

Humana CoverageFirst/Humana Value Plan

<https://feds.humana.com/>

Customer Service 1-800-4HUMANA

2022

A Consumer Driven Health Plan and a Point of Service Product

This plan's health coverage qualifies as minimum essential coverage and meets the minimum value standard for the benefits it provides. See page 8 for details. This plan is accredited. See page 13.

Serving:

The following metropolitan areas – Phoenix and Tucson, Arizona; Daytona, Orlando, Tampa and South Florida, Florida; Atlanta, Columbus and Macon, Georgia; Chicago, Illinois; Central Illinois; Kansas City, Kansas/Missouri; Lexington and Louisville, Kentucky; Cincinnati, Ohio; Austin, Corpus Christi, Houston and San Antonio, Texas; Knoxville, Tennessee.

Enrollment in this plan is limited. You must live or work in our geographic service area to enroll. See page 15 for requirements.

Enrollment codes for this Plan can be found in the Rate Information section.

IMPORTANT

- Rates: Back Cover
- Changes for 2022: Page 17
- Summary of Benefits: Page 130



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United States
Office of Personnel Management

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

RI 73-829

**Important Notice from Humana CoverageFirst/Humana Value Plan About
Our Prescription Drug Coverage and Medicare**

The Office of Personnel Management (OPM) has determined that Humana CoverageFirst/Humana Value Plan prescription drug coverage is, on average, expected to pay out as much as the standard Medicare prescription drug coverage will pay for all plan participants and is considered Creditable Coverage. This means you do not need to enroll in Medicare Part D and pay extra for prescription drug coverage. If you decide to enroll in Medicare Part D later, you will not have to pay a penalty for late enrollment as long as you keep your FEHB coverage.

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

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

Please be advised

If you lose or drop your FEHB coverage and go 63 days or longer without prescription drug coverage that is at least as good as Medicare's prescription drug coverage, your monthly Medicare Part D premium will go up at least 1 percent per month for every month that you did not have that coverage. For example, if you go 19 months without Medicare Part D prescription drug coverage, your premium will always be at least 19 percent higher than what many other people pay. You will have to pay this higher premium as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the next Annual Coordinated Election Period (October 15 through December 7) to enroll in Medicare Part D.

Medicare's Low Income Benefits

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

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

- Visit www.medicare.gov for personalized help.
- Call 800-MEDICARE 800-633-4227, TTY 877-486-2048.

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Introduction

This brochure describes the benefits of Humana CoverageFirst and Humana Value Plan under contract (CS 2887) between Humana and the United States Office of Personnel Management, as authorized by the Federal Employees Health Benefits law. Customer Service may be reached at 1-800-4HUMANA, 1-800-448-6262 or through our website: <https://feds.humana.com/>. This plan is underwritten by Humana Health Plan Inc., Humana Employers Health Plan of Georgia, Inc., Humana Health Plan of Texas, Inc., Humana Insurance Company, Humana Medical Plan, Inc., and Humana Health Plan of Ohio, Inc. The address for the CoverageFirst and the Value Plan administrative office is:

Humana Inc.
500 West Main Street
Louisville, KY 40201

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

If you are enrolled in this Plan, you are entitled to the benefits described in this brochure. If you are enrolled in Self Plus One or 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, 2022, unless those benefits are also shown in this brochure.

OPM negotiates benefits and rates with each plan annually. Benefit changes are effective January 1, 2022, and changes are summarized on page 17. Rates are shown at the end of this brochure.

Plain Language

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

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

Stop Healthcare Fraud!

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

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

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

- Do not give your plan identification (ID) number over the phone or to people you do not know, except for your healthcare providers, authorized health benefits plan, or OPM representative.
- Let only the appropriate medical professionals review your medical record or recommend services.
- Avoid using healthcare providers who say that an item or service is not usually covered, but they know how to bill us to get it paid.
- Carefully review explanations of benefits (EOBs) statements that you receive from us.
- Periodically review your claim history for accuracy to ensure we have not been billed for services you did not receive.
- Do not ask your doctor to make false entries on certificates, bills, or records in order to get us to pay for an item or service.

- If you suspect that a provider has charged you for services you did not receive, billed you twice for the same service, or misrepresented any information, do the following:
 - Call the provider and ask for an explanation. There may be an error.
 - If the provider does not resolve the matter, call us at 1-800-4HUMANA and explain the situation.
 - If we do not resolve the issue:

**CALL - THE HEALTHCARE FRAUD HOTLINE
1-877-499-7295**

OR go to www.opm.gov/our-inspector-general/hotline-to-report-fraud-waste-or-abuse/complaint-form/

The online reporting form is the desired method of reporting fraud in order to ensure accuracy, and a quicker response time.

You can also write to:

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

- Do not maintain as a family member on your policy:
 - Your former spouse after a divorce decree or annulment is final (even if a court order stipulates otherwise)
 - Your child age 26 or over (unless they are disabled and incapable of self-support prior to age 26)

A carrier may request that an enrollee verify the eligibility of any or all family members listed as covered under the enrollee's FEHB enrollment.

- If you have any questions about the eligibility of a dependent, check with your personnel office if you are employed, with your retirement office (such as OPM) if you are retired, or with the National Finance Center if you are enrolled under Temporary Continuation of Coverage (TCC).
- Fraud or intentional misrepresentation of material fact is prohibited under the Plan. You can be prosecuted for fraud and your agency may take action against you. Examples of fraud include, falsifying a claim to obtain FEHB benefits, trying to or obtaining service or coverage for yourself or for someone who is not eligible for coverage, or enrolling in the Plan when you are no longer eligible.
- If your enrollment continues after you are no longer eligible for coverage (i.e. you have separated from Federal service) and premiums are not paid, you will be responsible for all benefits paid during the period in which premiums were not paid. You may be billed by your provider for services received. You may be prosecuted for fraud for knowingly using health insurance benefits for which you have not paid premiums. It is your responsibility to know when you or a family member is no longer eligible to use your health insurance coverage.

Discrimination is Against the Law

Humana CoverageFirst/Humana Value Plan complies with all applicable Federal civil rights laws, including Title VII of the Civil Rights Act of 1964.

You can also file a civil rights complaint with the Office of Personnel Management by mail at:

Office of Personnel Management
Healthcare and Insurance
Federal Employee Insurance Operations
Attention: Assistant Director, FEIO
1900 E Street NW, Suite 3400-S
Washington, D.C. 20415-3610

If you believe that Humana Inc. and its subsidiaries have failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with Discrimination Grievances, P.O. Box 14618, Lexington, KY 40512-4618.

Multi-Language Interpreter Services

English: ATTENTION: If you do not speak English, language assistance services, free of charge, are available to you. Call **1-800-448-6262, TTY 711**.

Español (Spanish): ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al **1-800-448-6262, TTY 711**.

Tagalog (Tagalog – Filipino): PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa **1-800-448-6262, TTY 711**.

Kreyòl Ayisyen (French Creole): ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele **1-800-448-6262, TTY 711**.

Français (French): ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le **1-800-448-6262, TTY 711**.

Português (Portuguese): ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para **1-800-448-6262 TTY, 711**

Italiano (Italian): ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero **1-800-448-6262, TTY 711**

Deutsch (German): ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: **1-800-448-6262, TTY 711**.

Preventing Medical Mistakes

Medical mistakes continue to be a significant cause of preventable deaths within the United States. While death is the most tragic outcome, medical mistakes cause other problems such as permanent disabilities, extended hospital stays, longer recoveries, and even additional treatments. Medical mistakes and their consequences also add significantly to the overall cost of healthcare. Hospitals and healthcare providers are being held accountable for the quality of care and reduction in medical mistakes by their accrediting bodies. You can also improve the quality and safety of your own healthcare and that of your family members by learning more about and understanding your risks. Take these simple steps:

1. Ask questions if you have doubts or concerns.

- Ask questions and make sure you understand the answers.
- Choose a doctor with whom you feel comfortable talking.
- Take a relative or friend with you to help you take notes, ask questions and understand answers.

2. Keep and bring a list of all the medications you take.

- Bring the actual medication or give your doctor and pharmacist a list of all the medications and dosage that you take, including non-prescription (over-the-counter) medications and nutritional supplements.
- Tell your doctor and pharmacist about any drug, food, and other allergies you have, such as to latex.
- Ask about any risks or side effects of the medication and what to avoid while taking it. Be sure to write down what your doctor or pharmacist says.
- Make sure your medication is what the doctor ordered. Ask the pharmacist about your medication if it looks different than you expected.
- Read the label and patient package insert when you get your medication, including all warnings and instructions.
- Know how to use your medication. Especially note the times and conditions when your medication should and should not be taken.
- Contact your doctor or pharmacist if you have any questions.

