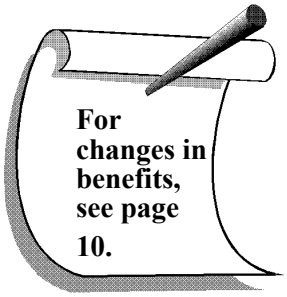
Humana CoverageFirst

http://feds.humana.com

2012

A Consumer Driven Individual Practice Plan



Serving:

The following metropolitan areas – Tampa and South Florida; Atlanta and Macon, Georgia; Chicago, Illinois; Central Illinois; Kansas City, Kansas/ Missouri; Lexington, Kentucky; Austin, Corpus Christi, and San Antonio, Texas

Enrollment in this plan is limited:

You must live or work in our geographic service area to enroll.
See pages 8 - 9 for details.

South Florida:
QP1 - Self Only
QP2 - Self and Family

Tampa, FL:
MJ1 - Self Only
MJ2 - Self and Family

Atlanta, GA:
AD1 - Self Only
AD2 - Self and Family

Macon, GA:
LM1 - Self Only
LM2 - Self and Family

Chicago, IL:
MW1 - Self Only
MW2 - Self and Family

Central IL:
GB1 - Self Only
GB2 - Self and Family

Corpus Christi, TX:
TP1 - Self Only
TP2 - Self and Family

San Antonio,TX:
TU1 - Self Only
TU2 - Self and Family

Kansas City, KS/MO:
PH1 - Self Only
PH2 - Self and Family

Lexington, KY:
6N1 - Self Only
6N2 - Self and Family

Austin, TX:
TV1 - Self Only
TV2 - Self and Family

Special Notice: We have expanded this Plans service area to include Central Illinois. See page 8.

Authorized for distribution by the:

United States
Office of Personnel Management

Healthcare and Insurance
http://www.opm.gov/insure

RI 73-829

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 (October 15th through December 7th) to enroll in Medicare Part D.

Medicare's Low Income Benefits

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

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

• Visit www.medicare.gov for personalized help.

• Call 1-800-MEDICARE (1-800-633-4227), (TTY 1-877-486-2048).

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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 Employees Health Plan of Georgia, Inc., Humana Medical Plan, Inc., and Humana Health Plan of Texas, Inc. The address for CoverageFirst administrative office 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, 2012, unless those benefits are also shown in this brochure.

OPM negotiates benefits and rates with each plan annually. Benefit changes are effective January 1, 2012, and changes are summarized on page 10. Rates are shown at the end of this brochure.

Plain Language

All FEHB brochures are written in plain language to make them easy to understand. Here are some examples:

- 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 or e-mail OPM at fehbwebcomments@opm.gov. You may also write to OPM at the U.S. Office of Personnel Management, Healthcare and Insurance, Federal Employee Insurance Operations, Program Analysis and Systems Support, 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.

- Please review your claims history periodically for accuracy to ensure services are not being billed to your accounts that were never rendered.
- 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)

  - Your child age 26 or over (unless he/she was disabled and incapable of self-support prior to age 26)
- 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.
- Fraud or intentional misrepresentation of material fact is prohibited under the Plan. You can be prosecuted for fraud and your agency may take action against you. Examples of fraud include, falsifying a claim to obtain FEHB benefits, trying to or obtaining service or coverage for yourself or for someone who is not eligible for coverage, or enrolling in the Plan when you are no longer eligible.
- If your enrollment continues after you are no longer eligible for coverage (i.e. you have separated from Federal service) and premiums are not paid, you will be responsible for all benefits paid during the period in which premiums were not paid. You may be billed by your provider for services received. You may be prosecuted for fraud for knowingly using health insurance benefits for which you have not paid premiums. It is your responsibility to know when you or a family member is no longer eligible to use your health insurance coverage.

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.

Patient Safety Links

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

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

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

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

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

Never Events

You will not be billed for inpatient services related to treatment of specific hospital acquired conditions or for inpatient services needed to correct never events, if you use Humana preferred providers. This policy helps to protect you from preventable medical errors and improve the quality of care you receive.

When you enter the hospital for treatment of one medical problem, you don't expect to leave with additional injuries, infections or other serious conditions that occur during the course of your stay. Although some of these complications may not be avoidable, too often patients suffer from injuries or illnesses that could have been prevented if the hospital had taken proper precautions.

We have a benefit payment policy that encourages hospitals to reduce the likelihood of hospital-acquired conditions such as certain infections, severe bedsores and fractures; and reduce medical errors that should never happen called "Never Events". When a Never Event occurs, neither your FEHB plan nor you will incur costs to correct the medical error.

Section 1. Facts about this Consumer Driven Health Plan

This plan is a "non-grandfathered health plan" under the Affordable Care Act. A non-grandfathered plan must meet immediate health care reforms legislated by the Act. Specifically, this plan must provide preventive services and screenings to you without any cost sharing; you may choose any available primary care provider for adult and pediatric care; visits for obstetrical or gynecological care do not require a referral; and emergency services, both in- and out-of-network, are essentially treated the same (i.e., the same cost sharing, no greater limits or requirements for one over the other; and no prior authorizations).

As a non-grandfathered health plan, this plan has also decided to follow the requirements that apply to grandfathered plans.

Questions regarding what protections apply may be directed to us at www.humana.com. You can also read additional information from the U.S. Department of Health and Human Services at www.healthcare.gov.

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 $1,000 of covered medical services for each person enrolled. We call this your benefit allowance. While using the $1,000 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 $1,000 benefit allowance:

- **Preventive Care** services are separate and do not apply toward the benefit allowance. 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 $1,000 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 – After your copays total $3,000 for Self Only, or $6,000 for Self and Family 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 excludes the deductible.

Non-participating providers – After your coinsurance totals $4,000 for Self Only, 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.

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) 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 1-800-4HUMANA. You may also contact us by visiting our website at 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.

Florida, South Florida – Enrollment code **QP** – Dade, Broward, Palm Beach and Martin.

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

Georgia, Atlanta – Enrollment code **AD –** Banks, Barrow, Barton, Butts, Cherokee, Clark, Clayton, Cobb, Coweta, DeKalb, Douglas, Fayette, Floyd, Forsyth, Fulton, Gwinett, Hall, Jackson, Lamar, Madison, Newton, Paulding, Polk, Rockdale, Spalding and Walton counties.

Georgia, Macon – Enrollment code **LM –** Jones, Bibb, Bleckley, Crawford, Houston, Laurens, Peach, Twiggs and Wilkinson 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.

Illinois, Central and Northwestern – Enrollment code **GB** – The Central and Northwestern Illinois counties of Boone, Bureau, DeKalb, DeWitt, Fulton, Henderson, Henry, Knox, LaSalle, Lee, Livingston, Marshall, McDonough, McLean, Mercer, Ogle, Peoria, Putnam, Stark, Stephenson, Tazewell, Warren, Whiteside, Winnebago and Woodford.

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.

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

Section 2. How we change for 2012

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.

Program-wide changes

- Sections 3, 7 and 8 have changed to reflect claims processing and disputed claims requirements of the Patient Protection and Affordable Care Act, Public Law 111-148.

Changes to this Plan

- South Florida, FL – Enrollment code QP - Your share of the non-Postal premium will decrease for Self Only and decrease for Self and Family. See page 78.
- Tampa, FL – Enrollment code MJ - Your share of the non-Postal premium will increase for Self Only and increase for Self and Family. See page 78.
- Atlanta, GA – Enrollment code AD – Your share of the non-Postal premium will stay the same for Self Only and stay the same for Self and Family. See page 78.
- Macon, GA – Enrollment code LM - Your share of the non-Postal premium will increase for Self Only and increase for Self and Family. See page 78.
- Chicago, IL – Enrollment code MW - Your share of the non-Postal premium will increase for Self Only and increase for Self and Family. See page 79.
- Kansas City, KS/MO – Enrollment code PH - Your share of the non-Postal premium will increase for Self Only and increase for Self and Family. See page 79.
- Lexington, KY – Enrollment code 6N - Your share of the non-Postal premium will increase for Self Only and increase for Self and Family. See page 79.
- Austin, TX – Enrollment code TV - Your share of the non-Postal premium will decrease for Self Only and decrease for Self and Family. See page 79.
- Corpus Christi, TX – Enrollment code TP - Your share of the non-Postal premium will increase for Self Only and increase for Self and Family. See page 79.
- San Antonio, TX – Enrollment code TU - Your share of the non-Postal premium will increase for Self Only and increase for Self and Family. See page 79.
- We have increased our service area to include Central Illinois. See page 8.

Section 3. How you get care

Identification cards

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

If you do not receive your ID card within 30 days after the effective date of your enrollment, or if you need replacement cards, call us at 1-800-4HUMANA or 1-800-448-6262. You may also request replacement cards through our Web site at http://feds.humana.com.

Where you get covered care

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

- **Plan providers**

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

We list Plan providers in the provider directory, which we update periodically. The list is also on our Web site at http://feds.humana.com.

- **Plan facilities**

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

What you must do to get covered care

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

- **Specialty care**

Here are things you should know about specialty care:

If you have a chronic and disabling condition and lose access to your specialist because we:

- terminate our contract with your specialist for other than cause;
- drop out of the Federal Employees Health Benefits (FEHB) Program and you enroll in another FEHB program Plan; or
- reduce our service area and you enroll in another FEHB Plan;

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

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

- **Hospital care**

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

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

We pay for covered services from the effective date of your enrollment. However, if you are in the hospital when your enrollment in our Plan begins, call our customer service department immediately at 1-800-426-2173. 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.

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;
- the day your benefits from your former plan run out; or
- the 92nd day after you become a member of this Plan, whichever happens first.

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

You need prior Plan approval for certain services

Since we do not have a primary care physician requirement and we allow you to use non-Plan providers, you need to obtain our approval before you receive certain services. The pre-service claim approval processes for inpatient hospital admissions (called precertification) and for other services, are detailed in this Section. A pre-service claim is any claim in whole or in part, that requires approval from us in advance of obtaining medical care of services. In other words, a pre-service claim for benefits (1) requires precertification, prior approval or a referral and (2) will result in a denial or reduction of benefits if you do not obtain precertification, prior approval or a referral.

