

Humana Medical Plan, Inc.

<http://www.humana.com>



2001

A Health Maintenance Organization

Serving: South Florida



Enrollment in this Plan is limited; see page 6 for requirements.



*This plan has accreditation
from the NCQA. See the 2001 Guide
for more information on NCQA.*

Enrollment codes for this Plan:

EE1 Self Only
EE2 Self and Family

Special notice for Humana Enrollees: Enrollment codes 7F, P5, P7, JH, and 9D have been eliminated. Ft. Myers, including the counties of Charlotte and Lee under enrollment code EE have been eliminated. Current enrollees in these areas must select another plan during Open Season. See page 7 for details.

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RETIREMENT AND INSURANCE SERVICE
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Introduction

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

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

If you are enrolled in this Plan, you are entitled to the benefits described in this brochure. If you are enrolled for Self and Family coverage, each eligible family member is also entitled to these benefits. You do not have a right to benefits that were available before January 1, 2001, unless those benefits are also shown in this brochure.

OPM negotiates benefits and rates with each plan annually. Benefit changes are effective January 1, 2001, and are summarized on page 8. Rates are shown at the end of this brochure.

Plain Language

The President and Vice President are making the Government's communication more responsive, accessible, and understandable to the public by requiring agencies to use plain language. In response, a team of health plan representatives and OPM staff worked cooperatively to make this brochure clearer. Except for necessary technical terms, we use common words. "You" means the enrollee or family member; "we" means Humana Medical Plan, Inc.

The plain language team reorganized the brochure and the way we describe our benefits. When you compare this Plan with other FEHB plans, you will find that the brochures have the same format and similar information to make comparisons easier.

If you have comments or suggestions about how to improve this brochure, let us know. Visit OPM's "Rate Us" feedback area at www.opm.gov/insure or e-mail us at fehbwebcomments@opm.gov or write to OPM at Insurance Planning and Evaluation Division, P.O. Box 436, Washington, DC 20044-0436.

Section 1. Facts about this HMO plan

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

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

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

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

How we pay providers

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

Who provides my healthcare?

The Plan's provider directory lists primary care doctors (family practitioners, pediatricians, and internists), with their locations and phone numbers, and notes whether or not the doctor is accepting new patients. Directories are updated on a regular basis and are available at the time of enrollment or upon request by calling **1-800/426-2173**; you can also find out if your doctor participates with this Plan by calling this number. If you are interested in receiving care from a specific provider who is listed in the directory, call the provider to verify that he or she still participates with the Plan and is accepting new patients. Important note: When you enroll in this plan, services (except for emergency benefits) are provided through the Plan's delivery system; the continued availability and/or participation of any one doctor, hospital, or other provider, cannot be guaranteed.

Patients' Bill of Rights

OPM requires that all FEHB Plans comply with the Patients' Bill of Rights, recommended by the President's Advisory Commission on Consumer Protection and Quality in the Health Care Industry. You may get information about us, our networks, providers and facilities. OPM's FEHB website (www.opm.gov/insure) lists the specific types of information that we must make available to you. Some of the required information is listed below.

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

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

Service Area

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

The Florida counties of Broward, Dade and Palm Beach.

Ordinarily, you must get your care from providers who contract with us. If you receive care outside our Service Area, we will pay only for emergency care. We will not pay for any other health care services.

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

Section 2. How we change for 2001

Program-wide changes

- The plain language team reorganized the brochure and the way we describe our benefits. We hope this will make it easier for you to compare plans.
- This year, the Federal Employees Health Benefits Program is implementing network mental health and substance abuse parity. This means that your coverage for mental health, substance abuse, medical, surgical, and hospital services from providers in our plan network will be the same with regard to deductibles, coinsurance, copays, and day and visit limitations when you follow a treatment plan that we approve. Previously, we placed shorter day or visit limitations on mental health and substance abuse services than we did on services to treat physical illness, injury, or disease.
- Many healthcare organizations have turned their attention this past year to improving healthcare quality and patient safety. OPM asked all FEHB plans to join them in this effort. You can find specific information on our patient safety activities by calling 1-800/4HUMANA, or checking our website, www.humana.com. You can find out more about patient safety on the OPM website, www.opm.gov/insure. To improve your healthcare, take these five steps:
 - Speak up if you have questions or concerns.
 - Keep a list of all the medicines you take.
 - Make sure you get the results of any test or procedure.
 - Talk with your doctor and health care team about your options if you need hospital care.
 - Make sure you understand what will happen if you need surgery.
- We clarified the language to show that anyone who needs a mastectomy may choose to have the procedure performed on an inpatient basis and remain in the hospital up to 48 hours after the procedure. Previously, the language referenced only women.

Changes to this Plan

- Your share of the non-Postal premium will increase by 25.2% for Self Only and Self and Family.
- Enrollment codes P7-Daytona, P5-Jacksonville, 7F-Orlando/Gainesville, 9D-Pensacola, and JH-Tampa have been eliminated. Members currently enrolled in these codes must select another plan during Open Season.
- Enrollment code EE has been reduced. Ft. Myers, including the counties of Charlotte and Lee have been eliminated. Members currently enrolled in these counties must select another plan during Open Season.
- There is a \$10 copay for specialist visits.