- Understand both the generic and brand names of your medication. This helps ensure you do not receive double dosing from taking both a generic and a brand. It also helps prevent you from taking a medication to which you are allergic.

3. Get the results of any test or procedure.

- Ask when and how you will get the results of tests or procedures. Will it be in person, by phone, mail, through the Plan or Provider's portal?
- Don't assume the results are fine if you do not get them when expected. Contact your healthcare provider and ask for your results.
- Ask what the results mean for your care.

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

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

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

- Make sure you, your doctor, and your surgeon all agree on exactly what will be done during the operation.
- Ask your doctor, "Who will manage my care when I am in the hospital?"
- Ask your surgeon:
 - "Exactly what will you be doing?"
 - "About how long will it take?"
 - "What will happen after surgery?"
 - "How can I expect to feel during recovery?"
- Tell the surgeon, anesthesiologist, and nurses about any allergies, bad reactions to anesthesia, and any medications or nutritional supplements you are taking.

Patient Safety Links

For more information on patient safety, please visit:

- www.jointcommission.org/speakup.aspx. The Joint Commission's Speak Up™ patient safety program.
- www.jointcommission.org/topics/patient_safety.aspx. The Joint Commission helps healthcare organizations to improve the quality and safety of the care they deliver.
- www.ahrq.gov/patients-consumers/. The Agency for Healthcare Research and Quality makes available a wide-ranging list of topics not only to inform consumers about patient safety but to help choose quality healthcare providers and improve the quality of care you receive.
- www.bemedwise.org. The National Council on Patient Information and Education is dedicated to improving communication about the safe, appropriate use of medication.
- www.leapfroggroup.org. The Leapfrog Group is active in promoting safe practices in hospital care.
- www.ahqa.org. The American Health Quality Association represents organizations and healthcare professionals working to improve patient safety.

Preventable Healthcare Acquired Conditions (“Never Events”)

When you enter the hospital for treatment of one medical problem, you do not expect to leave with additional injuries, infections, or other serious conditions that occur during the course of your stay. Although some of these complications may not be avoidable, patients do suffer from injuries or illnesses that could have been prevented if doctors or the hospital had taken proper precautions. Errors in medical care that are clearly identifiable, preventable and serious in their consequences for patients, can indicate a significant problem in the safety and credibility of a healthcare facility. These conditions and errors are sometimes called “Never Events” or “Serious Reportable Events.”

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

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

FEHB Facts

Coverage information

- **No pre-existing condition limitation** We will not refuse to cover the treatment of a condition you had before you enrolled in this Plan solely because you had the condition before you enrolled.
- **Minimum essential coverage (MEC)** Coverage under this plan qualifies as minimum essential coverage. Please visit the Internal Revenue Service (IRS) website at www.irs.gov/uac/Questions-and-Answers-on-the-Individual-Shared-Responsibility-Provision for more information on the individual requirement for MEC.
- **Minimum value standard** Our health coverage meets the minimum value standard of 60% established by the ACA. This means that we provide benefits to cover at least 60% of the total allowed costs of essential health benefits. The 60% standard is an actuarial value; your specific out-of-pocket costs are determined as explained in this brochure.
- **Where you can get information about enrolling in the FEHB Program** See www.opm.gov/healthcare-insurance for enrollment information as well as:
 - Information on the FEHB Program and plans available to you
 - A health plan comparison tool
 - A list of agencies that participate in Employee Express
 - A link to Employee Express
 - Information on and links to other electronic enrollment systems

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

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

We do not determine who is eligible for coverage and, in most cases, cannot change your enrollment status without information from your employing or retirement office. For information on your premium deductions, you must also contact your employing or retirement office.

Once enrolled in your FEHB Program Plan, you should contact Humana directly for address updates and questions about your benefit coverage.

- **Types of coverage available for you and your family** Self Only coverage is only for the enrollee. Self Plus One coverage is for the enrollee and one eligible family member. Self and Family coverage is for the enrollee, and one or more eligible family members. Family members include your spouse and your dependent children under age 26, including any foster children authorized for coverage by your employing agency or retirement office. Under certain circumstances, you may also continue coverage for a disabled child 26 years of age or older who is incapable of self-support.

If you have a Self Only enrollment, you may change to a Self Plus One or 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 Plus One or 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 Plus One or 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 are married. A carrier may request that an enrollee verify the eligibility of any or all family members listed as covered under the enrollee's FEHB enrollment.

Contact your carrier to obtain a Certificate of Creditable Coverage (COCC) or to add a dependent when there is already family Coverage.

Contact your employing or retirement office if you are changing from Self to Self Plus One or Self and Family or to add a newborn if you currently have a Self Only plan.

Your employing or retirement office will **not** notify you when a family member is no longer eligible to receive benefits, nor will we. Please tell us immediately of changes in family member status, including your marriage, divorce, annulment, or when your child reaches age 26.

If you or one of your family members is enrolled in one FEHB plan, you or they cannot be enrolled in or covered as a family member by another enrollee in another FEHB plan.

If you have a qualifying life event (QLE) - such as marriage, divorce, or the birth of a child - outside of the Federal Benefits Open Season, you may be eligible to enroll in the FEHB Program, change your enrollment, or cancel coverage. For a complete list of QLEs, visit the FEHB website at www.opm.gov/healthcare-insurance/life-events. If you need assistance, please contact your employing agency, Tribal Benefits Officer, personnel/payroll office, or retirement office.

• **Family member coverage**

Family members covered under your Self and Family enrollment are your spouse (including your spouse by valid common-law marriage from a state that recognizes common-law marriages) and children as described in the chart below. A Self Plus One enrollment covers you and your spouse, or one other eligible family member as described in the chart below.

Natural children, adopted children, and stepchildren

Coverage: Natural children, adopted children, and stepchildren are covered until their 26th birthday.

Foster children

Coverage: Foster children are eligible for coverage until their 26th birthday if you provide documentation of your regular and substantial support of the child and sign a certification stating that your foster child meets all the requirements. Contact your human resources office or retirement system for additional information.

Children incapable of self-support

Coverage: Children who are incapable of self-support because of a mental or physical disability that began before age 26 are eligible to continue coverage. Contact your human resources office or retirement system for additional information.

Married children

Coverage: Married children (but **NOT** their spouse or their own children) are covered until their 26th birthday.

Children with or eligible for employer-provided health insurance

Coverage: Children who are eligible for or have their own employer-provided health insurance are covered until their 26th birthday.

Newborns of covered children are insured only for routine nursery care during the covered portion of the mother's maternity stay.

You can find additional information at www.opm.gov/healthcare-insurance.

- **Children’s Equity Act**

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

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

- If you have no FEHB coverage, your employing office will enroll you for Self Plus One or Self and Family coverage, as appropriate, in the lowest-cost nationwide plan option as determined by OPM;
- If you have a Self Only enrollment in a fee-for-service plan or in an HMO that serves the area where your children live, your employing office will change your enrollment to Self Plus One or Self and Family, as appropriate, in the same option of the same plan; or
- If you are enrolled in an HMO that does not serve the area where the children live, your employing office will change your enrollment to Self Plus One or Self and Family, as appropriate, in the lowest-cost nationwide plan option as determined by OPM.

As long as the court/administrative order is in effect, and you have at least one child identified in the order who is still eligible under the FEHB Program, you cannot cancel your enrollment, change to Self Only, or change to a plan that does not serve the area in which your children live, unless you provide documentation that you have other coverage for the children.

If the court/administrative order is still in effect when you retire, and you have at least one child still eligible for FEHB coverage, you must continue your FEHB coverage into retirement (if eligible) and cannot cancel your coverage, change to Self Only, or change to a plan that does not serve the area in which your children live as long as the court/administrative order is in effect. Similarly, you cannot change to Self Plus One if the court/administrative order identifies more than one child. Contact your employing office for further information.

- **When benefits and premiums start**

The benefits in this brochure are effective January 1. If you joined this Plan during Open Season, your coverage begins on the first day of your first pay period that starts on or after January 1. **If you changed plans or plan options during Open Season and you receive care between January 1 and the effective date of coverage under your new plan or option, your claims will be processed according to the 2022 benefits of your prior plan or option.** If you have met (or pay cost-sharing that results in your meeting) the out-of-pocket maximum under the prior plan or option, you will not pay cost-sharing for services covered between January 1 and the effective date of coverage under your new plan or option. However, if your prior plan left the FEHB Program at the end of the year, you are covered under that plan’s 2021 benefits until the effective date of your coverage with your new plan. Annuitants’ coverage and premiums begin on January 1. If you joined at any other time during the year, your employing office will tell you the effective date of coverage.