- **Inpatient hospital admission**

Precertification is the process by which – prior to your inpatient hospital admission – we evaluate the medical necessity of your proposed stay and the number of days required to treat your condition.

- **Other services**

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

- 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
- Automatic Implantable Cardioverter Defibrillators (AICD)
- Oral surgeries
- Ventricular assist devices
- Pain Management Procedures
- Hyperbaric Therapy
- Outpatient Therapy Services for Physical, Occupational and Speech
- Genetic/Molecular Diagnostic Testing
- Chiropractic

- Radiation Therapy
- Acupuncture

How to request precertification for an admission or get prior authorization for Other services

First, your physician, your hospital, you, or your representative must call us at the phone number printed on your Humana ID card before admission or services requiring prior authorization are rendered.

Next, provide the following information:

- enrollee's name and Plan identification number;
- patient's name, birth date, identification number and phone number;
- reason for hospitalization, proposed treatment, or surgery ;
- name and phone number of admitting physician;
- name of hospital or facility; and
- number of planned days of confinement.

- **Non-urgent care claims**

For non-urgent care claims, we will then tell the physician and/or hospital the number of approved inpatient days, or the care that we approve for other services that must have prior authorization. We will make our decision within 15 days of receipt of the pre-service claim. If matters beyond our control require an extension of time, we may take up to an additional 15 days for review and we will notify you of the need for an extension of time before the end of the original 15 day period. Our notice will include the circumstances underlying the request for the extension and the date when a decision is expected.

If we need an extension because we have not received necessary information from you, our notice will describe the specific information required and we will allow you up to 60 days from the receipt of the notice to provide the information.

- **Urgent care claims**

If you have an urgent care claim (i.e., when waiting for the regular time limit for your medical care or treatment could seriously jeopardize your life, health, or ability to regain maximum function, or in the opinion of a physician with knowledge of your medical condition, would subject you to severe pain that cannot be adequately managed without this care or treatment), we will expedite our review and notify you of our decision within 72 hours. If you request that we review your claim as an urgent care claim, we will review the documentation you provide and decide whether it is an urgent care claim by applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine.

If you fail to provide sufficient information, we will contact you within 24 hours after we receive the claim to provide notice of the specific information we need to complete our review of the claim. We will allow you up to 48 hours from the receipt of this notice to provide the necessary information. We will make our decision on the claim within 48 hours of (1) the time we received the additional information or (2) the end of the time frame you received the notice to provide the additional information, whichever is earlier.

We may provide our decision orally within these time frames, but we will follow up with written or electronic notification within three days of oral notification.

- **Emergency inpatient admission**

If you have an emergency admission due to a condition that you reasonably believe puts your life in danger or could cause serious damage to bodily function, you, your representative, the physician, or the hospital must telephone us within two business days following the day of the emergency admission, even if you have been discharged from the hospital.

- **Maternity care**

Precertification is not required for maternity care.

• **If your treatment needs to be extended**	If you request an extension of an ongoing course of treatment at least 24 hours prior to the expiration of the approved time period and this is also an urgent care claim, then we will make a decision within 24 hours after we receive the claim.
What happens when you do not follow the precertification rules when using non-network facilities	You are responsible for the precertification rules when using non-network health care providers. If preauthorization is required but not obtained, benefits will be reduced by $500.
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.
If you disagree with our pre-service claim decision	If you have a **pre-service claim** and you do not agree with our decision regarding precertification of an inpatient admission or prior approval of other services, you may request a review in accord with the procedures detailed below. If you have already received the service, supply, or treatment, then you have a **post-service claim** and must follow the entire disputed claims process detailed in Section 8.
• **To reconsider a non-urgent care claim**	Within 6 months of our initial decision, you may ask us in writing to reconsider our initial decision. Follow Step 1 of the disputed claims process detailed in Section 8 of this brochure. In the case of a pre-service claim and subject to a request for additional information, we have 30 days from the date we receive your written request for reconsideration to 1. Precertify your hospital stay, or, if applicable, arrange for the health care provider to give you the care or grant your request for prior approval for a service, drug, or supply; or 2. Ask you or your provider for more information. You or your provider must send the information so that we receive it within 60 days of our request. We will then decide within 30 more days. If we do not receive the information within 60 days we will decide within 30 days of the date the information was due. We will base our decision on the information we already have. We will write to you with our decision. 3. Write to you and maintain our denial.
• **To reconsider an urgent care claim**	In the case of an appeal of a pre-service urgent care claim, within 6 months of our initial decision, you may ask us in writing to reconsider our initial decision. Follow Step 1 of the disputed claims process detailed in Section 8 of this brochure. Subject to a request for additional information, we will notify you of our decision within 72 hours after receipt of your reconsideration request. We will hasten the review process, which allows oral or written requests for appeals and the exchange of information by telephone, electronic mail, facsimile, or other expeditious methods.
• **To file an appeal with OPM**	After we reconsider your **pre-service claim**, if you do not agree with our decision, you may ask OPM to review it by following Step 3 of the disputed claims process detailed in Section 8 of this brochure.

Section 4. Your costs for covered services

Each covered member under Humana CoverageFirst has a $1,000 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 $1,000 benefit allowance, your only out-of-pocket costs are copayments.

Once your $1,000 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 Prescription drugs. Preventive care services are covered in full.

• **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.

Date of Service	**Service – Participating Provider**	**Cost of Service**	**YOU PAY**	**Applied to Benefit Allowance**	**Plan pays**
January	Specialist Office Visit – Preventive	$150	$0	$0	$150
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
	Totals	**$675**	**$85**	**$375**	**$215**

In this example, $375 was applied to the member's benefit allowance, leaving a balance of $625 for the remainder of the year.

* 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.

Date of Service	Service- Participating Providers	Cost of Service	YOU PAY	Applied to Benefit allowance	Applied to Deductible	Plan pays
March	Specialist office visit	$135	$45	$90	$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	$45	$0	$0	$80
	Totals	**$3760**	**$240**	**$990**	**$1000**	**$1530**

In this example, the member uses his benefit allowance and also meets his $1,000 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 $25 copayment. When you have outpatient surgery at a participating facility, you will pay a $150 copayment. Copayments do not reduce your $1,000 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 $1,000 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 $1,000 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 – After your copayments total $3,000 for Self Only, or $6,000 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 excludes the deductible. Non-participating providers – After your coinsurance totals $4,000 for Self Only, 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. Note: If you change options in this Plan during the year, we will credit the amount of covered expenses already accumulated toward the catastrophic out-of-pocket limit of your old option to the catastrophic protection limit of your new option.
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. You may be responsible to pay for certain services and charges. Contact the government facility directly for more information.

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 page 10 to see how we changed this year.

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

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- 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 $1,000 benefit allowance is depleted. The calendar year deductible is $1,000 for Self Only and $2,000 for Self and Family.

Non-participating providers – The $1,000 benefit allowance does not apply. The calendar year deductible is $3,000 for Self Only 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
Note: The calendar year deductible applies to almost all benefits in this Section. We say "(No deductible)" when it does not apply.	
Diagnostic and treatment services	
Professional services of physicians • In physician's office • Office medical consultations • At home • Second surgical opinion	Participating: $25 per office visit to a primary care physician; $45 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
• In an urgent care center	Participating: $45 copay (no deductible) Non-participating: 30% of our plan allowance and any difference between our allowance and the billed amount
• During a hospital stay • In a skilled nursing facility	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	
Tests, such as: • Blood tests • Urinalysis • Non-routine Pap tests • Pathology • X-rays • Non-routine mammograms	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
Lab, X-ray and other diagnostic tests (cont.)	
• CAT Scans/MRI (See *You need prior plan approval for certain services* in Section 3) • Ultrasound • Electrocardiogram and EEG	Participating: Nothing after deductible Non-participating: 30% of our plan allowance and any difference between our allowance and the billed amount
Preventive care, adult	
When receiving these services from a participating provider, it is not necessary to first meet your deductible. The cost of the services does not apply toward your $1,000 benefit allowance. You only have to pay your copayment. Annual routine physical, which includes: Routine screenings, such as: • A fasting lipoprotein profile (total cholesterol, LDL, HDL, and triglycerides) – once every five years for adults 20 or over; and • Colorectal Cancer Screening, including - Fecal occult blood test - Sigmoidoscopy, screening – every five years starting at age 50; or - Double contrast barium enema – once every five to ten years starting at age 50; or - Colonoscopy screening – once every ten years starting at age 50. • Bone density testing for women age 35 and older • Chlamydial infection screening • Routine Prostate Specific Antigen (PSA) test – one annually for men age 40 and older • Routine Pap test – one annually • Routine mammogram – covered for women age 35 and older, as follows: - From age 35 through 39, one during this five year period - From age 40 through 64, one every calendar year - At age 65 and older, one every two consecutive calendar years • Adult routine immunizations endorsed by the Centers for Disease Control and Prevention (CDC).	Participating: Nothing Non-participating: 30% of our plan allowance and any difference between our allowance and the billed amount
Not covered: Physical exams and immunizations required for obtaining or continuing employment or insurance, attending schools or camp, or travel.	*All charges*

Benefit Description	You pay
Preventive care, children	
When receiving these services from a participating provider, it is not necessary to first meet your deductible. The cost of the services does not apply toward your $1,000 benefit allowance. You only have to pay your copayment. • Childhood immunizations recommended by the American Academy of Pediatrics • Well-child care charges for routine examinations, immunizations and care (up to age 22) • Examinations, such as: - Eye exams through age 17 to determine the need for vision correction - Ear exams through age 17 to determine the need for hearing correction - Examinations done on the day of immunizations (up to age 22)	Participating: Nothing Non-participating: 30% of our plan allowance and any difference between our allowance and the billed amount
Maternity care	
Complete maternity (obstetrical) care, such as: • Prenatal care • Delivery • Postnatal care Note: Here are some things to keep in mind: • You do not need to precertify your normal delivery; see page 14 for other circumstances, such as extended stays for you or your baby. • You may remain in the hospital up to 48 hours after a regular delivery and 96 hours after a cesarean delivery. We will extend your inpatient stay for you or your baby if medically necessary. • We cover routine nursery care of the newborn child during the covered portion of the mother's maternity stay. We will cover other care of an infant who requires non-routine treatment only if we cover the infant under a Self and Family enrollment. Surgical benefits, not maternity benefits, apply to circumcision. • We pay hospitalization and surgeon services for non-maternity care the same as for illness and injury. • We offer Humana*Beginnings*. See *Special features* in Section 5(h).	Participating: $25 per office visit to a primary care physician; $45 per office visit to a specialist (no deductible) Copay applies to first visit only Non-participating: 30% of our plan allowance and any difference between our allowance and the billed amount