Section 3. How you get care

Identification cards

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

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

Where you get covered care

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

- Plan providers

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

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

- Plan facilities

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

What you must do to get

covered care

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

- Primary care

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

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

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

- Specialty care

Your primary care physician will refer you to a specialist for needed care. However, you may see the following participating providers without a referral:

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

- Podiatrists
- Chiropractors
- Dermatologists (for up to five visits each calendar year)
- Another doctor your primary care physician has designated to provide patient care when he or she is not available.

When you receive a referral from your primary care doctor, you must return to the primary care doctor after the consultation unless your doctor authorizes additional visits. All follow-up care must be provided or authorized by the primary care doctor. Do not go to the specialist for a second visit unless your primary care doctor has arranged for and the Plan has issued an authorization for the referral in advance.

Here are other things you should know about specialty care:

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

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

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

- Hospital care

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

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

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

- You are discharged, not merely moved to an alternative care center; or

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

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

Circumstances beyond our control

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

Services requiring our prior approval

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

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

- Growth hormone therapy
- Organ/Tissue transplants
- All elective medical and surgical hospitalizations
- Hysterectomy
- Lumbar laminectomy/disectomy
- Lumbar fusion
- MRI of the lumbar and cervical spine
- Blepharoplasty
- Reduction mammoplasty/breast reconstruction
- Septoplasty/submucous resection (with or without rhinoplasty)
- Rhinoplasty
- Uvulopalatopharyngoplasty (UPPP)
- Continuous positive airway pressure (CPAP)
- Gastric bypass
- Scar revisions
- Mandibular or maxillary osteotomy
- Speech therapy
- All durable medical equipment (DME) over \$500

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

Section 4. Your costs for covered services

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

- **Copayments**

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

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

- **Deductible**

We do not have a deductible.

- **Coinsurance**

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

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

Your out-of-pocket maximum for copayments and coinsurance

After your copayments total \$1,500 per person or \$3,000 per family enrollment in any calendar year, you do not have to pay any more for covered services. However, copayments for the following services do not count toward your out-of-pocket maximum, and you must continue to pay copayments for these services:

- Prescription drugs

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

Section 5. Benefits – OVERVIEW

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

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

(a) Medical services and supplies provided by physicians and other health care professionals	13-22
•Diagnostic and treatment services	
•Lab, x-ray, and other diagnostic tests	
•Preventive care, adult	
•Preventive care, children	
•Maternity care	
•Family planning	
•Infertility services	
•Allergy care	
•Treatment therapies	
•Rehabilitative therapies	
•Hearing services (testing, treatment, and supplies)	
•Vision services (testing, treatment, and supplies)	
•Foot care	
•Orthopedic and prosthetic devices	
•Durable medical equipment (DME)	
•Home health services	
•Alternative treatments	
•Educational classes and programs	
(b) Surgical and anesthesia services provided by physicians and other health care professionals	23-26
•Surgical procedures	
•Reconstructive surgery	
•Oral and maxillofacial surgery	
•Organ/tissue transplants	
•Anesthesia	
(c) Services provided by a hospital or other facility, and ambulance services	27-29
•Inpatient hospital	
•Outpatient hospital or ambulatory surgical center	
•Extended care benefits/skilled nursing care facility benefits	
•Ambulance	
(d) Emergency services/accidents	30-31
•Medical emergency	
•Ambulance	
(e) Mental health and substance abuse benefits	32-33
(f) Prescription drug benefits	34-36
(g) Special features	37
• Services for deaf and hearing impaired	
• High risk pregnancies	
• Centers of excellence for transplants/heart surgery/etc.	
• 24-hour nurse line	
(h) Dental benefits	38
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Section 5 (a). Medical services and supplies provided by physicians and other health care professionals

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

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

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Benefit Description

Diagnostic and treatment services	You pay
Professional services of physicians <ul style="list-style-type: none"> • In physician's office • In an urgent care center • Office medical consultations • At home 	\$10 per office visit
Professional services of physicians <ul style="list-style-type: none"> • During a hospital stay • In a skilled nursing facility • Initial examination of a newborn child covered under a family enrollment • Second surgical opinion 	Nothing
Lab, x-ray and other diagnostic tests	
Tests, such as: <ul style="list-style-type: none"> • Blood tests • Urinalysis • Non-routine pap tests • Pathology • X-rays • Non-routine Mammograms • CAT Scans/MRI • Ultrasound • Electrocardiogram and EEG 	Nothing if you receive these services during your office visit; otherwise, \$10 per visit.

Preventive care, adult	You pay
<p>Routine screenings, such as:</p> <ul style="list-style-type: none"> • Blood lead level – one annually • Total Blood Cholesterol – once every three years, ages 19 through 64 • Colorectal Cancer Screening, including <ul style="list-style-type: none"> ••Fecal occult blood test ••Sigmoidoscopy, screening – every five years starting at age 50 • Prostate Specific Antigen (PSA test) – one annually for men age 40 and older • Routine pap test – one annually <p>NOTE: The office visit is covered if pap test is received on the same day; see <i>Diagnostic and treatment services</i>, above.</p> <p>Routine mammogram – covered for women age 35 and older, as follows:</p> <ul style="list-style-type: none"> • From age 35 through 39, one during this five year period • From age 40 through 64, one every calendar year • At age 65 and older, one every two consecutive calendar years • When prescribed by the doctor as medically necessary to diagnose or treat illness 	<p>Nothing if you receive these services during your office visit; otherwise, \$10 per visit</p>
<p><i>Not covered: physical exams and immunizations required for obtaining or continuing employment or insurance, attending schools or camp, or travel.</i></p>	<p><i>All charges</i></p>
<p>Routine Immunizations, limited to:</p> <ul style="list-style-type: none"> • Tetanus-diphtheria (Td) booster – once every 10 years, ages 19 and over (except as provided for under Childhood immunizations) • Influenza/Pneumococcal vaccines, annually, age 65 and over, or in the presence of high risk, chronic conditions 	<p>Nothing if you receive these services during your office visit; otherwise, \$10 per visit .</p>