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

- **When you retire**

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

When you lose benefits

- **When FEHB coverage ends**

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

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

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

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

- **Upon divorce**

If you are divorced from a Federal employee, or an annuitant, you may not continue to get benefits under your former spouse's enrollment. This is the case even when the court has ordered your former spouse to provide health coverage to you. However, you may be eligible for your own FEHB coverage under either the spouse equity law or Temporary Continuation of Coverage (TCC). If you are recently divorced or are anticipating a divorce, contact your ex-spouse's employing or retirement office to get additional information about your coverage choices. You can also visit OPM's website at www.opm.gov/healthcare-insurance/healthcare/plan-information/. A carrier may request that an enrollee verify the eligibility of any or all family members listed as covered under the enrollee's FEHB enrollment.

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

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

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

Enrolling in TCC. Get the RI 79-27, which describes TCC, from your employing or retirement office or from www.opm.gov/healthcare-insurance. It explains what you have to do to enroll.

Alternatively, you can buy coverage through the Health Insurance Marketplace where, depending on your income, you could be eligible for a new kind of tax credit that lowers your monthly premiums. Visit www.HealthCare.gov to compare plans and see what your premium, deductible, and out-of-pocket costs would be before you make a decision to enroll. Finally, if you qualify for coverage under another group health plan (such as your spouse's plan), you may be able to enroll in that plan, as long as you apply within 30 days of losing FEHB Program coverage.

- **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 or Tribal service, your employing office will notify you of your right to convert. You must contact us in writing 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 contact us in writing 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, a waiting period will not be imposed and your coverage will not be limited due to pre-existing conditions. When you contact us, we will assist you in obtaining information about health benefits coverage inside or outside the Affordable Care Act's Health Insurance Marketplace in your state. For assistance in finding coverage, please contact customer service at 1-800-4HUMANA or visit <https://feds.humana.com>.

- **Health Insurance Marketplace**

If you would like to purchase health insurance through the ACA's Health Insurance Marketplace, please visit www.HealthCare.gov. This is a website provided by the U.S. Department of Health and Human Services that provides up-to-date information on the Marketplace.

Section 1. How This Plan Works

This Plan is a Consumer Driven Health Plan and a Point of Service product. OPM requires that FEHB plans be accredited to validate that plan operations and/or care management meet nationally recognized standards. Humana holds the following accreditations: The National Committee for Quality Assurance (NCQA). To learn more about this plan's accreditation(s), please visit the following websites: www.ncqa.gov. We recommend you to see specific physicians, hospitals, and other providers that contract with us. These Plan providers coordinate your healthcare services. We are solely responsible for the selection of these providers in your area. Contact us for a copy of our most recent provider directory. We give you a choice of enrollment in a Consumer Driven Health Plan (CDHP) or a Value Plan.

How we pay providers

Participating 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 cost-sharing (copayments, coinsurance, deductibles, and non-covered services and supplies).

Non-Participating Providers: For services rendered by non-participating physicians, the dollar amount of the deductible or benefit percentage is calculated based on a reimbursement schedule established by us.

When you use Participating Providers

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

When you use Non-Participating Providers

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

General features of our Consumer Driven Health Plan (CDHP)

Our Consumer Driven Health Plan is a comprehensive medical plan. You can see participating or non-participating providers without a referral.

The Plan pays the first \$1,000 of covered medical services for each person enrolled. We call this your benefit allowance. While using the \$1,000 benefit allowance, you are only responsible for the applicable copayments and coinsurance. The amount the plan deducts from your allowance for a particular service is based on the price Humana has negotiated with the healthcare provider. You do not have to submit receipts for reimbursement. **The benefit allowance can only be used to pay for covered medical services from participating providers.** Any benefit allowance that remains at the end of the Plan year cannot be "rolled over" or "cashed out."

The following services do not reduce your \$1,000 benefit allowance:

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

Once you spend your \$1,000 benefit allowance, you pay for medical services until you meet the deductible.

The copayment or coinsurance covers services billed as an office visit or consultation. Other services provided in the physician office, such as lab work, X-rays and surgery are subject to the deductible and coinsurance.

Preventive care services

Preventive care services are generally paid as first dollar coverage and are not subject to copayments, deductibles, or annual limits when received from a participating provider.

Annual deductible

The annual deductible of \$1,500 for Self Only, or \$3,000 for Self Plus One or Self and Family in-network and \$3,500 for Self Only, or \$7,000 for Self Plus One or Self and Family out-of-network, where applicable, must be met before Plan benefits are paid; not all benefits apply to the deductible, such as preventive care services.

Catastrophic protection

We protect you against catastrophic out-of-pocket expenses for covered services. The IRS limits annual out-of-pocket expenses for covered services, including deductibles and copayments, for participating providers, it cannot exceed \$7,000 for Self Only enrollment, and \$14,000 for a Self Plus One or Self and Family. For non-participating providers, it cannot exceed \$16,300 for Self Only, and \$32,600 for a Self Plus One or Self and Family. The out-of-pocket limit for this Plan may differ from the IRS limit, but cannot exceed the amount.

General features of our Value Plan

Our Value Plan is a comprehensive medical plan. You can see participating or non-participating providers without a referral.

Preventive care services

Preventive care services are generally paid as first dollar coverage and are not subject to copayments, deductibles, or annual limits when received from a participating provider.

Annual deductible

The annual deductible of \$1,500 for Self Only, or \$3,000 for Self Plus One or Self and Family in-network and \$3,500 for Self Only, or \$7,000 for Self Plus One or Self and Family out-of-network, where applicable, must be met before Plan benefits are paid; not all benefits apply to the deductible such as preventive care services.

Catastrophic protection

We protect you against catastrophic out-of-pocket expenses for covered services. The IRS limits annual out-of-pocket expenses for covered services, including deductibles and copayments, to no more than \$7,000 for Self Only enrollment, and \$14,000 for a Self Plus One or Self and Family. For non-participating providers, cannot exceed \$16,300 for Self Only, and \$32,600 for a Self Plus One or Self and Family. The out-of-pocket limit for this Plan may differ from the IRS limit, but cannot exceed that amount.

Your rights and responsibilities

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

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

You are also entitled to a wide range of consumer protections and have specific responsibilities as a member of this Plan. You can view the complete list of these rights and responsibilities by visiting our website, Humana at <https://feds.humana.com/>. You can also contact us to request that we mail a copy to you.

If you want more information about us, call 1-800-4HUMANA, or write to the Plan at P.O. Box 14602, Lexington, KY 40512-4602. You may also visit our website at <https://feds.humana.com/>.

By law, you have the right to access your protected health information (PHI). For more information regarding access to PHI, visit Humana's website at <https://feds.humana.com/> to obtain our Notice of Privacy Practices. You can also contact us to request that we mail you a copy of that Notice.

Your medical and claims records are confidential

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

Service Area

To enroll in this Plan you must live in or work in our service areas. This is where our providers practice. Our service areas are:

Arizona, Phoenix – Enrollment Code **R6** - Maricopa and Pinal counties

Arizona, Tucson – Enrollment Code **R9** - Pima County

Florida, Daytona - Enrollment Code **W9** - Flagler and Volusia counties

Florida, Orlando - Enrollment Code **X2** - Lake, Orange, Osceola, and Seminole counties

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

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

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

Georgia, Columbus – Enrollment code **S9** - Muscogee County

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

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

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

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

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

Kentucky, Louisville - Enrollment code **TC** - The Kentucky counties of Bullitt, Carroll, Green, Hardin, Henry, Jefferson, Larue, Meade, Nelson, Marion, Oldham, Shelby, Spencer, Taylor, Trimble, and Washington. The Indiana counties of Clark, Floyd, Harrison, Scott, and Washington

Ohio, Cincinnati - Enrollment Code **X3** - The Ohio counties of Adams, Brown, Butler, Clermont, Clinton, Gallia, Hamilton, Highland, Jackson, Lawrence, Pike, Scioto, and Warren; The Indiana counties of Dearborn, Franklin, Ohio, Ripley, Union; Kentucky: Boone, Campbell, Gallatin, Grant, Kenton, and Pendleton

Tennessee, Knoxville – Enrollment code **TT**- Anderson, Blount, Campbell, Claiborne, Cocke, Grainger, Hamblen, Jefferson, Knox, Loudon, Morgan, Roane, Scott, Sevier, and Union counties; the Tri-City counties of Carter, Greene, Hancock, Hawkins, Johnson, Sullivan, Unicoi, and Washington

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

Texas, Houston – Enrollment code **T3** - Austin, Brazoria, Chambers, Colorado, Fayette, Fort Bend, Galveston, Harris, Liberty, Montgomery, Waller and Wharton counties

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

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

If you or a covered family member visit a non-participating provider outside of our service area, you can utilize your out-of-network benefits. If you move outside of our service area, you do not have to wait until Open Season to change plans. Contact your employing or retirement office.