Benefit Description	You pay
Family planning	
A range of voluntary family planning services, limited to: • Surgically implanted contraceptives • Injectable contraceptive drugs (such as Depo Provera) • Intrauterine devices (IUDs) • Diaphragms • Voluntary sterilization (See *Surgical procedures,* Section 5b) Note: We cover oral contraceptives under the prescription drug benefit.	Participating: Nothing after deductible Non-participating: 30% of our plan allowance and any difference between our allowance and the billed amount
Not covered: Reversal of voluntary surgical sterilization	*All charges*
Infertility services	
Diagnosis and treatment of infertility, such as: • Artificial insemination: - Intravaginal insemination (IVI) - Intracervical insemination (ICI) - Intrauterine insemination (IUI) • Fertility drugs Note: We cover injectable fertility drugs under medical benefits and oral fertility drugs under the prescription drug benefit. See *You need prior plan approval for certain services* in Section 3.	Participating: 50% of charges 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
Not covered: • *Assisted reproductive technology (ART) procedures, such as:* - *In vitro fertilization* - *Embryo transfer, gamete intra-fallopian transfer (GIFT) and zygote intra-fallopian transfer (ZIFT)* • *Services and supplies related to excluded ART procedures* • *Cost of donor sperm* • *Cost of donor egg*	*All charges*
Allergy care	
• Testing and treatment	Participating: $25 per office visit to a primary care physician; $45 per office visit to a specialist (no deductible when received in physician's office) Non-participating: 30% of our plan allowance and any difference between our allowance and the billed amount
• Allergy injection	Participating: $5 copay per visit (no deductible) Non-participating: 30% of our plan allowance and any difference between our allowance and the billed amount

Allergy care - continued on next page

Benefit Description	You pay
Allergy care (cont.)	
• Allergy serum	Participating: Nothing Non-participating: 30% of our plan allowance and any difference between our allowance and the billed amount
Not covered: Provocative food testing and sublingual allergy desensitization	*All charges*
Treatment therapies	
• Chemotherapy and radiation therapy Note: High dose chemotherapy in association with autologous bone marrow transplants is limited to those transplants listed under *Organ/Tissue Transplants* on page 31. • Respiratory and inhalation therapy • Dialysis – hemodialysis and peritoneal dialysis • Intravenous (IV)/Infusion Therapy – Home IV and antibiotic therapy (See *You need prior plan approval for certain services* in Section 3). • Growth hormone therapy (GHT) Note: Growth hormone is covered under the Prescription Drug benefit. We only cover GHT when we preauthorize the treatment. Your Plan Physician will ask us to authorize GHT before you begin treatment. We will only cover GHT services and related services and supplies that we determine are medically necessary. See Section 3 under *Other Services*.	Participating: $45 copay per visit Non-participating: 30% of our plan allowance and any difference between our allowance and the billed amount
Physical, occupational and cardiac therapies	
60 visits per condition per year for the services of each of the following: • Qualified physical therapists • Occupational therapists Note: We only cover therapy to restore bodily function when there has been a total or partial loss of bodily function due to illness or injury. Cardiac rehabilitation following a heart transplant, bypass surgery or a myocardial infarction, is provided. See *You need prior plan approval for certain services* in Section 3.	Participating: Nothing after deductible Non-participating: 30% of our plan allowance and any difference between our allowance and the billed amount
Not covered: • *Long-term rehabilitative therapy* • *Exercise programs*	*All charges*

Benefit Description	You pay
Speech therapy	
• 60 visits per year See *You need prior plan approval for certain services* in Section 3.	Participating: Nothing after deductible Non-participating: 30% of our plan allowance and any difference between our allowance and the billed amount
Hearing services (testing, treatment, and supplies)	
• First hearing aid and testing only when necessitated by accidental injury	Participating: Nothing after deductible Non-participating: 30% of our plan allowance and any difference between our allowance and the billed amount
• Hearing testing for children through age 17, as shown in *Preventive care, children*	Participating: Nothing Non-participating: 30% of our plan allowance and any difference between our allowance and the billed amount
Not covered: • *All other hearing testing* • *Hearing aids, testing and examinations for them*	*All charges*
Vision services (testing, treatment, and supplies)	
• Diagnosis and treatment of diseases of the eye	Participating: $25 per office visit to a primary care physician; $45 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
• Eye exam to determine the need for vision correction for children through age 17 (see *Preventive care, children*)	Participating: Nothing Non-participating: 30% of our plan allowance and any difference between our allowance and the billed amount
• One pair of eyeglasses or contact lenses to correct an impairment directly caused by accidental ocular injury or intraocular surgery (such as for cataracts)	Participating: Nothing after deductible Non-participating: 30% of our plan allowance and any difference between our allowance and the billed amount
Not covered: • *Eyeglasses or contact lenses except as shown above* • *Eye exercises and orthoptics* • *Radial keratotomy and other refractive surgery*	*All charges*

Benefit Description	You pay
Foot care	
• Routine foot care when you are under active treatment for a metabolic or peripheral vascular disease, such as diabetes. See *Orthopedic and prosthetic devices* for information on podiatric shoe inserts.	Participating: $25 per office visit to a primary care physician; $45 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
Not covered: • *Cutting, trimming or removal of corns, calluses, or the free edge of toenails, and similar routine treatment of conditions of the foot, except as stated above* • *Treatment of weak, strained or flat feet or bunions or spurs; and of any instability, imbalance or subluxation of the foot (unless the treatment is by open cutting surgery)*	*All charges*
Orthopedic and prosthetic devices	
• Artificial limbs and eyes • Stump hose • Externally worn breast prostheses and surgical bras, including necessary replacements following a mastectomy • Corrective orthopedic appliances for non-dental treatment of temporomandibular joint (TMJ) pain dysfunction syndrome. • Internal prosthetic devices, such as artificial joints, pacemakers, cochlear implants, and surgically implanted breast implant following mastectomy. Note: For information on the professional charges for the surgery to insert an implant, see Section 5(b) *Surgical procedures.* For information on the hospital and/or ambulatory surgery center benefits, see Section 5(c) *Services provided by a hospital or other facility, and ambulance services.*	Participating: Nothing, after deductible Non-participating: 30% of our plan allowance and any difference between our allowance and the billed amount
Not covered: • *Orthopedic and corrective shoes, arch supports, foot orthotics, heel pads and heel cups* • *Lumbosacral supports* • *Corsets, trusses, elastic stockings, support hose, and other supportive devices* • *Prosthetic replacements provided less than 3 years after the last one we covered*	*All charges*

Benefit Description	You pay
Durable medical equipment (DME)	
We cover rental or purchase of durable medical equipment, at our option, including repair and adjustment. Covered items include: • Oxygen • Dialysis equipment • Hospital beds • Wheelchairs • Crutches • Walkers • Blood glucose monitors • Insulin pumps Note: Preauthorization is necessary for items over $750. See *You need prior plan approval for certain services* in Section 3.	Participating: Nothing, after deductible Non-participating: 30% of our plan allowance and any difference between our allowance and the billed amount
Not covered: Equipment such as exercise equipment, air cleaners	*All charges*
Home health services	
• Home health care ordered by a Plan physician and provided by a registered nurse (R.N.), licensed practical nurse (L.P.N.), licensed vocational nurse (L.V.N.), or home health aide. • Services include oxygen therapy, intravenous therapy and medications. See *You need prior plan approval for certain services* in Section 3.	Participating: Nothing, after deductible Non-participating: 30% of our plan allowance and any difference between our allowance and the billed amount
Not covered: • Nursing care requested by, or for the convenience of, the patient or the patient's family. • Home care primarily for personal assistance that does not include a medical component and is not diagnostic, therapeutic, or rehabilitative. • Private duty nurse	*All charges*
Chiropractic	
• Manipulation of the spine and extremities • Adjunctive procedures such as ultrasound, electrical muscle stimulation, vibratory therapy, and cold pack application See *You need prior plan approval for certain services* in Section 3.	Participating: $45 copay per office visit Non-participating: 30% of our plan allowance and any difference between our allowance and the billed amount

Benefit Description	You pay
Alternative treatments	
Acupuncture – by a licensed acupuncturist for: • anesthesia • pain relief See *You need prior plan approval for certain services* in Section 3.	Participating: $45 copay per office visit Non-participating: 30% of our plan allowance and any difference between our allowance and the billed amount
Not covered: • *Naturopathic services* • *Hypnotherapy* • *Biofeedback*	*All charges*
Educational classes and programs	
• Tobacco cessation programs, including: - Individual, group and telephone counseling - 2 quit attempts per year with up to 4 tobacco cessation counseling sessions per quit attempt - Approved tobacco cessation drugs (see *Prescription drug benefits*) • Childhood obesity education	Participating: Nothing Non-participating: 30% of our plan allowance and any difference between our allowance and the billed amount
• Diabetes self management training	Participating: $25 per office visit to a primary care physician; $45 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

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 Only and $2,000 for Self and Family.