Preventive care, children	You pay
<ul style="list-style-type: none"> • Childhood immunizations recommended by the American Academy of Pediatrics 	Nothing
<ul style="list-style-type: none"> • Examinations, such as: <ul style="list-style-type: none"> ••Eye exams through age 17 to determine the need for vision correction. ••Ear exams through age 17 to determine the need for hearing correction ••Examinations done on the day of immunizations (through age 22) • Well-child care charges for routine examinations, immunizations and care (through age 17) 	\$10 per office visit.
Maternity care	
<p>Complete maternity (obstetrical) care, such as:</p> <ul style="list-style-type: none"> • Prenatal care • Delivery • Postnatal care <p>NOTE: Here are some things to keep in mind:</p> <ul style="list-style-type: none"> • You may remain in the hospital up to 48 hours after a regular delivery and 96 hours after a cesarean delivery. We will extend your inpatient stay if medically necessary. • We cover routine nursery care of the newborn child during the covered portion of the mother’s maternity stay. We will cover other care of an infant who requires non-routine treatment only if we cover the infant under a Self and Family enrollment. • We pay hospitalization and surgeon services (delivery) the same as for illness and injury. See Hospital benefits (Section 5c) and Surgery benefits (Section 5b). 	<p>\$10 for the first pre-natal office visit. Subsequent visits are provided with no copay charge.</p>
<p><i>Not covered: routine sonograms to determine fetal age, size or sex</i></p>	<p><i>All charges</i></p>

Family planning	You pay
<ul style="list-style-type: none"> • Implantable drugs (such as Norplant) • Injectable drugs (such as Depo Provera) • Contraceptive devices • Oral contraceptive drugs covered under prescription drug benefits. See Section 5 (f). • Voluntary sterilization 	\$10 per office visit
<p><i>Not covered: reversal of voluntary surgical sterilization</i></p>	<p><i>All charges</i></p>
Infertility services	
<p>Diagnosis and treatment of infertility, such as:</p> <ul style="list-style-type: none"> • Artificial insemination: <ul style="list-style-type: none"> ••intra vaginal insemination (IVI) ••intra cervical insemination (ICI) ••intra uterine insemination (IUI) • Fertility drugs 	<p>50% of all charges after the Plan has paid for the first \$2,000 in charges.</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>assisted reproductive technology (ART) procedures, such as:</i> <ul style="list-style-type: none"> ••<i>in vitro fertilization</i> ••<i>embryo transfer and GIFT</i> • <i>services and supplies related to excluded ART procedures</i> • <i>cost of donor sperm</i> 	<p><i>All charges</i></p>
Allergy care	
<ul style="list-style-type: none"> • Testing and treatment, including test and treatment materials 	<p>Nothing if you receive these services during your office visit; otherwise, \$10 per visit .</p>
<ul style="list-style-type: none"> • Allergy serum 	<p>Nothing</p>
<p><i>Not covered: provocative food testing and sublingual allergy desensitization</i></p>	<p><i>All charges</i></p>

Treatment therapies	You pay
<ul style="list-style-type: none"> • Chemotherapy and radiation therapy <p>NOTE: High dose chemotherapy in association with autologous bone marrow transplants is limited to those transplants listed under Organ/Tissue Transplants on page 24.</p> <ul style="list-style-type: none"> • Respiratory and inhalation therapy • Dialysis – Hemodialysis and peritoneal dialysis 	<p>\$10 per office visit</p>
<ul style="list-style-type: none"> • Intravenous (IV)/Infusion Therapy – Home IV and antibiotic therapy • Growth hormone therapy (GHT) <p>NOTE: We will only cover Growth Hormone Therapy if the treatment is precertified and there is a laboratory confirmed diagnosis of Growth Hormone Deficiency. You will need to call the precertification telephone number on the back of your medical ID (identification) card. We will also ask that your physician submit information that establishes that the GHT is medically necessary. GHT must be authorized <u>before</u> you begin treatment.</p> <p>See <i>Services requiring our prior approval</i> in Section 3.</p>	<p>\$10 per office visit</p>