Section 2. Changes for 2022

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

Program-wide changes:

- Effective in 2022, premium rates are the same for Non-Postal and Postal employees.

Changes to both the Consumer Driven Health Plan and Value Plan:

- Arizona
 - Phoenix, AZ - Enrollment code R6 - Your share of the premium rate will increase for Self Only, Self Plus One, and Self and Family. (See pages 132)
 - Tucson, AZ - Enrollment code R9 - Your share of the premium rate will increase for Self Only, Self Plus One, and Self and Family. (See page 132)
- Florida
 - Daytona, FL – Enrollment code W9 - Your share of the premium rate will increase for Self Only, Self Plus One, and Self and Family. (See page 133)
 - Orlando, FL – Enrollment code X2 - Your share of the premium rate will increase for Self Only, Self Plus One, and Self and Family. (See page 133)
 - South Florida FL – Enrollment code QP (CDHP) - Your share of the premium rate will increase for Self Only, Self Plus One, and Self and Family. (See page 133)
 - South Florida FL – Enrollment code QP (VP) - Your share of the premium rate will remain the same for Self Only, Self Plus One, and Self and Family. (See page 133)
 - Tampa, FL – Enrollment code MJ (CDHP) - Your share of the premium rate will increase for Self Only, Self Plus One, and Self and Family. (See page 134)
 - Tampa, FL – Enrollment code MJ (VP) - Your share of the premium rate will remain the same for Self Only and Self Plus One. (See page 134)
 - Tampa, FL – Enrollment code MJ (VP) - Your share of the premium rate will increase for Self and Family. (See page 134)
- Georgia
 - Atlanta, GA – Enrollment code AD (CDHP) – Your share of the premium rate will increase for Self Only, Self Plus One, and Self and Family. (See page 134)
 - Atlanta, GA – Enrollment code AD (VP) – Your share of the premium rate will decrease for Self Only, Self Plus One, and Self and Family. (See page 134)
 - Columbus, GA - Enrollment code S9 - Your share of the premium rate will increase for Self Only, Self Plus One, and Self and Family. (See page 134)
 - Macon, GA – Enrollment code LM - Your share of the premium rate will increase for Self Only, Self Plus One, and Self and Family. (See page 135)
- Illinois
 - Central IL – Enrollment code GB - Your share of the premium rate will increase for Self Only, Self Plus One, and Self and Family. (See page 135)
 - Chicago, IL – Enrollment code MW (CDHP) - Your share of the premium rate will increase for Self Only, Self Plus One, and Self and Family. (See page 135)
 - Chicago, IL – Enrollment code MW (VP) - Your share of the premium rate will decrease for Self Only, Self Plus One, and Self and Family. (See page 135)

- Kansas/Missouri
 - Kansas City, KS/MO – Enrollment code PH (CDHP) - Your share of the premium rate will decrease for Self Only, Self Plus One, and Self and Family. (See page 136)
 - Kansas City, KS/MO – Enrollment code PH (VP) - Your share of the premium rate will increase for Self Only, Self Plus One, and Self and Family. (See page 136)
- Kentucky
 - Lexington, KY – Enrollment code 6N - Your share of the premium rate will increase for Self Only, Self Plus One, and Self and Family. (See page 136)
 - Louisville, KY – Enrollment code TC - Your share of the premium rate will increase for Self Only, Self Plus One, and Self and Family. (See page 136)
- Ohio
 - Cincinnati, OH – Enrollment code X3 - Your share of the premium rate will increase for Self Only, Self Plus One, and Self and Family. (See page 137)
- Tennessee
 - Knoxville, TN - Enrollment code TT - Your share of the premium rate will increase for Self Only, Self Plus One, and Self and Family. (See page 137)
- Texas
 - Austin, TX – Enrollment code TV (CDHP) - Your share of the premium rate will decrease for Self Only, Self Plus One, and Self and Family (See page 137)
 - Austin, TX – Enrollment code TV (VP) - Your share of the premium rate will decrease for Self Only and Self Plus One (See page 138)
 - Austin, TX – Enrollment code TV (VP) - Your share of the premium rate will remain the same for Self and Family (See page 138)
 - Corpus Christi, TX – Enrollment code TP (CDHP) - Your share of the premium rate will decrease for Self Only, Self Plus One, and Self and Family. (See page 138)
 - Corpus Christi, TX – Enrollment code TP (VP) - Your share of the premium rate will increase for Self Only, Self Plus One, and Self and Family. (See page 138)
 - Houston, TX – Enrollment code T3 - Your share of the premium rate will increase for Self Only, Self Plus One, and Self and Family. (See page 138)
 - San Antonio, TX – Enrollment code TU - Your share of the premium rate will increase for Self Only, Self Plus One, and Self and Family. (See page 138)
- **Medicare Coordination of Benefits:** Humana will not waive the medical copayments, coinsurance, and deductibles for member when original Medicare is the primary payor. Members must enroll in the Humana Value Plan code associated within the service areas listed on the Value Plan brochure and the Humana Medicare Advantage Plan to receive waivers for medical copayments, coinsurance, and deductibles. See the Value Plan brochure (RI 73-829) for more details.

Changes to the Consumer Driven Health Plan (CDHP):

- **Calendar year deductible:** Your in-network calendar year deductible has increased from \$1,000 to \$1,500 for Self Only enrollment and increased from \$2,000 to \$3,000 for Self Plus One and Self and Family enrollment.
- **Calendar year deductible:** Your out-of-network calendar year deductible has increased from \$3,000 to \$3,500 for Self Only enrollment and increased from \$6,000 to \$7,000 for Self Plus One and Self and Family enrollment.

Changes to the Value Plan:

- The Value Plan is now being offered in Lexington, KY and Louisville, KY.
- The Medicare Advantage Plan will be available to any eligible retiree that is enrolled as of 1/1/2022 in Medicare Parts A & B and is enrolled in a retiree division of the Value Plan. You will be reimbursed \$100 monthly towards your Medicare Part B premium. This Plan will utilize the Medicare Advantage PPO network.
- **Calendar year deductible:** Your in-network calendar year deductible has increased from \$1,000 to \$1,500 for Self Only enrollment and increased from \$2,000 to \$3,000 for Self Plus One and Self and Family enrollment.
- **Calendar year deductible:** Your out-of-network calendar year deductible has increased from \$3,000 to \$3,500 for Self Only enrollment and increased from \$6,000 to \$7,000 for Self Plus One and Self and Family enrollment.

Section 3. How You Get Care

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

If you do not receive your ID card within 30 days after the effective date of your enrollment, or if you need replacement cards, call us at 1-800-4HUMANA or 1-800-448-6262 or write to the Plan at P.O. Box 14602, Lexington, KY 40512-4602. You may also request replacement cards through our website <https://feds.humana.com/>.

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

• **Plan providers** Plan providers are physicians and other healthcare 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 <https://feds.humana.com/>.

This plan recognizes that transsexual, transgender, and gender-nonconforming members require health care delivered by healthcare providers experienced in transgender health. While gender reassignment surgeons (benefit details found in Section 5(b)) and hormone therapy providers (benefit details found in Section 5(f)) play important roles in preventive care, you should see a primary care provider familiar with your overall health care needs. Benefits described in this brochure are available to all members meeting medical necessity guidelines.

• **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 <https://feds.humana.com/>.

Balance Billing Protection FEHB Carriers must have clauses in their in-network (participating) providers agreements. These clauses provide that, for a service that is a covered benefit in the plan brochure or for services determined not medically necessary, the in-network provider agrees to hold the covered individual harmless (and may not bill) for the difference between the billed charge and the in network contracted amount. If an in-network provider bills you for covered services over your normal cost share (deductible, copay, coinsurance) contact Humana to enforce the terms of its provider contract.