Non-participating providers - The calendar year deductible is $3,000 for Self Only 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
Note: The calendar year deductible applies to almost all benefits in this Section. We say "(No deductible)" when it does not apply.	
Surgical procedures	
A comprehensive range of services, such as: • Operative procedures • Treatment of fractures, including casting • Normal pre- and post-operative care by the surgeon • Correction of amblyopia and strabismus • Endoscopy procedures • Biopsy procedures • Removal of tumors and cysts • Correction of congenital anomalies (see *Reconstructive surgery*) • Surgical treatment for morbid obesity (bariatric surgery). Some of the requirements that must be met before surgery can be authorized are: - Patient is 18 years of age or older - Body Mass Index of ≥40, or a Body Mass Index of ≥35 with associated comorbidity such as: • Hypertension • Type two diabetes	Participating: Nothing after deductible Non-participating: 30% of our plan allowance and any difference between our allowance and the billed amount

Surgical procedures - continued on next page

Benefit Description	You pay
Surgical procedures (cont.)	
• Life-threatening cardiopulmonary problems - Physician's documentation which indicates that you have had unsuccessful attempt(s) with nonoperative medically-supervised weight-reduction program(s) - To obtain network benefits, you must receive services at a participating bariatric Centers of Excellence. • Insertion of internal prosthetic devices. See Section 5(a) *Orthopedic and prosthetic devices* for device coverage information • Treatment of burns • Voluntary sterilization (e.g., Tubal ligation, Vasectomy) Note: Generally, we pay for internal prostheses (devices) according to where the procedure is done. For example, we pay Hospital benefits for a pacemaker and Surgery benefits for insertion of the pacemaker.	Participating: Nothing after deductible Non-participating: 30% of our plan allowance and any difference between our allowance and the billed amount
Not covered: • *Reversal of voluntary sterilization* • *Radial keratotomy and other refractive surgery* • *Routine treatment of conditions of the foot: See Foot care in Section 5(a)*	*All charges*
Reconstructive surgery	
• Surgery to correct a functional defect • Surgery to correct a condition caused by injury or illness if: - the condition produced a major effect on the member's appearance and - the condition can reasonably be expected to be corrected by such surgery • Surgery to correct a condition that existed at or from birth and that is a significant deviation from the common form or norm. Examples of congenital anomalies are: protruding ear deformities; cleft lip; cleft palate; birth marks; webbed fingers and webbed toes. • All stages of breast reconstruction surgery following a mastectomy, such as: - surgery to produce a symmetrical appearance of breasts; - treatment of any physical complications, such as lymphedemas; - breast prostheses and surgical bras and replacements (see *Orthopedic and Prosthetic devices*) Note: If you need a mastectomy, you may choose to have the procedure performed on an inpatient basis and remain in the hospital up to 48 hours after the procedure.	Participating: Nothing after deductible Non-participating: 30% of our plan allowance and any difference between our allowance and the billed amount

Reconstructive surgery - continued on next page

Benefit Description	You pay
Reconstructive surgery (cont.)	
Not covered: • Cosmetic surgery – any surgical procedure (or any portion of a procedure) performed primarily to improve physical appearance through change in bodily form, except repair of accidental injury • Surgeries related to sex transformation	*All charges*
Oral and maxillofacial surgery	
Oral surgical procedures, limited to: • Reduction of fractures of the jaws or facial bones; • Surgical correction of cleft lip, cleft palate or severe functional malocclusion; • Removal of stones from salivary ducts; • Excision of leukoplakia or malignancies; • Excision of cysts and incision of abscesses when done as independent procedures; • Excision of partially or completely impacted teeth; and • Other surgical procedures that do not involve the teeth or their supporting structures.	Participating: Nothing after deductible Non-participating: 30% of our plan allowance and any difference between our allowance and the billed amount
Not covered: • *Procedures that involve the teeth or their supporting structures (such as the periodontal membrane, gingiva, and alveolar bone)* • *Oral implants and transplants* • *Dental work related to treatment of temporomandibular joint syndrome (TMJ)*	*All charges*
Organ/tissue transplants	
These **solid organ transplants** are covered. Solid organ transplants are limited to: • Cornea • Heart • Heart/lung • Intestinal transplants - Small intestine - Small intestine with the liver - Small intestine with multiple organs, such as the liver, stomach, and pancreas • Kidney • Liver • Lung: single/bilateral • Pancreas	Participating: Nothing after deductible Non-participating: 30% of our plan allowance and any difference between our allowance and the billed amount Non-participating transplant services do not apply toward the maximum out-of-pocket expense limit. 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.

Organ/tissue transplants - continued on next page

Benefit Description	You pay
Organ/tissue transplants (cont.)	
These **tandem blood or marrow stem cell transplants for covered transplants** are subject to medical necessity review by the Plan. Refer to *Other services* in Section 3 for prior authorization procedures. • Autologous tandem transplants for - AL Amyloidosis - Multiple myeloma (de novo and treated) - Recurrent germ cell tumors (including testicular cancer) **Blood or marrow stem cell transplants** limited to the stages of the following diagnoses. For the diagnoses listed below, the medical necessity limitation is considered satisfied if the patient meets the staging description. • Allogeneic transplants for - Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia - Advanced Hodgkin's lymphoma with reoccurrence (relapsed) - Advanced non-Hodgkin's lymphoma with reoccurrence (relapsed) - Acute myeloid leukemia - Advanced Myeloproliferative Disorders (MPDs) - Advanced neuroblastoma - Amyloidosis - Chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL) - Hemoglobinopathy - Infantile malignant osteopetrosis - Kostmann's syndrome - Leukocyte adhesion deficiencies - Marrow failure and related disorders (i.e., Fanconi's, PNH, Pure Red Cell Aplasia) - Mucolipidosis (e.g., Gaucher's disease, metachromatic leukodystrophy, adrenoleukodystrophy) - Mucopolysaccharidosis (e.g., Hunter's syndrome, Hurler's syndrome, Sanfillippo's syndrome, Maroteaux-Lamy syndrome variants) - Myelodysplasia/Myelodysplastic syndromes - Paroxysmal Nocturnal Hemoglobinuria - Phagocytic/Hemophagocytic deficiency diseases (e.g., Wiskott-Aldrich syndrome) - Severe combined immunodeficiency - Severe or very severe aplastic anemia - Sickle cell anemia - X-linked lymphoproliferative syndrome	Participating: Nothing after deductible Non-participating: 30% of our plan allowance and any difference between our allowance and the billed amount Non-participating transplant services do not apply toward the maximum out-of-pocket expense limit. 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.

Organ/tissue transplants - continued on next page

Benefit Description	You pay
Organ/tissue transplants (cont.)	
• Autologous transplants for - Acute lymphocytic or nonlymphocytic (i.e., myelogenous) leukemia - Advanced Hodgkin's lymphoma with reoccurrence (relapsed) - Advanced non-Hodgkin's lymphoma with reoccurrence (relapsed) - Amyloidosis - Ependymoblastoma - Ewing's sarcoma - Multiple myeloma - Medulloblastoma - Pineoblastoma - Neuroblastoma - Testicular, Mediastinal, Retroperitoneal, and ovarian germ cell tumors **Mini-transplants performed in a clinical trial setting** (non-myeloablative, reduced intensity conditioning or RIC) for members with a diagnosis listed below are subject to medical necessity review by the Plan. Refer to *Other services* in Section 3 for prior authorization procedures: • Allogeneic transplants for - Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia - Advanced Hodgkin's lymphoma with reoccurrence (relapsed) - Advanced non-Hodgkin's lymphoma with reoccurrence (relapsed) - Acute myeloid leukemia - Advanced Myeloproliferative Disorders (MPDs) - Amyloidosis - Chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL) - Hemoglobinopathy - Marrow failure and related disorders (i.e., Fanconi's, PNH, Pure Red Cell Aplasia) - Myelodysplasia/Myelodysplastic syndromes - Paroxysmal Nocturnal Hemoglobinuria - Severe combined immunodeficiency - Severe or very severe aplastic anemia • Autologous transplants for - Acute lymphocytic or nonlymphocytic (i.e., myelogenous) leukemia	Participating: Nothing after deductible Non-participating: 30% of our plan allowance and any difference between our allowance and the billed amount Non-participating transplant services do not apply toward the maximum out-of-pocket expense limit. 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.

Organ/tissue transplants - continued on next page

Benefit Description	You pay
Organ/tissue transplants (cont.)	
- Advanced Hodgkin's lymphoma with reoccurrence (relapsed) - Advanced non-Hodgkin's lymphoma with reoccurrence (relapsed) - Amyloidosis - Neuroblastoma These blood or marrow stem cell transplants are covered only in a National Cancer Institute or National Institutes of health **approved clinical trial** or a Plan-designated center of excellence and if approved by the Plan's medical director in accordance with the Plan's protocols. If you are a participant in a clinical trial, the Plan will provide benefits for related routine care that is medically necessary (such as doctor visits, lab tests, x-rays and scans, and hospitalization related to treating the patient's condition) if it is not provided by the clinical trial. Section 9 has additional information on costs related to clinical trials. We encourage you to contact the Plan to discuss specific services if you participate in a clinical trial. • Allogeneic transplants for - Advanced Hodgkin's lymphoma - Advanced non-Hodgkin's lymphoma - Beta Thalassemia Major - Early stage (indolent or non-advanced) small cell lymphocytic lymphoma - Multiple myeloma - Multiple sclerosis - Sickle Cell anemia • Mini-transplants (non-myeloablative allogeneic, reduced intensity conditioning or RIC) for - Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia - Advanced Hodgkin's lymphoma - Advanced non-Hodgkin's lymphoma - Breast cancer - Chronic lymphocytic leukemia - Chronic myelogenous leukemia - Colon cancer - Chronic lymphocytic lymphoma/small lymphocytic lymphoma (CLL/SLL) - Early stage (indolent or non-advanced) small cell lymphocytic lymphoma - Multiple myeloma - Multiple sclerosis - Myeloproliferative disorders (MSDs)	Participating: Nothing after deductible Non-participating: 30% of our plan allowance and any difference between our allowance and the billed amount Non-participating transplant services do not apply toward the maximum out-of-pocket expense limit. 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.