Rehabilitative therapies	You pay
<p>Physical therapy, occupational therapy and speech therapy on an inpatient or outpatient basis</p> <ul style="list-style-type: none"> • Up to two consecutive months per condition for the services of each of the following if significant improvement can be expected within two months: <ul style="list-style-type: none"> ••qualified physical therapists; ••speech therapists; and ••occupational therapists. <p>NOTE: Speech therapy is limited to treatment of certain speech impairments of organic origin. Occupational therapy is limited to services that assist the member to achieve and maintain self-care and improved functioning in other activities of daily living.</p>	Nothing
<ul style="list-style-type: none"> • Cardiac rehabilitation following a heart transplant, bypass surgery or a myocardial infarction, is provided for up to 12 weeks. 	Nothing
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>long-term rehabilitative therapy</i> • <i>exercise programs</i> 	<i>All charges</i>
Hearing services (testing, treatment, and supplies)	
<ul style="list-style-type: none"> • Screening hearing testing for children through age 17 (see <i>Preventive care, children</i>) 	\$10 per office visit
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>all other hearing testing</i> • <i>hearing aids, testing and examinations for them</i> 	<i>All charges</i>
Vision services (testing, treatment, and supplies)	
<ul style="list-style-type: none"> • One pair of eyeglasses or contact lenses to correct an impairment directly caused by accidental ocular injury or intraocular surgery (such as for cataracts) • Diagnosis and treatment of diseases of the eye. • Screening eye exam to determine the need for vision correction for children through age 17 (see preventive care) 	\$10 per office visit

Vision services (testing, treatment, and supplies) (Continued)	You pay
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>eyeglasses or contact lenses and, after age 17, examinations for them</i> • <i>eye exercises and orthoptics</i> • <i>radial keratotomy and other refractive surgery</i> 	<p><i>All charges</i></p>
Foot care	
<p>Routine foot care when you are under active treatment for a metabolic or peripheral vascular disease, such as diabetes.</p> <p>See orthopedic and prosthetic devices for information on podiatric shoe inserts.</p>	<p>\$10 per office visit</p>
<p><i>Not covered,:</i></p> <ul style="list-style-type: none"> • <i>cutting, trimming or removal of corns, calluses, or the free edge of toenails, and similar routine treatment of conditions of the foot, unless primary medical condition requires such care</i> • <i>treatment of weak, strained or flat feet or bunions or spurs; and of any instability, imbalance or subluxation of the foot (unless the treatment is by open cutting surgery)</i> 	<p><i>All charges</i></p>
Orthopedic and prosthetic devices	
<ul style="list-style-type: none"> • Artificial limbs • Orthopedic devices such as braces (except for dental braces) that are custom-fitted or custom-made. • Externally worn breast prostheses and surgical bras, including necessary replacements, following a mastectomy • Internal prosthetic devices, such as artificial joints and pacemakers. NOTE: See 5(b) for coverage of the surgery to insert the device. • Corrective orthopedic appliances for non-dental treatment of temporomandibular joint (TMJ) pain dysfunction syndrome. 	<p>Nothing</p>

Orthopedic and prosthetic devices <i>(Continued)</i>	You pay
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>foot orthotics</i> • <i>orthopedic and corrective shoes</i> • <i>arch supports</i> • <i>heel pads and heel cups</i> • <i>lumbosacral supports</i> • <i>corsets, trusses, elastic stockings, support hose, and other supportive devices</i> • <i>prosthetic replacements</i> 	<i>All charges</i>
Durable medical equipment (DME)	
<p>Rental or purchase, at our option, including repair and adjustment, of durable medical equipment prescribed by your Plan physician, such as oxygen and dialysis equipment. Under this benefit, we also cover:</p> <ul style="list-style-type: none"> • Hospital beds • Wheelchairs • Crutches • Walkers • Blood glucose monitors • Insulin pumps 	Nothing
Home health services	
<ul style="list-style-type: none"> • Home health care ordered by a Plan physician and provided by a registered nurse (R.N.), licensed practical nurse (L.P.N.), licensed vocational nurse (L.V.N.), or home health aide. • Services includes intravenous therapy and medications. 	\$10 per visit
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>nursing care requested by, or for the convenience of, the patient or the patient's family;</i> • <i>nursing care primarily for hygiene, feeding, exercising, moving the patient, homemaking, companionship or giving oral medication.</i> 	<i>All charges</i>

Alternative treatments	You pay
<ul style="list-style-type: none"> • Chiropractic services 	\$10 per office visit
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • acupuncture • naturopathic services • hypnotherapy • biofeedback 	<i>All charges</i>
Educational classes and programs	
<p>Lifestyle management programs are offered by Magellan Behavioral Health, e.g. Smoking cessation, stress management and weight management. For information call 1-800-741-1017.</p>	Nothing

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

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

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

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Benefit Description

Surgical procedures	You pay
<ul style="list-style-type: none"> • Treatment of fractures, including casting • Normal pre- and post-operative care by the surgeon • Endoscopy procedure • Biopsy procedure • Removal of tumors and cysts • Correction of congenital anomalies (see reconstructive surgery) • Surgical treatment of morbid obesity – a condition in which an individual weighs 100 pounds or 100% over his or her normal weight according to current underwriting standards; eligible members must be age 18 or over. • Insertion of internal prosthetic devices. See 5(a) – Orthopedic braces and prosthetic devices for device coverage information. • Surgically implanting of contraceptives such as Norplant, and contraceptive devices. NOTE: Devices are covered under 5(a). • Treatment of burns • Voluntary sterilization 	<p>Nothing for inpatient services; \$10 per office visit.</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>reversal of voluntary sterilization</i> 	<p><i>All charges</i></p>