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

• **Primary care** Your primary care physician can be a general practitioner, family practitioner, internist, or pediatrician. Your primary care physician will provide most of your healthcare.

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

• **Specialty care** You may see any participating specialist without a referral, including:

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

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

Here are some other things you should know about specialty care:

- If you have a chronic and disabling condition and lose access to your specialist because we:
 - terminate our contract with your specialist for other than cause;
 - drop out of the Federal Employees Health Benefits (FEHB) Program and you enroll in another FEHB 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 hospitalized when your enrollment begins**

We pay for covered services from the effective date of your enrollment. However, if you are in the hospital when your enrollment in our Plan begins, call our customer service department immediately at 1-800-426-2173. If you are new to the FEHB Program, we will arrange for you to receive care and provide benefits for your covered services while you are in the hospital beginning on the effective date of your coverage.

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

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

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

You need prior Plan approval for certain services

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

- **Inpatient hospital admission**

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

- **Other services**

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

- Organ/tissue transplants
- All elective medical and surgical hospitalizations (Including Inpatient Hospice)
- Non-emergent admissions for mental health, skilled nursing, acute rehabilitation facilities and long term acute care facilities
- MRI, MRA, PET, CT Scan, and SPECT Scan
- Surgical treatment for morbid obesity
- All durable medical equipment (DME) over \$750
- Home healthcare services (Including Home Hospice)
- Infertility testing and treatment
- Some specialty drugs when delivered in the physician's office, clinic, outpatient or home setting
- All surgeries which may be considered plastic or cosmetic surgery only for repair of accidental injury
- Oral surgeries
- Outpatient Therapy Services for Physical, Occupational and Speech
- Genetic/Molecular Diagnostic Testing – (Genetic testing is covered under the laboratory services benefit, limitations may apply)
- Chiropractic
- Radiation Therapy
- Acupuncture
- Esophagogastroduodenoscopy (EGD)
- Coronary angiography
- Colonoscopy repeat testing

For a complete listing of services requiring prior authorization, please visit our website at www.humana.com.

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

First, your physician, your hospital, you, or your representative must call us at 1-800-4HUMANA before admission or services requiring prior authorization are rendered.

Next, provide the following information:

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

• Non-urgent care claims

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

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

- **Urgent care claims**

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

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

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

You may request that your urgent care claim on appeal be reviewed simultaneously by us and OPM. Please let us know that you would like a simultaneous review of your urgent care claim by OPM either in writing at the time you appeal our initial decision, or by calling us at 1-800-4HUMANA or 1-800-448-6262. You may also call OPM's Health Insurance 3 at 1-(202) 606-0755 between 8 a.m. and 5 p.m. Eastern Time to ask for the simultaneous review. We will cooperate with OPM so they can quickly review your claim on appeal. In addition, if you did not indicate that your claim was a claim for urgent care, call us at 1-800-4HUMANA or 1-800-448-6262. If it is determined that your claim is an urgent care claim, we will expedite our review (if we have not yet responded to your claim).

- **Concurrent care claims**

A concurrent care claim involves care provided over a period of time or over a number of treatments. We will treat any reduction or termination of our pre-approved course of treatment before the end of the approved period of time or number of treatments as an appealable decision. This does not include reduction or termination due to benefit changes or if your enrollment ends. If we believe a reduction or termination is warranted, we will allow you sufficient time to appeal and obtain a decision from us before the reduction or termination takes effect.

If you request an extension of an ongoing course of treatment at least 24 hours prior to the expiration of the approved time period and this is also an urgent care claim, we will make a decision within 24 hours after we receive the claim.

- **The Federal Flexible Spending Account Program - *FSAFEDS***

- **HealthCare FSA (HCFSA)** – Reimburses you for eligible out-of-pocket healthcare expenses (such as copayments, deductibles, **physician prescribed** over-the-counter drugs and medications, vision and dental expenses, and much more) for you and your tax dependents, including adult children (through the end of the calendar year in which they turn 26).
- FSAFEDS offers paperless reimbursement for your HCFSA through a number of FEHB and FEDVIP plans. This means that when you or your provider files claims with your FEHB or FEDVIP plan, FSAFEDS will automatically reimburse your eligible out-of-pocket expenses based on the claim information it receives from your plan.

- **Emergency inpatient admission** If you have an emergency admission due to a condition that you reasonably believe puts your life in danger or could cause serious damage to bodily function, you, your representative, the physician, or the hospital must phone us within two business days following the day of the emergency admission, even if you have been discharged from the hospital.
 - **Maternity care** Precertification is not required for maternity care.
 - **If your treatment needs to be extended** If you request an extension of an ongoing course of treatment at least 24 hours prior to the expiration of the approved time period and this is also an urgent care claim, we will make a decision within 24 hours after we receive the claim.
- What happens when you do not follow the precertification rules when using non-network facilities** You are responsible for the precertification rules when using non-network healthcare providers. If preauthorization is required but not obtained, benefits will be reduced by \$500.
- Circumstances beyond our control** Under certain extraordinary circumstances, such as natural disasters, we may have to delay your services or we may be unable to provide them. In that case, we will make all reasonable efforts to provide you with the necessary care.
- If you disagree with our pre-service claim decision** If you have a **pre-service claim** and you do not agree with our decision regarding precertification of an inpatient admission or prior approval of other services, you may request a review in accord with the procedures detailed below.
- If you have already received the service, supply, or treatment, then you have a **post-service claim** and must follow the entire disputed claims process detailed in Section 8.
- **To reconsider a non-urgent care claim**

Within 6 months of our initial decision, you may ask us in writing to reconsider our initial decision. Follow Step 1 of the disputed claims process detailed in Section 8 of this brochure.

In the case of a pre-service claim and subject to a request for additional information, we have 30 days from the date we receive your written request for reconsideration to

 1. Precertify your hospital stay or, if applicable, arrange for the healthcare provider to give you the care or grant your request for prior approval for a service, drug, or supply; or
 2. Ask you or your provider for more information.

You or your provider must send the information so that we receive it within 60 days of our request. We will then decide within 30 more days.

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

 3. Write to you and maintain our denial.
 - **To reconsider an urgent care claim**

In the case of an appeal of a pre-service urgent care claim, within 6 months of our initial decision, you may ask us in writing to reconsider our initial decision. Follow Step 1 of the disputed claims process detailed in Section 8 of this brochure.

Unless we request additional information, we will notify you of our decision within 72 hours after receipt of your reconsideration request. We will expedite the review process, which allows oral or written requests for appeals and the exchange of information by phone, electronic mail, facsimile, or other expeditious methods.

- **To file an appeal with OPM**

After we reconsider your **pre-service claim**, if you do not agree with our decision, you may ask OPM to review it by following Step 3 of the disputed claims process detailed in Section 8 of this brochure.

Section 4. Your Cost for Covered Services

This is what you will pay out-of-pocket for covered care:

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

Coinsurance Coinsurance is the percentage of our allowance that you must pay for your care. Coinsurance does not begin until you have met your calendar year deductible.

Participating providers example: You pay 50% of charges for in-network infertility services under the CDHP and the Value Plan.

Non-participating providers example: You pay 40% up to \$5,000 limit of Plan allowance and any difference between allowance and the billed amount for out-of-network infertility services under the CDHP. You pay 50% up to \$5,000 limit of Plan allowance and any difference between allowance and the billed amount for out-of-network infertility services under the Value Plan.

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

Copayments apply, even after you meet your deductible.

Example: When you see a participating primary care physician (PCP), you will pay a \$40 copayment under the CDHP and a \$50 copayment under the Value Plan.

Deductible A deductible is a fixed expense you must incur for certain covered services and supplies before we start paying benefits for them. Deductible and out-of-pocket limits for participating and non-participating benefits are calculated separately.

Consumer Driven Health Plan (CDHP)

Participating providers – If you use participating providers, you do not have to meet a deductible until your \$1,000 benefit allowance is depleted. The calendar year deductible is \$1,500 for Self Only. The deductible for Self Plus One or Self and Family coverage is \$3,000.

Non-participating providers – If you use non-participating providers, the \$1,000 benefit allowance does not apply. Before benefits are payable, the calendar year deductible of \$3,500 for Self Only must be met. The deductible for Self Plus One or Self and Family coverage is \$7,000.

Value Plan

Participating providers – The calendar year deductible for Self Only is \$1,500. The deductible for Self Plus One or Self and Family is \$3,000.

Non-participating providers – The calendar year deductible for Self Only is \$3,500. The deductible for Self Plus One or Self and Family is \$7,000.