Organ/tissue transplants - continued on next page

Benefit Description	You pay
Organ/tissue transplants (cont.)	
- Non-small cell lung cancer - Ovarian cancer - Prostate cancer - Renal cell carcinoma - Sarcomas - Sickle cell anemia • Autologous Transplants for - Advanced childhood kidney cancers - Advanced Ewing sarcoma - Advanced Hodgkin's lymphoma - Advanced non-Hodgkin's lymphoma - Breast cancer - Childhood rhabdomyosarcoma - Chronic myelogenous leukemia - Chronic lymphocytic lymphoma/small lymphocytic lymphoma (CLL/SLL) - Early stage (indolent or non-advanced) small cell lymphocytic lymphoma - Epithelial ovarian cancer - Mantle cell (non-Hodgkin lymphoma) - Multiple sclerosis - Small cell lung cancer - Systemic lupus erythematosus - Systemic sclerosis Benefits are available for Allogeneic and Autologous blood or marrow stem cell transplants utilizing a phase two or higher protocol. National Transplant Program (NTP) - all services are determined and authorized through our transplant department, utilizing our National Transplant Network. Note: We cover related medical and hospital expenses of the donor when we cover the recipient. We cover donor testing for the actual solid organ donor or up to four bone marrow/stem cell transplant donors in addition to the testing of family members. See *You need prior plan approval for certain services* in Section 3.	Participating: Nothing after deductible Non-participating: 30% of our plan allowance and any difference between our allowance and the billed amount Non-participating transplant services do not apply toward the maximum out-of-pocket expense limit. 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.
Not covered: • *Donor screening tests and donor search expenses, except as shown above* • *Implants of artificial organs* • *Transplants not listed as covered*	*All charges*

Benefit Description	You pay
Anesthesia	
Professional services provided in – • Hospital (inpatient) • Hospital outpatient department • Skilled nursing facility • Ambulatory surgical center	Participating: Nothing after deductible Non-participating: 30% of our plan allowance and any difference between our allowance and the billed amount
Professional services provided in – • Office	Participating: Nothing if you receive these services during an office visit Non-participating: 30% of our plan allowance and any difference between our allowance and the billed amount

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 $1,000 benefit allowance is depleted. The calendar year deductible is $1,000 for Self Only and $2,000 for Self and Family.

Non-participating providers – The $1,000 benefit allowance does not apply. The calendar year deductible is $3,000 for Self Only 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
NOTE: The calendar year deductible applies to almost all benefits in this section. We say "no deductible" when the deductible does not apply.	
Inpatient hospital	
Room and board, such as: • Ward, semiprivate, or intensive care accommodations • General nursing care • Meals and special diets Note: If you want a private room when it is not medically necessary, you pay the additional charge above the semiprivate room rate.	Participating: $300 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: • Operating, recovery, maternity, and other treatment rooms • Prescribed drugs and medicines • Diagnostic laboratory tests and x-rays • Dressings, splints, casts, and sterile tray services • Medical supplies and equipment, including oxygen • Anesthetics, including nurse anesthetist services • Take-home items • Medical supplies, appliances, medical equipment, and any covered items billed by a hospital for use at home.	Nothing after deductible

Inpatient hospital - continued on next page

Benefit Description	You pay
Inpatient hospital (cont.)	
Not covered: • *Custodial care* • *Non-covered facilities, such as nursing homes, schools* • *Personal comfort items, such as telephone, television, barber services, guest meals and beds* • *Blood and blood components if not replaced*	*All charges*
Outpatient hospital or ambulatory surgical center	
• Operating, recovery, and other treatment rooms • Prescribed drugs and medicines • Diagnostic laboratory tests, x-rays, and pathology services • Administration of blood, blood plasma, and other biologicals • Pre-surgical testing • Dressings, casts, and sterile tray services • Medical supplies, including oxygen • Anesthetics and anesthesia service Note: We cover hospital services and supplies related to dental procedures when necessitated by a non-dental physical impairment. We do not cover the dental procedures.	Participating: $150 copay per visit Non-participating: 30% of our plan allowance and any difference between our allowance and the billed amount
Outpatient Hospital Services such as: MRI, MRA, CAT, PET, and SPECT both at a Hospital and Free Standing Facility.	Participating: $100 copay Non-participating: 30 % of our plan allowance and any difference between our allowance and the billed amount
Other outpatient non-surgical care such as mammograms, laboratory tests and x-rays Note: We cover hospital services and supplies related to dental procedures when necessitated by a non-dental physical impairment. We do not cover the dental procedures.	Participating: $50 copay Non-participating: 30% of our plan allowance and any difference between our allowance and the billed amount
Not covered: Blood and Blood components if not replaced by the member.	*All charges*
Extended care benefits/Skilled nursing care facility benefits	
Extended care benefit: Up to 60 days per calendar year, including: • Bed and board • General nursing care • Drugs, biologicals, supplies and equipment provided by the facility Note: Coverage is provided when full-time skilled nursing care is necessary and confinement in a skilled nursing facility is medically appropriate as determined by a Plan doctor and approved by the Plan.	Participating: Nothing after deductible Non-participating: 30% of our plan allowance and any difference between our allowance and the billed amount

Extended care benefits/Skilled nursing care facility benefits - continued on next page

Benefit Description	You pay
Extended care benefits/Skilled nursing care facility benefits (cont.)	
Not covered: Custodial care	*All charges*
Hospice care	
Supportive and palliative care for a terminally ill member is covered in the home or hospice facility. Includes: • Inpatient and outpatient services and supplies Note: These services must be described in a Hospice Care program that has been approved by us. See *You need prior plan approval for certain services* in Section 3.	Participating: Nothing after deductible Non-participating: 30% of our plan allowance and any difference between our allowance and the billed amount
Not covered: Independent nursing; homemaker services	*All charges*
Ambulance	
Professional ambulance service when medically appropriate	Nothing after deductible

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 $1,000 benefit allowance is depleted. The calendar year deductible is $1,000 for Self Only and $2,000 for Self and Family.

Non-participating providers – The $1,000 benefit allowance does not apply. The calendar year deductible is $3,000 for Self Only 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
Note: The calendar year deductible applies to almost all benefits in this Section. We say "(No deductible)" when it does not apply.	
Emergency services	
• Emergency care at a doctor's office	$25 at a primary care physician's office; $45 at a specialist's office (no deductible)
• Emergency care at an urgent care center	$45 copayment (no deductible)
• Emergency care at a hospital, including doctors' services Note: If admitted, hospital copays apply. See Section 5(c) for *Inpatient hospital* services.	$175 per visit; copay is waived if admitted
Not covered: • *Elective care or non-emergency care* • *Emergency care provided outside the service area if the need for care could have been foreseen before leaving the service area*	*All charges*

Emergency services - continued on next page

Benefit Description	You pay
Emergency services (cont.)	
• *Medical and hospital costs resulting from a normal full-term delivery of a baby outside the service area*	*All charges*
Ambulance	
Professional ambulance service when medically appropriate See Section 5(c) for non-emergency service.	Nothing after deductible

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 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 or, for facility care, the inpatient deductible applies to almost all benefits in this Section. We added "(No deductible)" to show when a deductible does not apply.
- The calendar year deductible is:

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

Non-participating providers – The $1,000 benefit allowance does not apply. The calendar year deductible is $3,000 for Self Only 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.** 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. The treatment plan may include services, drugs, and supplies described elsewhere in this brochure. To be eligible to receive full benefits, you must follow the preauthorization process and get Plan approval of your treatment plan:

Contact Humana Behavioral Health at 1-866-778-3405
to obtain Mental Health or Substance Abuse treatment services.

- 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.

Benefit Description	You pay
Note: The calendar year deductible applies to almost all benefits in this Section. We say "(No deductible)" when it does not apply.	
Professional services	
When we approve a treatment plan, we cover professional services by licensed professional mental health and substance abuse practitioners when acting within the scope of their license, such as psychiatrists, psychologists, clinical social workers, licensed professional counselors, or marriage and family therapists.	Your cost-sharing responsibilities are no greater than for other illnesses or conditions.
Diagnosis and treatment of psychiatric conditions, mental illness, or mental disorders. Services include: • Diagnostic evaluation	Participating: $25 copay per visit Non-participating: 30% of our plan allowance and any difference between our allowance and the billed amount

Professional services - continued on next page

Benefit Description	You pay
Professional services (cont.)	
• Crisis intervention and stabilization for acute episodes • Medication evaluation and management (pharmacotherapy) • Psychological and neuropsychological testing necessary to determine the appropriate psychiatric treatment • Treatment and counseling (including individual or group therapy visits) • Diagnosis and treatment of alcoholism and drug abuse, including detoxification, treatment and counseling • Professional charges for intensive outpatient treatment in a provider's office or other professional setting • Electroconvulsive therapy	Participating: $25 copay per visit Non-participating: 30% of our plan allowance and any difference between our allowance and the billed amount
Diagnostics	
• Outpatient diagnostic tests provided and billed by a licensed mental health and substance abuse practitioner • Outpatient diagnostic tests provided and billed by a laboratory, hospital or other covered facility • Inpatient diagnostic tests provided and billed by a hospital or other covered facility	Participating: Nothing after deductible Non-participating: 30% of our plan allowance and any difference between our allowance and the billed amount
• Outpatient services, such as: MRI, MRA, CT, PET, and SPECT	Participating: $100 copay Non-participating: 30% of our plan allowance and any difference between our allowance and the billed amount
• Other outpatient non-surgical services	Participating: $50 copay Non-participating: 30% of our plan allowance and any difference between our allowance and the billed amount
Inpatient hospital or other covered facility	
Inpatient services provided and billed by a hospital or other covered facility • Room and board, such as semiprivate or intensive accommodations, general nursing care, meals and special diets, and other hospital services	Participating: $300 copay 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

Benefit Description	You pay
Outpatient hospital or other covered facility	
Outpatient services provided and billed by a hospital or other covered facility • Services in approved treatment programs, such as partial hospitalization or full-day hospitalization	Participating: Nothing after deductible Non-participating: 30% of our plan allowance and any difference between our allowance and the billed amount
• Facility-based intensive outpatient treatment	Participating: $25 copay per visit Non-participating: 30% of our plan allowance and any difference between our allowance and the billed amount
Not covered	
Services that are not part of a preauthorized approved treatment plan	*All charges*

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, licensed dentist, or other provider approved by your state may 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. Members can also fill their maintenance medications for 90 days at a retail pharmacy for their appropriate copayment.
- **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 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. That may save you money.

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

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** – Some medications need special monitoring and may require prior authorization. These drugs have different approval criteria based on indication, safety and appropriate use. Prior authorization (PA) requires a physician to obtain pre-approval in order to provide coverage for a drug prescribed to a member.
- **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 or at one of our retail pharmacies.