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

Oral and maxillofacial surgery	
<p>Oral surgical procedures, such as:</p> <ul style="list-style-type: none"> • Reduction of fractures of the jaws or facial bones; • Surgical correction of congenital defects such as cleft lip, cleft palate or severe functional malocclusion; • Removal of stones from salivary ducts; • Excision of leukoplakia or malignancies; • Excision of cysts and incision of abscesses when done as independent procedures; • Other surgical procedures that do not involve the teeth or supporting structures; • Diagnosis and non-dental treatment of temporomandibular joint (TMJ) pain dysfunction syndrome. 	<p>Nothing for inpatient services; \$10 copay per office visit.</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>procedures that involve the teeth or their supporting structures (such as the periodontal membrane, gingiva, and alveolar bone)</i> • <i>dental work related to treatment for temporomandibular joint (TMJ)</i> 	<p><i>All charges</i></p>

Organ/tissue transplants	You pay
<p>Limited to:</p> <ul style="list-style-type: none"> • Cornea • Heart • Kidney/Pancreas • Liver • Pancreas • Allogeneic (donor) bone marrow transplants • Autologous bone marrow transplants (autologous stem cell and peripheral stem cell support) for the following conditions: acute lymphocytic or non-lymphocytic leukemia; advanced Hodgkin's lymphoma; advanced non-Hodgkin's lymphoma; advanced neuroblastoma; breast cancer; multiple myeloma; epithelial ovarian cancer; Wiskott-Aldrich syndrome; severe combined immunodeficiency syndrome; aplastic anemia; ewings sarcoma; and testicular, mediastinal, retroperitoneal and ovarian germ cell tumors. <p>Limited Benefits – Treatment for breast cancer, multiple myeloma, and epithelial ovarian cancer may be provided in an NCI- or NIH-approved clinical trial at a Plan-designated center of excellence and if approved by the Plan's medical director in accordance with the Plan's protocols.</p> <p>NOTE: We cover related medical and hospital expenses of the donor when we cover the recipient.</p>	Nothing.
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>donor screening tests and donor search expenses, except those performed for the actual donor</i> • <i>implants of artificial organs</i> • <i>transplants not listed as covered</i> 	<i>All charges</i>
Anesthesia	
<p>Professional services provided in –</p> <ul style="list-style-type: none"> • Hospital (inpatient) 	Nothing
<p>Professional services provided in –</p> <ul style="list-style-type: none"> • Hospital outpatient department • Skilled nursing facility • Ambulatory surgical center 	Nothing
<p>Professional services provided in –</p> <ul style="list-style-type: none"> • Office 	\$10 per office visit

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

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Here are some important things to remember about these benefits:

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

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Benefit Description	
Inpatient hospital	You pay
<p>Room and board, such as</p> <ul style="list-style-type: none"> • Semiprivate, intensive care or cardiac care accommodations; • General nursing care; • Private accommodations when a Plan doctor determines it is medically necessary; • Private duty nursing when Plan doctor determines medically necessary; and • Meals and special diets. <p>NOTE: If you want a private room when it is not medically necessary, you pay the additional charge above the semiprivate room rate.</p>	Nothing
<p>Other hospital services and supplies, such as:</p> <ul style="list-style-type: none"> • Operating, recovery, maternity, and other treatment rooms • Prescribed drugs and medicines • Diagnostic laboratory tests and x-rays • Administration of blood and blood products • Dressings, splints, casts, and sterile tray services • Medical supplies and equipment, including oxygen • Anesthetics, including nurse anesthetist services • Take-home items • Medical supplies, appliances, medical equipment, and any covered items billed by a hospital for use at home 	Nothing

Inpatient hospital (Continued)	You pay
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>custodial care, rest cures, domiciliary or convalescent care</i> • <i>personal comfort items, such as telephone and television</i> • <i>blood and blood derivatives not replaced by the member</i> 	<p><i>All charges</i></p>
Outpatient hospital or ambulatory surgical center	
<ul style="list-style-type: none"> • Operating, recovery, and other treatment rooms • Prescribed drugs and medicines • Laboratory tests, x-rays, and pathology services • Administration of blood, blood plasma, and other biologicals • Pre-surgical testing • Dressings, casts, and sterile tray services • Medical supplies, including oxygen • Anesthetics and anesthesia service <p>NOTE: We cover hospital services and supplies related to dental procedures when necessitated by a non-dental physical impairment. We do not cover the dental procedures.</p>	<p>Nothing</p>
<p><i>Not covered: blood and blood derivatives not replaced by the member</i></p>	<p><i>All charges</i></p>
Extended care benefits/skilled nursing care facility benefits	
<p>Extended care benefit:</p> <ul style="list-style-type: none"> • Up to 100 days per calendar year, including <ul style="list-style-type: none"> •• bed and board; •• general nursing care •• drugs, biologicals, supplies and equipment provided by the facility <p>NOTE: Coverage is provided when full-time skilled nursing care is necessary and confinement in a skilled nursing facility is medically appropriate as determined by a Plan doctor and approved by the Plan.</p>	<p>Nothing</p>
<p><i>Not covered: custodial care, rest cures, convalescent care</i></p>	<p><i>All charges</i></p>

Ambulance	You pay
<ul style="list-style-type: none">• Local professional ambulance service when medically appropriate.	Nothing

Section 5 (d). Emergency services/accidents

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

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

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What is a medical emergency?