Note: If you change plans during Open Season, you do not have to start a new deductible under your prior plan between January 1 and the effective date of your new plan. If you change plans at another time during the year, you must begin a new deductible under your new plan.

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

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

You should also see section *Important Notice About Surprise Billing – Know Your Rights* below that describes your protections against surprise billing under the No Surprises Act.

Your catastrophic protection out-of-pocket maximum

Out-of-pocket maximums are the amount of out-of-pocket expenses that a Self Only, Self Plus One or a Self and Family will have to pay in a plan year. Out -of-pocket maximums apply on a calendar year basis only. The non-participating maximum out-of-pocket expense limits exclude expenses for covered organ transplants.

CDHP

Participating providers – After your (copayments and coinsurance) total \$8,150 for Self Only, or \$16,300 for a Self Plus One or Self and Family enrollment in any calendar year, you do not have to pay any more for covered services.

Non-participating providers – After your (copayments and coinsurance) total \$16,300 for Self Only, or \$32,600 for a Self Plus One or Self and Family enrollment in any calendar year, you do not have to pay any more for covered services.

The maximum annual limitation on cost sharing listed under Self Only of \$8,150 for participating providers and \$16,300 for non-participating providers applies to each individual, regardless of whether the individual is enrolled in Self Only, Self Plus One, or Self and Family.

Example Scenario: Your plan has a \$8,150 Self Only maximum out-of-pocket limit and a \$16,300 Self Plus One or Self and Family maximum out-of-pocket limit. If you or one of your eligible family members has out-of-pocket qualified medical expenses of \$8,150 or more for the calendar year, any remaining qualified medical expenses for that individual will be covered fully by your health plan. With a Self and Family enrollment out-of-pocket maximum of \$16,300, a second family member, or an aggregate of other eligible family members, will continue to accrue out-of-pocket qualified medical expenses up to a maximum of \$8,150 for the calendar year before their qualified medical expenses will begin to be covered in full.

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

Value Plan

Participating providers – After your (copayments and coinsurance) total \$8,150 for Self Only, or \$16,300 for a Self Plus One or Self and Family enrollment in any calendar year, you do not have to pay any more for covered services.

Non-participating providers – After your (copayments and coinsurance) total \$16,300 for Self Only, or \$32,600 for a Self Plus One or Self and Family enrollment in any calendar year, you do not have to pay any more for covered services.

The maximum annual limitation on cost sharing listed under Self Only of \$8,150 for participating providers and \$16,300 for non-participating providers applies to each individual, regardless of whether the individual is enrolled in Self Only, Self Plus One, or Self and Family.

Example Scenario: Your plan has a \$8,150 Self Only maximum out-of-pocket limit and a \$16,300 Self Plus One or Self and Family maximum out-of-pocket limit. If you or one of your eligible family members has out-of-pocket qualified medical expenses of \$8,150 or more for the calendar year, any remaining qualified medical expenses for that individual will be covered fully by your health plan. With a Self and Family enrollment out-of-pocket maximum of \$16,300, a second family member, or an aggregate of other eligible family members, will continue to accrue out-of-pocket qualified medical expenses up to a maximum of \$8,150 for the calendar year before their qualified medical expenses will begin to be covered in full.

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

Carryover

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

When Government facilities bill us

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

Important Notice About Surprise Billing – Know Your Rights

The No Surprises Act (NSA) is a federal law that provides you with protections against "surprise billing" and "balance billing" under certain circumstances. A surprise bill is an unexpected bill you receive from a nonparticipating healthcare provider, facility, or air ambulance service for healthcare. Surprise bills can happen when you receive emergency care – when you have little or no say in the facility or provider from whom you receive care. They can also happen when you receive non-emergency services at participating facilities, but you receive some care from nonparticipating providers.

Balance billing happens when you receive a bill from the nonparticipating provider, facility, or air ambulance service for the difference between the nonparticipating provider's charge and the amount payable by your health plan.

Your health plan must comply with the NSA protections that hold you harmless from unexpected bills.

In addition, your health plan adopts and complies with the surprise billing laws of Arizona, Florida, Georgia, Illinois, Kansas, Kentucky, Ohio, Tennessee, and Texas.

For specific information on surprise billing, the rights and protections you have, and your responsibilities go to <https://humana.com> or contact the health plan at 1-800-4HUMANA.

Section 5. Consumer Driven Health Plan (CDHP) Benefits

See page 17 for how our benefits changed this year and page 130 for the benefits summary.

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Section 5. Consumer Driven Health Plan Benefits Overview

This Plan offers a Consumer Driven Health Plan (CDHP). The CDHP benefit package is described in Section 5. Make sure that you review the benefits that are available under the benefit product in which you are enrolled.

CDHP Section 5, which describes the CDHP benefits, is divided into subsections. Please read important things you should keep in mind at the beginning of the subsections. Also read the general exclusions in Section 6; they apply to the benefits in the following subsections. To obtain claim forms, claims filing advice, or more information about CDHP benefits, contact us at 1-800-4HUMANA or on our website at <https://feds.humana.com/>.

This CDHP focuses on you, the healthcare consumer, and gives you greater control in how you use your healthcare benefits. With this plan, eligible in-network medical preventive care is covered in full, and you can use the benefit allowance for any covered care. If you use up your benefit allowance, the Traditional Medical Coverage begins after you satisfy your deductible.

Network Availability

The CDHP includes:

Humana contracts with both private office physicians and with physician groups. Referrals are not required for participating providers. The CoverageFirst plan will utilize the National Point of Service (NPOS) network.

Benefit Allowance

Members have a \$1,000 in-network benefit allowance to use before they must meet a deductible. Once your benefit allowance has been exhausted, you must satisfy your in-network deductible: \$1,500 for Self Only, or \$3,000 for Self Plus One or Self and Family. After the deductible has been met, you are only responsible for your copays or coinsurance.

Pharmacy

Your pharmacy plan is an Rx5 Plan, which allows members access to appropriate drugs used to treat conditions the medical plan covers. See drug levels listed below:

- **Level One** – preferred generic and lowest-cost generic
- **Level Two** – non-preferred generic and low-cost generic
- **Level Three** – preferred brand and higher-cost generic
- **Level Four** – non-preferred brand and some non-preferred higher-cost generics
- **Level Five** – most self-administered injectable medications and high-technology drugs that are often newly approved by the U.S. Food and Drug Administration.

Check your pharmacy and drug coverage details at MyHumana.com.

feds.Humana.com

Online tools include:

- Newly hired employees can easily navigate their plan choices
- Ability to view benefits and rates available to you based on service area ZIP code
- Learn “What’s New” about Humana’s plan offerings and other health topics
- Enroll in medical plans online
- Educate yourself about Humana’s health and wellness programs
- Find in-network doctors, hospitals and pharmacies near you
- Search Humana’s Drug List for prescription drugs and their estimated retail prices

Section 5. Preventive Care

Important things you should keep in mind about these benefits:

- Preventive care services listed in this Section are not subject to the deductible.
- The cost of the services does not apply toward your \$1,000 benefit allowance.
- For all other covered expenses, please see Section 5. *Traditional Medical Coverage Subject to the Deductible*.
- Humana will not waive the medical copayments, coinsurance, and deductibles for member when original Medicare is the primary payor. Members must enroll in the Humana Value Plan code associated within the service areas listed on the Value Plan brochure and the Humana Medicare Advantage Plan to receive waivers for medical copayments, coinsurance, and deductibles. See the Value Plan brochure (RI 73-829) for more details.