When brand name drugs are purchased and a generic is available, you must pay the difference between the brand name and generic cost plus any applicable generic copay, unless the physician writes "dispense as written" on the prescription. The physician must write "dispense as written" on the prescription for you to receive a brand name drug and only pay the brand name copay, if a generic is available.

You can visit our web site at 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.

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
Note: The calendar year deductible applies to almost all benefits in this Section. We say "(No deductible)" when it does not apply.	
Covered medications and supplies	
We cover the following medications and supplies prescribed by a plan physician and obtained from a Plan pharmacy or through our mail order program: • Drugs and medicines that by Federal law of the United States require a physician's prescription for their purchase, except those listed as *Not covered.* • Insulin • Disposable needles and syringes for the administration of covered medications • Diabetes supplies including testing agents, lancet devices, alcohol swabs, glucose elevating agents, insulin delivery devices and blood glucose monitors approved by us • Self administered injectable drugs • Oral fertility drugs • Oral contraceptive drugs • Growth hormone • Prenatal vitamins • Drugs for sexual dysfunction Note: Drugs to treat sexual dysfunction are limited. Contact the Plan for dosage limits. You pay the applicable drug copay up to the dosage limits, and all charges after that.	At participating pharmacies: $10 for Level One drugs $40 for Level Two drugs $60 for Level Three drugs 25% of the amount that the plan pays to the dispensing pharmacy for Level Four drugs Out-of-pocket maximum for Level Four drugs is $2,500 per member per calendar year 2 applicable copays for a 90-day supply of prescribed maintenance drugs, when ordered through our mail-order program At non-participating pharmacies: 30% of charges plus applicable copay
• Tobacco cessation drugs Note: Over-the-counter and prescription drugs approved by the FDA to treat tobacco dependence require a written prescription by an approved provider.	Nothing
Not covered: • *Drugs available without a prescription, or for which there is a non-prescription equivalent available* • *Drugs and supplies for cosmetic purposes (such as Rogaine)* • *Vitamins, fluoride, nutrients and food supplements even if a physician prescribes or administers them*	*All charges*

Covered medications and supplies - continued on next page

Benefit Description	You pay
Covered medications and supplies (cont.)	
• *Drugs obtained at a non-Plan pharmacy except for out-of-area emergencies* • *Drugs to enhance athletic performance* • *Any drug used for the purpose of weight control* • *Medical supplies such as dressings and antiseptics*	*All charges*

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

Section 5(h). Special features

Feature	Description
Flexible benefits option	Under the flexible benefits option: we determine the most effective way to provide services. • We may identify medically appropriate alternatives to regular contract benefits as a less costly alternative. If we identify a less costly alternative, we will ask you to sign an alternative benefit agreement that will include all of the following terms in addition to other terms as necessary. Until you sign and return the agreement regular contract benefits will continue. • Alternative benefits will be made available for a limited time period and are subject to our ongoing review. You must cooperate with the review process. • By approving an alternative benefit, we do not guarantee you will get it in the future. • The decision to offer an alternative benefit is solely ours, and except as expressly provided in the agreement, we may withdraw it at any time and resume regular contract benefits. • If you sign the agreement, we will provide the agreed-upon alternative benefits for the stated time period (unless circumstances change). You may request an extension of the time period, but regular contract benefits will resume if we do not approve your request. • Our decision to offer or withdraw alternative benefits is not subject to OPM review under the disputed claims process. However, if at the time we make a decision regarding alternative benefits, we also decide that regular contract benefits are not payable, then you may dispute our regular contract benefits decision under the OPM disputed claim process (see Section 8).
Health Assessment	This confidential, personalized, online quiz will help you discover your overall health status, recommend possible areas for improvement, and suggest positive changes to help you stay on the path to good health. Find the Health Assessment on MyHumana, your password-protected home page on Humana's Website.
***My*Humana(Humana.com)**	Once you've taken the Health Assessment, check out MyHumana for resources and information to help you improve your overall health. You'll also find shop-and-compare tools to help you choose hospitals and doctors, as well as health encyclopedias and practical information about health conditions, prescription drugs, and other health issues. The site also has video and audio health libraries, discounts and coupons for health-related programs.
Wellness Reminders	You may receive messages by phone, mail or e-mail on topics such as mammograms, immunizations, and more.
***Right*SourceRx℠**	*Right*Source, a prescription home delivery service, is a wholly owned subsidiary of Humana that gives members convenience, savings, guidance, and excellent Customer Service. *Right*Source is a fast and easy alternative to retail pharmacies. Depending on your location and benefits, you may be able to use *Right*Source.
HumanaFirst®	HumanaFirst Nurse Advice Line is your toll-free, 24-hour health information, guidance, and support line. Get information about your medical condition and find out how Humana's clinical programs can help. Or talk with a nurse about an immediate health concern.
PlanProfessor℠ and e-Plan Professor℠	PlanProfessor is a year-round e-mail program that provides easy-to-read guidance about health, wellness, and getting the most from your coverage.
Humana*Beginnings*®	Registered nurses offer education and support to mothers throughout pregnancy and the baby's first months.

Feature	Description
Case Management	Nurses provide assistance for those facing a crisis or major medical procedure - includes support for parents during neonatal intensive care.
Transplant Management	This specialized team helps transplant recipients coordinate benefits, facilitate services, and follow their treatment plans.
Maximize Your Benefit (MYB)	The Maximize Your Benefit (MYB) program, available to Humana members, offers guidance in helping you control the rising cost of prescription drugs with information about generics, lower cost alternatives and prescription home delivery service.
Personal Nurse®	Registered nurses assist those who are following treatment plans or who need continued guidance in reaching their long-term health goals.
Disease Management	Are programs that focus on: asthma, cancer, congestive heart failure, coronary artery disease, diabetes, chronic kidney disease, end-stage renal disease, cystic fibrosis, multiple sclerosis, Parkinson's disease, and 10 other conditions.
Services for deaf and hearing impaired	Humana offers telecommunication devices for the deaf (TDD) and Teletype (TTY) phone lines for the hearing impaired. Call 1-800-432-7482 to access the service.
Humana Health Coaching	Humana's Health Coaching offers you personalized action plans and assistance from phone-based, certified health coaches. Your health coaches are specially trained experts who will educate, motivate, and support you to address: Weight management, Physical activity, Back care, Nutrition, Stress management, and Tobacco cessation. Find out more under "Wellness" in the Health & Wellness section on www.MyHumana.com.
Employee Assistance Program (EAP)	Life, relationships, work, money, legal, family and everyday issues, all can be challenging. Sometimes you need help and guidance to come up with the answers and practical solutions. Your Employee Assistance (EAP) & Work-Life Program is here for you and your family – any day, anytime, as often as you need it. Best of all, this is a completely confidential service at no cost to you.

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 http://feds.humana.com.

Complementary and Alternative Medicine (CAM) discount program

- CAM discount services are provided to Humana members through a unique partnership between Humana and Healthways WholeHealth Network Inc. The network includes more than 25,000 practitioners.
- No referral is required for visits to participating massage therapists, acupuncturists or chiropractors, since the CAM program is not part of the insurance policy. However, certain CAM services are covered by some Humana health plans, so members should use their insured benefits whenever possible. Members may visit Healthways WholeHealth Network Inc. network providers as often as they like, although we encourage them to let their primary care physicians know about any CAM treatment they are considering.
- To access CAM services, members may select a provider through MySavings, on *My*Humana at www.humana.com or call the Customer Service number printed on their Humana ID card. At the time of service, members simply present their Humana discount card, available on *My*Humana, to receive the specified discount.

Vision Discount Programs

Humana members have access to two well-known vision programs, EyeMed and TruVision. Both offer special discounts for Humana members.

- EyeMed offers access to approximately 35,000 national providers - including optometrists, ophthalmologist and opticians - at over 20,000 locations nationwide. Members can select a participating provider from MySavings, on *My*Humana at www.humana.com or by calling EyeMed's provider locator service at 1-866-995-9316. To request a discount, members need only present their Humana discount card, available on *My*Humana, when they arrive at their provider's office or location. The EyeMed provider will take care of the rest.
- TruVision offers traditional and custom LASIK to correct vision problems such as nearsightedness, farsightedness and astigmatism. Through agreements at more than 200 laser centers across the United States, TruVison offers services including: a telephone screening, a comprehensive eye exam, the LASIK procedure, postoperative care and a retreatment warranty. To schedule a preoperative exam, determine price, or find a laser location, members can call 1-877-580-2020 and speak with a Customer service representative.

Prescription drug discount program

Through Humana's Rx4 or RxValue prescription drug discount program, Humana members can receive a 20 percent discount (average savings) on prescription drugs not currently covered in their benefit. Examples of discounted items are drugs for weight loss, hair growth and many more. As a Humana member your can visit www.humana.com to find out if a drug is covered or qualifies for the discount.

HumanaOne

Humana offers a wide choice of individual affordable health insurance options including Medical, Dental and Vision products. Go to http://feds.humana.com for more information.

Disability Income Insurance

Humana's disability plan will help with day-to-day expenses, such as housing, food, car payments, and additional medical costs - if an illness or accident disables members away from the workplace. Members won't have to worry about using their savings or incurring additional debt to cover these costs and care for their family. This plan is available in selected markets for 2012. Go to http://feds.humana.com for more information.

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 it is medically necessary to prevent, diagnose, or treat your illness, disease, injury, or condition. For information on obtaining prior approval for specific services, such as transplants, see Section 3 *You need prior Plan approval for certain services.*

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.
- Services, drugs, or supplies you receive without charge while in active military service.
- Extra care costs and Research costs associated with Clinical Trials.

Section 7. Filing a claim for covered services

This Section primarily deals with post-service claims (claims for services, drugs or supplies you have already received). See Section 3 for information on pre-service claims procedures (services, drugs or supplies requiring prior Plan approval), including urgent care claims procedures. 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 CMS-1500, Health Insurance Claim Form. Your facility will file on the UB-04 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 CMS-1500 or a claim form that includes the information shown below. Bills and receipts should be itemized and show:

- Covered member's name, date of birth, address, phone number 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 payor – such as the Medicare Summary Notice (MSN)
- Receipts, if you paid for your services

Note: Canceled checks, cash register receipts, or balance due statements are not acceptable substitutes for itemized bills.