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

What to do in case of emergency:

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

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

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

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

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

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

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

Benefit Description	
Emergency within our service area	You pay
<ul style="list-style-type: none"> • Emergency care at a doctor's office • Emergency care at an urgent care center 	\$10 per visit
<ul style="list-style-type: none"> • Emergency care as an outpatient at a hospital, including doctors' services <p>If the emergency results in an admission to the hospital, the emergency care copay is waived.</p>	\$25 per visit
<i>Not covered: elective care or non-emergency care</i>	<i>All charges</i>
Emergency outside our service area	
<ul style="list-style-type: none"> • Emergency care as an outpatient at a hospital, including doctor's services <p>If the emergency results in admission to a hospital, the emergency care copay is waived.</p>	25% of charges up to a \$50 maximum per visit
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>elective care or non-emergency care</i> • <i>emergency care provided outside the service area if the need for care could have been foreseen before leaving the service area</i> • <i>medical and hospital costs resulting from a normal full-term delivery of a baby outside the service area</i> 	<i>All charges</i>
Ambulance	
<ul style="list-style-type: none"> • Professional ambulance service approved by the Plan. See 5(c) for non-emergency service. <p>NOTE: Air ambulance is covered only when point of pick-up is inaccessible by land vehicle; or great distances or other obstacles are involved in getting a patient to the nearest hospital with appropriate facilities when prompt admission is essential.</p>	Nothing

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

I M P O R T A N T	<p>Parity</p> <p>Beginning in 2001, all FEHB plans’ mental health and substance abuse benefits will achieve “parity” with other benefits. This means that we will provide mental health and substance abuse benefits differently than in the past.</p> <p>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.</p> <p>Here are some important things to keep in mind about these benefits:</p> <ul style="list-style-type: none"> • All benefits are subject to the definitions, limitations, and exclusions in this brochure. • Be sure to read Section 4, <i>Your costs for covered services</i> for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare. <p>YOU MUST GET PREAUTHORIZATION OF THESE SERVICES. See the instructions after the benefits description below.</p>	I M P O R T A N T
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Description	
Mental health and substance abuse benefits	You pay
<p>All diagnostic and treatment services recommended by a Plan provider and contained in a treatment plan that we approve. The treatment plan may include services, drugs, and supplies described elsewhere in this brochure.</p> <p>NOTE: Plan benefits are payable only when we determine the care is clinically appropriate to treat your condition and only when you receive the care as part of a treatment plan that we approve.</p>	<p>Your cost sharing responsibilities are no greater than for other illness or conditions.</p>
<ul style="list-style-type: none"> • Professional services, including individual or group therapy by providers such as psychiatrists, psychologists, or clinical social workers • Medication management 	<p>\$10 per office visit</p>
<ul style="list-style-type: none"> • Diagnostic tests 	<p>Nothing</p>
<ul style="list-style-type: none"> • Services provided by a hospital or other facility • Services in approved alternative care settings such as partial hospitalization, half-way house, residential treatment, full-day hospitalization, facility based intensive outpatient treatment 	<p>Nothing</p>

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

Mental health and substance abuse benefits – *CONTINUED*

Not covered: services we have not approved.

All charges

NOTE:OPM will base its review of disputes about treatment plans on the treatment plan's clinical appropriateness. OPM will generally not order us to pay or provide one clinically appropriate treatment plan in favor of another.

Preauthorization

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

- Please contact Magellan Behavioral Health at 1-800/777-7753 to obtain Mental Health/Substance Abuse treatment services.

Special transitional benefit

If a mental health or substance abuse professional provider is treating you under our plan as of January 1, 2001, you will be eligible for continued coverage with your provider for up to 90 days under the following conditions:

- If your mental health or substance abuse professional provider with whom you are currently in treatment leaves the plan at our request for other than cause.

If this condition applies to you, we will allow you reasonable time to transfer your care to a Plan mental health or substance abuse professional provider. During the transitional period, you may continue to see your treating provider and will not pay any more out-of-pocket than you did in the year 2000 for services. This transitional period will begin with our notice to you of the change in coverage and will end 90 days after you receive our notice. If we write to you before October 1, 2000, the 90-day period ends before January 1 and this transitional benefit does not apply.

Limitation

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

Section 5 (f). Prescription drug benefits

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

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

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

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

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

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

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

- **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.

Prescription drug benefits begin on the next page.

Benefit Description

Covered medications and supplies	You pay
<p>We cover the following medications and supplies prescribed by a licensed physician and obtained from a Plan pharmacy or through our mail order program:</p> <ul style="list-style-type: none"> • Drugs and medicines that by Federal law of the United States require a physician’s prescription for their purchase. • Insulin • Disposable needles and syringes for the administration of covered medications • Diabetic supplies including testing agents, lancet devices, alcohol swabs, glucose elevating agents, and insulin delivery devices • Self administered injectable drugs • Oral contraceptive drugs <p>NOTE: Drugs to treat sexual dysfunction are limited. Contact the Plan for dosage limits. You pay the applicable drug copay up to the dosage limits, and all charges after that.</p>	<p>\$5 for generic drugs listed on our formulary</p> <p>\$10 for brand name drugs with no generic equivalent listed on our formulary.</p> <p>\$25 for generic or brand name drugs not listed on our formulary.</p> <p>3 applicable copays for a 90-day supply of prescribed maintenance drugs, when ordered through our mail-order program.</p> <p>NOTE: If there is no generic equivalent available, you will still have to pay the brand name formulary copay.</p>
<p>Here are some things to keep in mind about our prescription drug program:</p> <ul style="list-style-type: none"> • If generic is available, and you or your doctor request the brand name, you pay the applicable generic formulary or non-formulary copay plus the difference in cost between the brand name and generic drugs. • We have an open formulary. If your physician believes a name brand product is necessary or there is no generic available, your physician may prescribe a name brand drug from a formulary list. This list of name brand drugs is a preferred list of drugs that we selected to meet patient needs at a lower cost. To order a prescription drug brochure, call 1-800/4HUMANA. 	

