations, and exclusions in this brochure. On this page we summarize specific expenses we cover; for more detail, look inside.
- If you want to enroll or change your enrollment in this Plan, be sure to put the correct enrollment code from the cover on your enrollment form.
- Members have a \$1,000 benefit allowance to use before they must meet a deductible. Once your benefit allowance has been exhausted, you must satisfy your deductible: \$1,000 for an individual or \$2,000 for a family. After the deductible has been met, you are only responsible for your copays (except for infertility benefits).

Benefits	You Pay	Page
<b>Medical services provided by physicians:</b> <ul style="list-style-type: none"> <li>• Diagnostic and treatment services provided in the office</li> </ul>	Office visit copay: \$20 primary care; \$35 specialist	19
<b>Services provided by a hospital:</b> <ul style="list-style-type: none"> <li>• Inpatient</li> </ul>	\$250 copay per day for the first five days per admission	32
<ul style="list-style-type: none"> <li>• Outpatient - surgery</li> </ul>	\$150 per visit	33
<ul style="list-style-type: none"> <li>• MRI, MRA, CT, PET, SPECT</li> <li>• Outpatient – other services</li> </ul>	\$100 per visit \$50 per visit	33
<b>Emergency benefits:</b> <ul style="list-style-type: none"> <li>• At a doctor’s office</li> </ul>	\$20 primary care; \$35 specialist	35
<ul style="list-style-type: none"> <li>• At a hospital</li> </ul>	\$150 copay	36
<b>Mental health and substance abuse treatment:</b>	Regular cost sharing	37
<b>Prescription drugs:</b> <ul style="list-style-type: none"> <li>• Level One drugs</li> </ul>	\$10 copay	40
<ul style="list-style-type: none"> <li>• Level Two drugs</li> </ul>	\$30 copay	40
<ul style="list-style-type: none"> <li>• Level Three drugs</li> </ul>	\$50 copay	40
<ul style="list-style-type: none"> <li>• Level Four drugs</li> </ul>	25% of the amount the plan pays	40
<ul style="list-style-type: none"> <li>• Maintenance drugs (90-day supply) when ordered through our mail-order program</li> </ul>	2 applicable copays	40
<b>Dental care:</b> Accidental injury benefit only	Same as any other injury	42
<b>Vision care:</b>	No benefit	
<b>Special features:</b> Personal Nurse; HumanaFirst; MyHumana; Humana <i>Beginnings</i> ; Disease management; Transplant management; Case management; TDD and TTY phone lines		41
<b>Protection against catastrophic costs</b> (out-of-pocket maximum):	None	16

## 2008 Rate Information for Humana

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

**Postal Category 1 rates** apply to certain career non-law enforcement Postal Service employees. **Postal Category 2 rates** apply to other career non-law enforcement Postal Service employees. *PostalEASE*, the employee self service system used for FEHB enrollment, automatically provides the applicable premium to individual employees. Career non-law enforcement employees may also refer to the *Guide to Federal Benefits for United States Postal Service Employees, RI 70-2*, to determine their rates. Different rates apply and a special Guide is published for Postal Service Inspectors and Office of Inspector General (OIG) employees (see RI 70-2IN).

For further assistance, Postal Service employees should call:

Human Resources Shared Service Center  
1-877-477-3273, Option 5  
TTY: 1-866-260-7507

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

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

### Arizona: Phoenix, Tucson

<b>CDHP Option Self Only</b>	DB1	89.38	29.79	193.65	64.55	14.90	13.41
<b>CDHP Option Self and Family</b>	DB2	205.58	68.52	445.41	148.47	34.26	30.84

### Colorado: Colorado Springs

<b>CDHP Option Self Only</b>	FC1	105.15	35.05	227.83	75.94	17.52	15.77
<b>CDHP Option Self and Family</b>	FC2	241.85	80.62	524.02	174.67	40.31	36.28

### Colorado: Denver

<b>CDHP Option Self Only</b>	7T1	99.90	33.30	216.45	72.15	16.65	14.98
<b>CDHP Option Self and Family</b>	7T2	229.77	76.59	497.84	165.94	38.29	34.47

### Florida: Daytona

<b>CDHP Option Self Only</b>	DL1	126.19	42.06	273.41	91.13	21.03	18.93
<b>CDHP Option Self and Family</b>	DL2	290.24	96.75	628.86	209.62	48.37	43.54

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

Florida: Jacksonville

CDHP Option Self Only	MQ1	120.93	40.31	262.01	87.34	20.15	18.14
CDHP Option Self and Family	MQ2	278.13	92.71	602.62	200.87	46.35	41.72

Florida: Orlando

CDHP Option Self Only	YG1	115.67	38.56	250.63	83.54	19.28	17.35
CDHP Option Self and Family	YG2	266.05	88.68	576.44	192.14	44.34	39.91

Florida: Pensacola/Ft. Walton

CDHP Option Self Only	BP1	115.67	38.56	250.63	83.54	19.28	17.35
CDHP Option Self and Family	BP2	266.05	88.68	576.44	192.14	44.34	39.91