Submit your claims to: Humana Claims Office
P.O. Box 14601
Lexington, Kentucky 40512-4601

Prescription drugs and other supplies or services

Submit your claims to: Humana Claims Office at the address listed above or call us at 1-800-4HUMANA or 1-800-448-6262.

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.

Post-service claims procedures

We will notify you of our decision within 30 days after we receive your post-service claim. If matters beyond our control require an extension of time, we may take up to an additional 15 days for review and we will notify you before the expiration of the original 30-day period. Our notice will include the circumstances underlying the request for the extension and the date when a decision is expected.

If we need an extension because we have not received necessary information from you, our notice will describe the specific information required and we will allow you up to 60 days from the receipt of the notice to provide the information.

If you do not agree with our initial decision, you may ask us to review it by following the disputed claims process detailed in Section 8 of this brochure.

Authorized Representative

You may designate an authorized representative to act on your behalf for filing a claim or to appeal claims decisions to us. For urgent care claims, we will permit a health care professional with knowledge of your medical condition to act as your authorized representative without your express consent. For the purposes of this section, we are also referring to your authorized representative when we refer to you.

Section 8. The disputed claims process

You may be able to appeal directly to the Office of Personnel Management (OPM) if we do not follow required claims processes. For more information about situations in which you are entitled to immediately appeal to OPM, including additional requirements not listed in Sections 3, 7 and 8 of this brochure, please visit http://feds.humana.com.

Please follow this Federal Employees Health Benefits Program disputed claims process if you disagree with our decision on your post-service claim (a claim where services, drugs or supplies have already been provided). In Section 3 *If you disagree with our pre-service claim decision,* we describe the process you need to follow if you have a claim for services, referrals, drugs or supplies that must have prior Plan approval, such as inpatient hospital admissions.

To help you prepare your appeal, you may arrange with us to review and copy, free of charge, all relevant materials and Plan documents under our control relating to your claim, including those that involve any expert review(s) of your claim.

Step	Description
1	Ask us in writing to reconsider our initial decision. You must: a) Write to us within 6 months from the date of our decision; and b) Send your request to us at: Humana Claims Office, Attn: Grievance & Appeals, P.O. Box 14546, Lexington, KY 40512-4601; and c) Include a statement about why you believe our initial decision was wrong, based on specific benefit provisions in this brochure; and d) Include copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms. e) Include your email address (optional for member), if you would like to receive our decision via email. Please note that by giving us your email, we may be able to provide our decision more quickly. We will provide you, free of charge and in a timely manner, with any new or additional evidence considered, relied upon, or generated by us or at our direction in connection with your claim and any new rationale for our claim decision. We will provide you with this information sufficiently in advance of the date that we are required to provide you with our reconsideration decision to allow you a reasonable opportunity to respond to us before that date. However, our failure to provide you with new evidence or rationale in sufficient time to allow you to timely respond shall not invalidate our decision on reconsideration. You may respond to that new evidence or rationale at the OPM review stage described in step 4.
2	In the case of a post-service claim, we have 30 days from the date we receive your request to: a) Pay the claim or b) Write to you and maintain our denial or c) Ask you or your provider for more information You or your provider must send the information so that we receive it within 60 days of our request. We will then decide within 30 more days. If we do not receive the information within 60 days we will decide within 30 days of the date the information was due. We will base our decision on the information we already have. We will write to you with our decision.
3	If you do not agree with our decision, you may ask OPM to review it. You must write to OPM within: • 90 days after the date of our letter upholding our initial decision; or • 120 days after you first wrote to us - if we did not answer that request in some way within 30 days; or • 120 days after we asked for additional information.

Write to OPM at: United States Office of Personnel Management, Healthcare and Insurance, Federal Employee Insurance Operations, Health Insurance 3, 1900 E Street, NW, Washington, DC 20415-3630.

Send OPM the following information:

- A statement about why you believe our decision was wrong, based on specific benefit provisions in this brochure;
- Copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms;
- Copies of all letters you sent to us about the claim;
- Copies of all letters we sent to you about the claim; and
- Your daytime phone number and the best time to call.
- Your email address, if you would like to receive OPM's decision via email. Please note that by providing your email address, you may receive OPM's decision more quickly.

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

Note: You are the only person who has a right to file a disputed claim with OPM. Parties acting as your representative, such as medical providers, must include a copy of your specific written consent with the review request. However, for urgent care claims, a health care professional with knowledge of your medical condition may act as your authorized representative without your express consent.

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

4 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 you did not indicate that your claim was a claim for urgent care, then call us at 1-800-523-0023. We will hasten our review (if we have not yet responded to your claim); or we will inform OPM so they can quickly review your claim on appeal. You may call OPM's Health Insurance 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 payor and the other plan pays a reduced benefit as the secondary payor. We, like other insurers, determine which coverage is primary according to the National Association of Insurance Commissioners' guidelines.

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

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

What is Medicare?

Medicare is a health insurance program for:

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

Medicare has four parts:

- Part A (Hospital Insurance). Most people do not have to pay for Part A. If you or your spouse worked for at least 10 years in Medicare-covered employment, you should be able to qualify for premium-free Part A insurance. (If you were a Federal employee at any time both before and during January 1983, you will receive credit for your Federal employment before January 1983). Otherwise, if you are age 65 or older, you may be able to buy it. Contact 1-800-MEDICARE (TTY 1-800-633-4227), (TTY 1-877-486-2048) 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, 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 (TTY 1-800-325-0778) 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 do not sign up for Medicare Part B when you are first eligible, you may be charged a Medicare Part B late enrollment penalty of a 10% increase in premium for every 12 months you are not enrolled. If you didn't take Part B at age 65 because you were covered under FEHB as an active employee (or you were covered under your spouse's group health insurance plan and he/she was an active employee), you may sign up for Part B (generally without an increased premium) within 8 months from the time you or your spouse stop working or are no longer covered by the group plan. You also can sign up at any time while you are covered by the group plan.

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.

All physicians and other providers are required by law to file claims directly to Medicare for members with Medicare Part B, when Medicare is primary. This is true whether or not they accept Medicare.

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

Claims process when you have the Original Medicare Plan – You 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 payor, we process the claim first.
- When Original Medicare is the primary payor, 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: http://feds.humana.com.

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

- **Tell us about your Medicare coverage**

You must tell us if you or a covered family member has Medicare coverage, and let us obtain information about services denied or paid under Medicare if we ask. You must also tell us about other coverage you or your covered family members may have, as this coverage may affect the primary/secondary status of this Plan and Medicare.

- **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), (TTY 1-877-486-2048) or at 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 payor, we process the claim first. If you enroll in Medicare Part D and we are the secondary payor, 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 payor. The following chart illustrates whether Medicare or this Plan should be the primary payor 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. **(Having coverage under more than two health plans may change the order of benefits determined on this chart.)**

Primary Payor Chart		
A. When you - or your covered spouse - are age 65 or over and have Medicare and you...	**The primary payor for the individual with Medicare is...**	
	Medicare	**This Plan**
1) Have FEHB coverage on your own as an active employee		✓
2) Have FEHB coverage on your own as an annuitant or through your spouse who is an annuitant	✓	
3) Have FEHB through your spouse who is an active employee		✓
4) 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 #3 above	✓	
5) 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	✓	
6) 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 #3 above	✓	
7) Are enrolled in Part B only, regardless of your employment status	✓ for Part B services	✓ for other services
8) Are a Federal employee receiving Workers' Compensation disability benefits for six months or more	✓*	
B. When you or a covered family member...		
1) Have Medicare solely based on end stage renal disease (ESRD) and...		
• It is within the first 30 months of eligibility for or entitlement to Medicare due to ESRD **(30-month coordination period)**		✓
• It is beyond the 30-month coordination period and you or a family member are still entitled to Medicare due to ESRD	✓	
2) Become eligible for Medicare due to ESRD while already a Medicare beneficiary and...		
• This Plan was the primary payor before eligibility due to ESRD **(for 30 month coordination period)**		✓
• Medicare was the primary payor before eligibility due to ESRD	✓	
3) Have Temporary Continuation of Coverage (TCC) and...		
• Medicare based on age and disability	✓	
• Medicare based on ESRD **(for the 30 month coordination period)**		✓
• Medicare based on ESRD **(after the 30 month coordination period)**	✓	
C. When either you or a covered family member are eligible for Medicare solely due to disability and you...		
1) Have FEHB coverage on your own as an active employee or through a family member who is an active employee		✓
2) Have FEHB coverage on your own as an annuitant or through a family member who is an annuitant	✓	
D. When you are covered under the FEHB Spouse Equity provision as a former spouse	✓	

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

TRICARE and CHAMPVA

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

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

Workers' Compensation

We do not cover services that:

- You (or a covered family member) 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 www.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.

Clinical Trials

If you are a participant in a clinical trial, this health plan will provide related care as follows, if it is not provided by the clinical trial:

- Routine care costs - costs for routine services such as doctor visits, lab tests, x-rays and scans, and hospitalizations related to treating the patient's condition whether the patient is in a clinical trial or is receiving standard therapy. These costs are covered by this plan.
- Extra care costs - costs related to taking part in a clinical trial such as additional tests that a patient may need as part of the trial, but not as part of the patient's routine care. This plan does not cover these costs.
- Research costs - costs related to conducting the clinical trial such as research physician and nurse time, analysis of results, and clinical tests performed only for research purposes. These costs are generally covered by the clinical trials, but this plan does not cover these costs.

Section 10. Definitions of terms we use in this brochure

Calendar year

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

Clinical Trials Cost Categories

- Routine care costs - costs for routine services such as doctor visits, lab tests, x-rays and scans, and hospitalizations related to treating the patient's condition whether the patient is in a clinical trial or is receiving standard therapy
- Extra care costs - costs related to taking part in a clinical trial such as additional tests that a patient may need as part of the trial, but not as part of the patient's routine care.
- Research costs - costs related to conducting the clinical trial such as research physician and nurse time, analysis of results, and clinical tests performed only for research purposes.