Covered medications and supplies <i>(Continued)</i>	You pay
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>drugs available without a prescription, or for which there is a non-prescription equivalent available</i> • <i>drugs and supplies for cosmetic purposes</i> • <i>vitamins, fluoride, nutrients and food supplements even if a physician prescribes or administers them</i> • <i>drugs obtained at a non-Plan pharmacy except for out of area emergencies</i> • <i>drugs to enhance athletic performance</i> • <i>smoking cessation drugs and medications, including nicotine patches</i> • <i>any drug used for the purpose of weight control</i> • <i>prescriptions that are to be taken by or administered to the member in whole or part, while a patient in a hospital, skilled nursing facility, convalescent hospital, inpatient facility or other facility where drugs are ordinarily provided by the facility on an inpatient basis</i> • <i>medical supplies such as dressings and antiseptics</i> 	<p><i>All charges</i></p>

Section 5 (g). Special Features

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

Section 5 (h). Dental benefits

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

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan dentists must provide or arrange your care.
- We cover hospitalization for dental procedures only when a nondental physical impairment exists which makes hospitalization necessary to safeguard the health of the patient; we do not cover the dental procedure unless it is described below.
- Be sure to read Section 4, *Your costs for covered services* for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

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

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

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

Expanded dental benefits

- DEN-988

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

- DEN-997

- All dental services at discounted fees as listed in the separate plan description.
- No additional premium required; no application to complete.
- Administered by HumanaDental 1-800-955-0782.

CREDIT CARD PAYMENT NOW AVAILABLE.
See application for details.

Vision care

- VIS-920

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

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

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

Benefits on this page are not part of the FEHB contract.

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

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

We do not cover the following:

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

Section 7. Filing a claim for covered services

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

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

Medical and hospital benefits

In most cases, providers and facilities file claims for you. Physicians must file on the form HCFA-1500, Health Insurance Claim Form. Facilities will file on the UB-92 form. For claims questions and assistance, call us at 1-800/426-2173.

When you must file a claim – such as for out-of-area care – submit it on the HCFA-1500 or a claim form that includes the information shown below. Bills and receipts should be itemized and show:

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

**Submit your claims to: Humana Medical Plan, Inc.
P.O. Box 19080F
Jacksonville, FL 32245-9080**

Deadline for filing your claim

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

When we need more information

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

Section 8. The disputed claims process

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

Step	Description
------	-------------

- | | |
|----------|--|
| 1 | Ask us in writing to reconsider our initial decision. You must:
(a) Write to us within 6 months from the date of our decision; and
(b) Send your request to us at: Humana Medical Plan, Inc., P.O. Box 19080F, Jacksonville, FL 32245-9080; and
(c) Include a statement about why you believe our initial decision was wrong, based on specific benefit provisions in this brochure; and
(d) Include copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms. |
| 2 | We have 30 days from the date we receive your request to:
(a) Pay the claim (or, if applicable, arrange for the health care provider to give you the care); or
(b) Write to you and maintain our denial – go to step 4; or
(c) Ask you or your provider for more information. If we ask your provider, we will send you a copy of our request – go to step 3. |
| 3 | You or your provider must send the information so that we receive it within 60 days of our request. We will then decide within 30 more days.

If we do not receive the information within 60 days, we will decide within 30 days of the date the information was due. We will base our decision on the information we already have.

We will write to you with our decision. |
| 4 | If you do not agree with our decision, you may ask OPM to review it.

You must write to OPM within: <ul style="list-style-type: none">• 90 days after the date of our letter upholding our initial decision; or• 120 days after you first wrote to us – if we did not answer that request in some way within 30 days; or• 120 days after we asked for additional information. |

Write to OPM at: Office of Personnel Management, Office of Insurance Programs, Contracts Division III, P.O. Box 436, Washington, D.C. 20044-0436.

The disputed claims process – Continued on next page

Step	Description
------	-------------

Send OPM the following information:

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

NOTE: If you want OPM to review different claims, you must clearly identify which documents apply to which claim.

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

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

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

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

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

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

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

(a) We haven't responded yet to your initial request for care or preauthorization/prior approval, then call us at 1-800/426-2173 and we will expedite our review; or

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

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

Section 9. Coordinating benefits with other coverage

When you have other health coverage

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

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

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

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

• What is Medicare?

Medicare is a Health Insurance Program for:

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

Medicare has two parts:

- Part A (Hospital Insurance). Most people do not have to pay for Part A.
- Part B (Medical Insurance). Most people pay monthly for Part B.

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

• The Original Medicare Plan

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

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

We will not waive any of our copayments or coinsurance.

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

(Primary payer chart begins on next page.)

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

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

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

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

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

• **Medicare managed care plan**

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

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

This Plan and another Plan’s Medicare managed care plan: You may enroll in another plan’s Medicare managed care plan and also remain enrolled in our FEHB plan. We will still provide benefits when your Medicare managed care plan is primary even out of the managed care plan’s network and/or service area (if you use our Plan providers), but we will not waive any of our copayments.