Benefit Description	You pay
<p>Note: The calendar year deductible applies to almost all benefits in this Section. We say “(No deductible)” when it does not apply.</p>	
Preventive care, adult	CDHP
<p>Routine physical every year</p> <p>The following preventive services are covered at the time interval recommended at each of the links below:</p> <ul style="list-style-type: none"> • Immunizations such as Pneumococcal, influenza, shingles, tetanus/DTaP, and human papillomavirus (HPV). For a complete list of immunizations go to the Centers for Disease Control (CDC) website at https://www.cdc.gov/vaccines/schedules/ • Screenings such as cancer, osteoporosis, depression, diabetes, high blood pressure, total blood cholesterol, HIV, and colorectal cancer screening. For a complete list of screenings go to the U.S. Preventive Services Task Force (USPSTF) website at https://www.uspreventiveservicestaskforce.org • Individual counseling on prevention and reducing health risks • Well woman care such as Pap smears, gonorrhea prophylactic medication to protect newborns, annual counseling for sexually transmitted infections, contraceptive methods, and screening for interpersonal and domestic violence. For a complete list of Well Women preventive care services please visit the Health and Human Services (HHS) website at https://www.healthcare.gov/preventive-care-women/ • To build your personalized list of preventive services go to https://health.gov/myhealthfinder 	<p>Participating: Nothing (No deductible)</p> <p>Non-participating: 40% of our plan allowance and any difference between our allowance and the billed amount</p>
<ul style="list-style-type: none"> • Routine mammogram – covered for women 	<p>Participating: Nothing (No deductible)</p> <p>Non-participating: 40% of our plan allowance and any difference between our allowance and the billed amount</p>
<ul style="list-style-type: none"> • Adult immunizations endorsed by the Centers for Disease Control and Prevention (CDC): based on the Advisory Committee on Immunization Practices (ACIP) schedule. 	<p>Participating: Nothing (No deductible)</p> <p>Non-participating: 40% of our plan allowance and any difference between our allowance and the billed amount</p>

Preventive care, adult - continued on next page

Benefit Description	You pay
Preventive care, adult (cont.)	CDHP
<p>Note: Any procedure, injection, diagnostic service, laboratory, or X-ray service done in conjunction with a routine examination and is not included in the preventive recommended listing of services will be subject to the applicable member copayments, coinsurance, and deductible.</p>	<p>Participating: Nothing (No deductible)</p> <p>Non-participating: 40% of our plan allowance and any difference between our allowance and the billed amount</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Physical exams required for obtaining or continuing employment or insurance, attending schools or camp, athletic exams, or travel.</i> • <i>Immunizations, boosters, and medications for travel or work-related exposure.</i> 	<p><i>All charges</i></p>
Preventive care, children	CDHP
<ul style="list-style-type: none"> • Well-child visits, examinations, and other preventive services as described in the Bright Future Guidelines provided by the American Academy of Pediatrics. For a complete list of the American Academy of Pediatrics Bright Futures Guidelines go to https://brightfutures.aap.org • Immunizations such as DTaP, Polio, Measles, Mumps, and Rubella (MMR), and Varicella. For a complete list of immunizations go to the Centers for Disease Control (CDC) website at: https://www.cdc.gov/vaccines/schedules/ • You can also find a complete list of preventive care services recommended under the U.S. Preventive Services Task Force (USPSTF) online at https://www.uspreventiveservicestaskforce.org <p>Note: When receiving these services from a participating provider, it is not necessary to first meet your deductible. The cost of the services does not apply toward your \$1,000 benefit allowance. You only have to pay your copayment.</p> <p>Note: Any procedure, injection, diagnostic service, laboratory, or X-ray service done in conjunction with a routine examination and is not included in the preventive recommended listing of services will be subject to the applicable member copayments, coinsurance, and deductible.</p>	<p>Participating: Nothing (No deductible)</p> <p>Non-participating: 40% of our plan allowance and any difference between our allowance and the billed amount</p>

Section 5. Traditional Medical Coverage Subject to the Deductible

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- In-network preventive care is covered at 100% (see page 32) and is not subject to the calendar year deductible.
- The deductible is \$1,500 per person (\$3,000 per Self Plus One enrollment, or \$3,000 per Self and Family enrollment). The family deductible can be satisfied by one or more family members. The deductible applies to almost all benefits under Traditional medical coverage. You must pay your deductible before your Traditional medical coverage may begin.
- Under Traditional medical coverage, you are responsible for your coinsurance and copayments for covered expenses.
- When you use network providers, you are protected by an annual catastrophic maximum on out-of-pocket expenses for covered services. After your coinsurance, copayments and deductibles total \$8,150 per person, \$16,300 per Self Plus One enrollment or \$16,300 per Self and Family enrollment in any calendar year, you do not have to pay any more for covered services from network providers. However, certain expenses do not count toward your out-of-pocket maximum and you must continue to pay these expenses once you reach your out-of-pocket maximum (such as expenses in excess of the Plan’s benefit maximum, or if you use out-of-network providers, amounts in excess of the Plan allowance).
- In-network benefits apply only when you use a network provider. When a network provider is not available, out-of-network benefits apply.
- 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.
- Humana will not waive the medical copayments, coinsurance, and deductibles for member when original Medicare is the primary payor. Members must enroll in the Humana Value Plan code associated within the service areas listed on the Value Plan brochure and the Humana Medicare Advantage Plan to receive waivers for medical copayments, coinsurance, and deductibles. See the Value Plan brochure (RI 73-829) for more details.

Benefit Description	You pay After the calendar year deductible...
Deductible before Traditional medical coverage begins	CDHP
The deductible applies to almost all benefits in this Section. In the You pay column, we say “No deductible” when it does not apply. When you receive covered services from network providers, you are responsible for paying the allowable charges until you meet the deductible.	100% of allowable charges until you meet the deductible of \$1,500 per person, \$3,000 per Self Plus One enrollment or \$3,000 per Self and Family enrollment.
After you meet the deductible, we pay the allowable charge (less your coinsurance or copayment) until you meet the annual catastrophic out-of-pocket maximum.	In-network: After you meet the deductible, you pay the indicated coinsurance or copayments for covered services. Out-of-network: After you meet the deductible, you pay the indicated coinsurance based on our Plan allowance and any difference between our allowance and the billed amount.

Section 5(a). Medical Services and Supplies Provided by Physicians and Other Healthcare Professionals

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- A facility copay applies to services that appear in this section but are performed in an ambulatory surgical center or the outpatient department of a hospital.
- The calendar year deductible is:
 - Participating providers – You do not have to meet a deductible until your \$1,000 benefit allowance is depleted. The calendar year deductible is: \$1,500 for Self Only, (\$3,000 for Self Plus One and Self and Family.) The calendar year deductible applies to almost all benefits in this Section. We added “(No deductible)” to show when the calendar year deductible does not apply.
 - Non-participating providers – The \$1,000 benefit allowance does not apply. The calendar year deductible is \$3,500 for Self Only, (\$7,000 for Self Plus One or Self and Family.) The calendar year deductible applies to almost all benefits in this Section. We added “(No deductible)” to show when the calendar year deductible does not apply.
- After you have satisfied your deductible, your Traditional medical coverage begins.
- Under your Traditional medical coverage, you will be responsible for your coinsurance amounts or copayments for eligible medical expenses and prescriptions.
- Be sure to read Section 4, *Your cost for covered services*, for valuable information about how cost-sharing works. Also, read Section 9 about coordinating benefits with other coverage, including with Medicare.
- Humana will not waive the medical copayments, coinsurance, and deductibles for member when original Medicare is the primary payor. Members must enroll in the Humana Value Plan code associated within the service areas listed on the Value Plan brochure and the Humana Medicare Advantage Plan to receive waivers for medical copayments, coinsurance, and deductibles. See the Value Plan brochure (RI 73-829) for more details.

Benefit Description	You pay After the calendar year deductible...
<p>Note: The calendar year deductible applies to almost all benefits in this Section. We say “(No deductible)” when it does not apply.</p>	
Diagnostic and treatment services	CDHP
Professional services of physicians <ul style="list-style-type: none"> • In physician’s office • Office medical consultations • At home • Second surgical opinion • Advance care planning 	Participating: \$40 copay per office visit to a primary care physician; \$60 copay per office visit to a specialist (no deductible) Non-participating: 40% of our plan allowance and any difference between our allowance and the billed amount
<ul style="list-style-type: none"> • In an urgent care center 	Participating: \$60 copay (no deductible) Non-participating: 40% of our plan allowance and any difference between our allowance and the billed amount