Coinsurance

Coinsurance is the percentage of our allowance that you must pay for your care. See page 17.

Consumer Driven Plan

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

Copayment

A copayment is a fixed amount of money you pay when you receive covered services. See page 16.

Cost-sharing

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

Covered services

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

Custodial care

Services provided to you such as assistance with dressing, bathing, preparation and feeding of special diets, walking, supervision of medication which is ordinarily self-administered, getting in and out of bed, and maintaining continence, which are not likely to improve your condition. Custodial care that lasts 90 days or more is sometimes known as long term care.

Deductible

A deductible is a fixed amount of covered expenses you must incur for certain covered services and supplies before we start paying benefits for those services. See page 16.

Durable Medical Equipment (DME)

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

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

Experimental or investigational services

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

- when applied to the circumstances of a particular patient is the subject of ongoing phase I, II or III clinical trials, or

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

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

Health care professional A physician or other health care professional licensed, accredited, or certified to perform specified health services consistent with state law.

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.

Post-service claims Any claims that are not pre-service claims. In other words, post-service claims are those claims where treatment has been performed and the claims have been sent to us in order to apply for benefits.

Pre-service claims Those claims (1) that require precertification, prior approval, or a referral and (2) where failure to obtain precertification, prior approval, or a referral results in a reduction of benefits.

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

Urgent care claims A claim for medical care or treatment is an urgent care claim if waiting for the regular time limit for non-urgent care claims could have one of the following impacts:

• Waiting could seriously jeopardize your life or health;
• Waiting could seriously jeopardize your ability to regain maximum function; or
• In the opinion of a physician with knowledge of your medical condition, waiting would subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

Urgent care claims usually involve Pre-service claims and not Post-service claims. We will judge whether a claim is an urgent care claim by applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine.

If you believe your claim qualifies as an urgent care claim, please contact our Customer Service Department at the number printed on your Humana ID card. You may also prove that your claim is an urgent care claim by providing evidence that a physician with knowledge of your medical condition has determined that your claim involves urgent care.

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 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
- What happens when your enrollment ends
- 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. For information on your premium deductions, you must also contact 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 dependent children under age 26, including any foster children your employing or retirement office authorizes coverage for. Under certain circumstances, you may also continue coverage for a disabled child 26 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 of changes in family member status, including your marriage, divorce, annulment, or when your child reaches age 26.

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.

- **Family member coverage**

Family members covered under your Self and Family enrollment are your spouse (including a valid common law marriage) and children as described in the chart below.

Children	Coverage
Natural, adopted children, and stepchildren	Natural, adopted children and stepchildren are covered until their 26th birthday.
Foster Children	Foster children are eligible for coverage until their 26th birthday if you provide documentation of your regular and substantial support of the child and sign a certification stating that your foster child meets all the requirements. Contact your human resources office or retirement system for additional information.
Children Incapable of Self-Support	Children who are incapable of self-support because of a mental or physical disability that began before age 26 are eligible to continue coverage. Contact your human resources office or retirement system for additional information.
Married Children	Married children (but **NOT** their spouse or their own children) are covered until their 26th birthday.
Children with or eligible for employer-provided health insurance	Children who are eligible for or have their own employer-provided health insurance are covered until their 26th birthday.

You can find additional information at www.opm.gov/insure.

- **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 2012 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 2011 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.

If your enrollment continues after you are no longer eligible for coverage (i.e. you have separated from Federal service) and premiums are not paid, you will be responsible for all benefits paid during the period in which premiums were not paid. You may be billed for services received directly from your provider. You may be prosecuted for fraud for knowingly using health insurance benefits for which you have not paid premiums. It is your responsibility to know when you or a family member are no longer eligible to use your health insurance coverage.

- **When you retire**

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

When you lose benefits

- **When FEHB coverage ends**

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

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

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

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

- **Upon divorce**

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

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

If you leave Federal service, or if you lose coverage because you no longer qualify as a family member, you may be eligible for Temporary Continuation of Coverage (TCC). For example, you can receive TCC if you are not able to continue your FEHB enrollment after you retire, if you lose your Federal job, if you are a covered dependent child and you turn 26, etc.

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

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

- **Converting to individual coverage**

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

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

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

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

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

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

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

Section 12. Other Federal Programs

Important information about three Federal programs that complement the FEHB Program

First, the **Federal Flexible Spending Account (FSA) Program**, also known as **FSAFEDS**, lets you set aside pre-tax money from your salary to reimburse you for eligible dependent care and/or health care expenses. You pay less in taxes so you save money. The result can be a discount of 20% to more than 40% on services/products you routinely pay for out-of-pocket.

Second, 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 eligible dependents.

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

The Federal Flexible Spending Account Program (FSAFEDS)

What is an FSA?

It is an account where you contribute money from your salary **BEFORE** taxes are withheld, then incur eligible expenses and get reimbursed. You pay less in taxes so you save money. **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) –** Reimburses you for eligible health care expenses (such as copayments, deductibles, insulin, products, physician prescribed over-the-counter drugs and medications, vision and dental expenses, and much more) for you and your tax dependents, including adult children (through the end of the calendar year in which they turn 26) 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 tax dependents, including adult children (through the end of the calendar year in which they turn 26) which are not covered or reimbursed by FEHBP or FEDVIP coverage or any other insurance.
- **Dependent Care FSA (DCFSA) –** Reimburses you for eligible **non-medical** day care expenses for your child(ren) under age 13 or for any person you claim as a dependents on your Federal Income Tax return who is mentally or physcially incapable of self-care. You (and your spouse if married) must be working, looking for work (income must be earned during the year), or attending school full-time to be eligible for a DCFSA.
- If you are a new or newly hired eligible employee you have 60 days from your hire date to enroll in an HCFSA or LEX HCFSA and/or DCFSA, but you must also enroll before October 1. If you are hired or become eligible on or after October 1 you must wait and enroll during the Federal Benefits Open Season held each fall.

Where can I get more information about FSAFEDS?

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

The Federal Employees Dental and Vision Insurance Program (FEDVIP)

Important Information

The Federal Employees Dental and Vision Insurance Program (FEDVIP) is separate and different from the FEHB Program and was established by the Federal Employee Dental and Vision Benefits Enhancement Act of 2004. **This program provides comprehensive dental and vision insurance at competitive group rates with no pre-existing condition limitations for enrollment.**

FEDVIP is available to eligible Federal and Postal Service employees, retirees, and their eligible family members on an enrollee-pay-all basis. Employee premiums are withheld from salary on a pre-tax basis.

Dental Insurance

All dental plans provide a comprehensive range of services, including:

- 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 for dependent children up to age 19.

Vision Insurance

All 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/vision or www.opm.gov/insure/dental. These sites also provide 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. For those without access to a computer, call 1-877-888-3337 (TTY 1-877-889-5680).

The Federal Long Term Care Insurance Program (FLTCIP)

It's important protection

The Federal Long Term Care Insurance program (FLTCIP) can help 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 such as Alzheimer's disease. For example, long term care can be received in your home from a home health aide, in a nursing home, in an assisted living facility or in adult day care. To qualify for coverage under the FLTCIP, you must apply and pass a medical screening (called underwriting). Federal and U.S. Postal Service employees and annuitants, active and retired members of the uniformed services, and qualified relatives, are eligible to apply. Certain medical conditions, or combinations of conditions, will prevent some people from being approved for coverage. You must apply to know if you will be approved for enrollment. For more information, call 1-800-LTC-FEDS (1-800-582-3337) (TTY 1-800-843-3557) or visit www.ltcfeds.com.

Pre-existing Condition Insurance Program (PCIP)

Do you know someone who needs health insurance but can't get it? The Pre-Existing Condition Insurance Plan (PCIP) may help.

An individual is eligible to buy coverage in PCIP if:

- He or she has a pre-existing medical condition or has been denied coverage because of the health condition;
- He or she has been without health coverage for at least the last six months. (If the individual currently has insurance coverage that does not cover the pre-existing condition or is enrolled in a state high risk pool then that person is not eligible for PCIP.);
- He or she is a citizen or national of the United States or resides in the U.S. legally.

The Federal government administers PCIP in the following states: Alabama, Arizona, District of Columbia, Delaware, Florida, Georgia, Hawaii, Idaho, Indiana, Kentucky, Louisiana, Massachusetts, Minnesota, Mississippi, North Dakota, Nebraska, Nevada, South Carolina, Tennessee, Texas, Vermont, Virginia, West Virginia, and Wyoming. To find out about eligibility, visit www.pcip.gov and/or www.healthcare.gov or call 1-866-717-5826 (TTY 1-866-561-1604).

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

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Notes

Notes

2012 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
Medical services provided by physicians: • Diagnostic and treatment services provided in the office	$25 primary care; $45 specialist	20
Services provided by a hospital: • Inpatient	$300 per day for the first five days per admission	37
• Outpatient – surgery	$150 per visit	38
• Outpatient – MRI, MRA, CT, PET, SPECT	$100 per visit	38
• Outpatient – other services	$50 copay per visit	38
Emergency benefits: • At a doctor's office	$25 primary care; $45 specialist	40
• In and out-of-area (emergency room)	$175 copay	40
Mental health and substance abuse treatment:	Regular cost-sharing	42
Prescription drugs: • Level One drugs	$10 copay	46
• Level Two drugs	$40 copay	46
• Level Three drugs	$60 copay	46
• Level Four drugs	25% of the amount the plan pays	46
• Maintenance drugs (90-day supply) when ordered through our mail-order program	2 applicable copays	46
Dental care: Accidental injury benefit only	Nothing	48
Vision care:	No benefit	
Special features: Personal Nurse; HumanaFirst; *My*Humana; Humana *Beginnings*; Disease management; Transplant management; Case management; Humana Health Coaching; TDD and TTY phone lines		49
Protection against catastrophic costs (out-of-pocket maximum): *Some costs do not count towards this maximum.*	Nothing after $3,000 per person or $6,000 per family not including the deducible per contract year.	17

Notes

2012 Rate Information

For 2012 health premium information, please see http://www.opm.gov/insure/health/tribes/rates/ or contact your tribe's Human Resources department.