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

• **Enrollment in Medicare Part B**

NOTE: If you choose not to enroll in Medicare Part B, you can still be covered under the FEHB Program. We cannot require you to enroll in Medicare.

TRICARE

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

Workers' Compensation

We do not cover services that:

- you need because of a workplace-related disease 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 benefits. You must use our providers.

Medicaid

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

When other Government agencies are responsible for your care

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

When others are responsible for injuries

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

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

Section 10. Definitions of terms we use in this brochure

Calendar year	January 1 through December 31 of the same year. For new enrollees, the calendar year begins on the effective date of their enrollment and ends on December 31 of the same year.
Copayment	A copayment is a fixed amount of money you pay when you receive covered services. See page 11.
Coinsurance	Coinsurance is the percentage of our allowance that you must pay for your care. See page 11.
Covered services	Care we provide benefits for, as described in this brochure.
Custodial care	Services provided to you such as assistance with dressing, bathing, preparation and feeding of special diets, walking, supervision of medication which is ordinarily self-administered, getting in and out of bed, and maintaining continence and are not likely to improve your condition.
Experimental or investigational services	<p>A drug, biological product, device, medical treatment, or procedure is determined to be experimental or investigational if reliable evidence shows it meets one of the following criteria:</p> <ul style="list-style-type: none">• when applied to the circumstances of a particular patient is the subject of ongoing phase I, II or III clinical trials, or• when applied to the circumstances of a particular patient is under study with written protocol to determine maximum tolerated dose, toxicity, safety, efficacy, or efficacy in comparison to conventional alternatives, or• is being delivered or should be delivered subject to the approval and supervision of an Institutional Review Board as required and defined by the USFDA or Department of Health and Human Services• is not generally accepted by the medical community <p>Reliable evidence means, but is not limited to, published reports and articles in authoritative medical scientific literature or regulations and other official actions and publications issued by the USFDA or the Department of Health and Human Services.</p>
Medical necessity	Services necessary for the treatment or product that a licensed Physician or licensed healthcare provider would provide his or her patient for the purpose of diagnosing, treating a sickness, illness, disease or its symptoms.
Us/We	Us and we refer Humana Medical Plan, Inc.
You	You refers to the enrollee and each covered family member.

Section 11. FEHB facts

No pre-existing condition limitation

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

Where you can get information about enrolling in the FEHB Program

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

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

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

Types of coverage available for you and your family

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

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

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

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

When benefits and premiums start

The benefits in this brochure are effective on January 1. If you are new to this Plan, your coverage and premiums begin on the first day of your first pay period that starts on or after January 1. Annuitants' premiums begin on January 1.

Your medical and claims records are confidential

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

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

When you retire

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

When you lose benefits

- When FEHB coverage ends

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

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

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

- Spouse equity coverage

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

- 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.

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

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

- 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

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.

Inspector General Advisory

Stop health care fraud! Fraud increases the cost of health care for everyone. If you suspect that a physician, pharmacy, or hospital has charged you for services you did not receive, billed you twice for the same service, or misrepresented any information, do the following:

- Call the provider and ask for an explanation. There may be an error.
- If the provider does not resolve the matter, call us at 1-800/426-2173 and explain the situation.
- If we do not resolve the issue, call **THE HEALTH CARE FRAUD HOTLINE – 202/418-3300** or write to: The United States Office of Personnel Management, Office of the Inspector General Fraud Hotline, 1900 E Street, NW, Room 6400, Washington, DC 20415.

Penalties for Fraud

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

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Do not rely on this page; it is for your convenience and does not explain your benefit coverage.

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NOTES:

Summary of benefits for Humana Medical Plan, Inc. – 2001

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

Benefits	You Pay	Page
Medical services provided by physicians: • Diagnostic and treatment services provided in the office	Office visit copay: \$10 primary care; \$10 specialist	13
Services provided by a hospital: • Inpatient	Nothing	25-26
• Outpatient	Nothing	26
Emergency benefits: • In-area	\$25 per visit	29
• Out-of-area	25% of charges up to a \$50 maximum per visit.	29
Mental health and substance abuse treatment	Regular cost sharing	30-31
Prescription drugs: • Generic formulary drugs	\$5 copay	33
• Brand name formulary drugs	\$10 copay	33
• Non formulary drugs	\$25 copay	33
• Maintenance drugs (90-day supply) when ordered through our mail-order program	3 applicable copays	33
Dental Care • Accidental injury benefit	Nothing	36
Vision Care	No benefit	
Special features: <i>TDD and TTY phone lines; HumanaBeginnings; National Transplant Network; and HumanaFirst®</i>		35
Out-of-pocket maximum	Nothing after \$1,500/per person or \$3,000/Family enrollment per year. Some costs do not count toward this maximum.	11

2001 Rate Information for Humana Medical Plan, Inc.

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

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

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

Type of Enrollment	Code	Non-Postal Premium				Postal Premium	
		Biweekly		Monthly		Biweekly	
		Gov't Share	Your Share	Gov't Share	Your Share	USPS Share	Your Share
Self Only	EE1	\$76.10	\$25.36	\$164.87	\$54.96	\$90.05	\$11.41
Self and Family	EE2	\$190.25	\$63.41	\$412.20	\$137.40	\$225.12	\$28.54