Florida: South Florida

CDHP Option Self Only	QP1	94.61	31.53	204.98	68.32	15.77	14.19
CDHP Option Self and Family	QP2	217.61	72.53	471.48	157.16	36.27	32.64

Florida: Tampa

CDHP Option Self Only	MJ1	105.15	35.05	227.83	75.94	17.52	15.77
CDHP Option Self and Family	MJ2	241.85	80.62	524.02	174.67	40.31	36.28

Georgia: Atlanta

CDHP Option Self Only	AD1	89.38	29.79	193.65	64.55	14.90	13.41
CDHP Option Self and Family	AD2	205.58	68.52	445.41	148.47	34.26	30.84

Georgia: Macon

CDHP Option Self Only	LM1	110.41	36.80	239.22	79.74	18.40	16.56
CDHP Option Self and Family	LM2	253.94	84.65	550.21	183.40	42.32	38.09

Illinois: Chicago

CDHP Option Self Only	MW1	89.36	29.79	193.62	64.54	14.89	13.40
CDHP Option Self and Family	MW2	205.52	68.50	445.28	148.43	34.25	30.83

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

Indiana: Indianapolis

CDHP Option Self Only	HZ1	105.15	35.05	227.83	75.94	17.52	15.77
CDHP Option Self and Family	HZ2	241.85	80.62	524.02	174.67	40.31	36.28

Kansas/Missouri: Kansas City

CDHP Option Self Only	PH1	84.11	28.03	182.23	60.74	14.02	12.62
CDHP Option Self and Family	PH2	193.44	64.48	419.12	139.71	32.24	29.02

Kentucky: Lexington

CDHP Option Self Only	6N1	115.67	38.56	250.63	83.54	19.28	17.35
CDHP Option Self and Family	6N2	266.05	88.68	576.44	192.14	44.34	39.91

Louisiana: Baton Rouge

CDHP Option Self Only	9L1	110.41	36.80	239.22	79.74	18.40	16.56
CDHP Option Self and Family	9L2	253.94	84.65	550.21	183.40	42.32	38.09

Louisiana: New Orleans

CDHP Option Self Only	9J1	99.90	33.30	216.45	72.15	16.65	14.98
CDHP Option Self and Family	9J2	229.77	76.59	497.84	165.94	38.29	34.47

Michigan: Detroit

CDHP Option Self Only	BW1	89.38	29.79	193.65	64.55	14.90	13.41
CDHP Option Self and Family	BW2	205.58	68.52	445.41	148.47	34.26	30.84

Michigan: Grand Rapids

CDHP Option Self Only	GT1	110.41	36.80	239.22	79.74	18.40	16.56
CDHP Option Self and Family	GT2	253.94	84.65	550.21	183.40	42.32	38.09

Michigan: Other areas

CDHP Option Self Only	FT1	105.15	35.05	227.83	75.94	17.52	15.77
CDHP Option Self and Family	FT2	241.85	80.62	524.02	174.67	40.31	36.28

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

Ohio: Cincinnati

CDHP Option Self Only	L81	105.15	35.05	227.83	75.94	17.52	15.77
CDHP Option Self and Family	L82	241.85	80.62	524.02	174.67	40.31	36.28

Tennessee: Memphis

CDHP Option Self Only	L61	115.67	38.56	250.63	83.54	19.28	17.35
CDHP Option Self and Family	L62	266.05	88.68	576.44	192.14	44.34	39.91

Tennessee: Nashville

CDHP Option Self Only	BT1	115.67	38.56	250.63	83.54	19.28	17.35
CDHP Option Self and Family	BT2	266.05	88.68	576.44	192.14	44.34	39.91

Texas: Austin

CDHP Option Self Only	TV1	110.41	36.80	239.22	79.74	18.40	16.56
CDHP Option Self and Family	TV2	253.94	84.65	550.21	183.40	42.32	38.09

Texas: Corpus Christi

CDHP Option Self Only	TP1	110.41	36.80	239.22	79.74	18.40	16.56
CDHP Option Self and Family	TP2	253.94	84.65	550.21	183.40	42.32	38.09

Texas: Dallas/Ft. Worth

CDHP Option Self Only	T81	126.19	42.06	273.41	91.13	21.03	18.93
CDHP Option Self and Family	T82	290.24	96.75	628.86	209.62	48.37	43.54

Texas: Houston

CDHP Option Self Only	T21	110.41	36.80	239.22	79.74	18.40	16.56
CDHP Option Self and Family	T22	253.94	84.65	550.21	183.40	42.32	38.09

Texas: San Antonio

CDHP Option Self Only	TU1	105.14	35.04	227.79	75.93	17.52	15.77
CDHP Option Self and Family	TU2	241.82	80.61	523.95	174.65	40.30	36.27

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

Wisconsin: Milwaukee

<b>CDHP Option Self Only</b>	FB1	120.93	40.31	262.01	87.34	20.15	18.14
<b>CDHP Option Self and Family</b>	FB2	278.13	92.71	602.62	200.87	46.35	41.72