Diagnostic and treatment services - continued on next page

Benefit Description	You pay After the calendar year deductible...
Diagnostic and treatment services (cont.)	
<ul style="list-style-type: none"> • During a hospital stay • In a skilled nursing facility 	<p>CDHP</p> <p>Participating: 10% coinsurance</p> <p>Non-participating: 40% of our plan allowance and any difference between our allowance and the billed amount</p>
Telehealth services	
<p>Telemedicine (also known as “telehealth,” “virtual visits” or “video visits”) uses information technology and telecommunications to provide virtual clinical care to patients. Patients can interact with Network Primary/Specialty Care providers through video and app technology by using smartphones, tablets, and laptops.</p> <p>With Humana's telemedicine benefit delivered by Doctor On Demand, you can:</p> <ul style="list-style-type: none"> • Connect with a physician from one of Doctor On Demand’s U.S. board-certified doctors • Immediately see a doctor 24 hours a day, 7 days a week from any location • Your primary care physician can access your telemedicine visit at your request • If medically necessary, the telemedicine doctor can send a prescription to a preferred pharmacy <p>Note: In addition to using Doctor On Demand for telehealth visits, you can talk to other providers to see if they are offering video chat or phone-only visits at normal cost-share.</p>	<p>CDHP</p> <p>\$40 copay per office visit</p>
Lab, X-ray and other diagnostic tests	
<p>Tests, such as:</p> <ul style="list-style-type: none"> • Blood tests • Urinalysis • Non-routine pap test • Pathology • X-ray • Non-routine mammogram • Ultrasound • Electrocardiogram and EEG • Coronary angiography (Note: See You need prior plan approval for certain services in Section 3) 	<p>CDHP</p> <p>Participating: 10% coinsurance</p> <p>Non-participating: 40% of our plan allowance and any difference between our allowance and the billed amount</p>
<p>Other tests:</p> <ul style="list-style-type: none"> • Genetic counseling and Genetic testing when medically necessary. (Note: See <i>You need prior plan approval for certain services in Section 3</i>) 	<p>CDHP</p> <p>Participating: 10% coinsurance</p> <p>Non-participating: 40% of our plan allowance and any difference between our allowance and the billed amount</p>

Benefit Description	You pay After the calendar year deductible...
Maternity care	
<p>Complete maternity (obstetrical) care, such as:</p> <ul style="list-style-type: none"> • Prenatal care • Screening for gestational diabetes for pregnant women • Delivery • Postnatal care <p>Note: Here are some things to keep in mind:</p> <ul style="list-style-type: none"> • You do not need to precertify your vaginal delivery; see page 24 for other circumstances, such as extended stays for you or your baby. • You may remain in the hospital up to 48 hours after a vaginal delivery and 96 hours after a cesarean delivery. We will extend your inpatient stay for you and/or your baby if medically necessary. • We cover routine nursery care of the newborn child during the covered portion of the mother’s maternity stay. We will cover other care of an infant who requires non-routine treatment only if we cover the infant under a Self Plus One or Self and Family enrollment. Surgical benefits, not maternity benefits, apply to circumcision. • We pay hospitalization and surgeon services for non-maternity care the same as for illness and injury. • Hospital services are covered under Section 5(c) and Surgical benefits Section 5(b). <p>Note: When a newborn requires definitive treatment during or after the mother’s confinement, the newborn is considered a patient in their own right. If the newborn is eligible for coverage, regular medical or surgical benefits apply rather than maternity benefits.</p> <p>Note: We offer Humana <i>Beginnings</i>. See <i>Special features</i> in Section 5(h).</p>	<p>Participating: Nothing</p> <p>Non-participating: 40% of our plan allowance and any difference between our allowance and the billed amount</p> <p>Facility coinsurance and deductible applies to delivery</p>
<p>Breastfeeding support, supplies and counseling for each birth</p>	<p>Participating: Nothing</p> <p>Non-participating: 40% of our plan allowance and any difference between our allowance and the billed amount</p>
Family planning	
<p>Contraceptive counseling on an annual basis</p>	<p>Nothing</p>
<p>A range of voluntary family planning services, limited to:</p> <ul style="list-style-type: none"> • Voluntary sterilization (See <i>Surgical procedures</i>, Section 5(b)) • Surgically implanted contraceptives • Injectable contraceptive drugs (such as Depo-Provera) • Intrauterine devices (IUDs) • Diaphragms <p>Note: We cover oral contraceptives under the prescription drug benefit.</p>	<p>Participating: Nothing (no deductible)</p> <p>Non-participating: 40% of our plan allowance and any difference between our allowance and the billed amount</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Reversal of voluntary surgical sterilization</i> 	<p><i>All charges</i></p>

Benefit Description	You pay After the calendar year deductible...
<p>Infertility services</p> <p>Infertility is the condition of an individual who is unable to conceive or produce conception during a period of 1 year if the female is age 35 or younger or during a period of 6 months if the female is over the age of 35. For women without male partners or exposure to sperm, infertility is the inability to conceive after six cycles of artificial insemination or intrauterine insemination performed by a qualified specialist using normal quality donor sperm. These 6 cycles (including donor sperm) are not covered by the plan as a diagnosis of infertility is not established until the cycles have been completed.</p> <p>Covered benefits including evaluation and treatment:</p> <p>Females - ovulation evaluation, tubal patency, hormonal evaluation, and cervical factor evaluation.</p> <p>Males – includes sperm analysis, hormonal analysis, sperm functioning and medical imaging. Treatment would include correction of any defect found in the evaluation of both male and female partners.</p> <p>Diagnosis and treatment of infertility, such as:</p> <ul style="list-style-type: none"> • Artificial insemination: <ul style="list-style-type: none"> - Intravaginal insemination (IVI) - Intracervical insemination (ICI) - Intrauterine insemination (IUI) • Fertility drugs <p>Note: We cover Self-Injectable and oral fertility drugs under the prescription drug benefit (See <i>You need prior plan approval for certain services</i> in Section 3).</p>	<p>CDHP</p> <p>Participating: 50% of charges</p> <p>Non-participating: 40% up to \$5,000 limit per plan year, of our plan allowance and any difference between our allowance and the billed amount</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Assisted reproductive technology (ART) procedures, such as:</i> <ul style="list-style-type: none"> - <i>In vitro fertilization (IVF)</i> - <i>Embryo transfer, gamete intra-fallopian transfer (GIFT) and zygote intra-fallopian transfer (ZIFT)</i> • <i>Services and supplies related to excluded ART procedures</i> • <i>Cost of donor sperm</i> • <i>Cost of donor egg</i> 	<p><i>All charges</i></p>
<p>Allergy care</p> <p>Testing and treatment</p>	<p>CDHP</p> <p>Participating: \$40 copay per office visit to a primary care physician; \$60 copay per office visit to a specialist (no deductible when received in physician’s office)</p> <p>Non-participating: 40% of our plan allowance and any difference between our allowance and the billed amount</p>

Allergy care - continued on next page

Benefit Description	You pay After the calendar year deductible...
Allergy care (cont.)	CDHP
Allergy injection	Participating: \$5 copay per visit (no deductible) Non-participating: 40% of our plan allowance and any difference between our allowance and the billed amount
Allergy serum	Participating: Nothing Non-participating: 40% of our plan allowance and any difference between our allowance and the billed amount
<i>Not covered:</i> <ul style="list-style-type: none"> • <i>Provocative food testing</i> • <i>Sublingual allergy desensitization</i> 	<i>All charges</i>
Treatment therapies	CDHP
<ul style="list-style-type: none"> • Chemotherapy and radiation therapy (Note: See <i>You need prior plan approval for certain services</i> in Section 3) <p>Note: High dose chemotherapy in association with autologous bone marrow transplants is limited to those transplants listed under <i>Organ/Tissue Transplants</i> on page 48.</p> <p>Note: Oral chemotherapy medications are covered under the Pharmacy benefit (See Section 5(f) for details).</p> <ul style="list-style-type: none"> • Respiratory and inhalation therapy • Cardiac rehabilitation following qualifying event/condition is provided. No visit limitations apply • Dialysis – hemodialysis and peritoneal dialysis • Intravenous (IV)/Infusion Therapy – Home IV and antibiotic therapy (Note: See <i>You need prior plan approval for certain services</i> in Section 3) • Growth hormone therapy (GHT) <p>Note: Growth hormone is covered under the prescription drug benefit.</p> <p>Note: We only cover GHT when we preauthorize the treatment. We will ask you to submit information that establishes that the GHT is medically necessary. Your Plan Physician will ask us to authorize GHT before you begin treatment. We will only cover GHT services and related services and supplies that we determine are medically necessary. See <i>Other services, You need prior Plan approval for certain services</i> on page 21.</p> <p>Note: Applied Behavior Analysis (ABA) children with Autism Spectrum Disorder is described in Section 5(e).</p>	Participating: 10% coinsurance Non-participating: 40% of our plan allowance and any difference between our allowance and the billed amount

Benefit Description	You pay After the calendar year deductible...
Physical, occupational and cardiac therapies	
<p>60 visits per condition per year for the services of each of the following:</p> <ul style="list-style-type: none"> • Qualified physical therapists • Occupational therapists <p>Note: We only cover therapy when a physician:</p> <ul style="list-style-type: none"> • Orders the care • Identifies the specific professional skills the patient requires and the medical necessity for skilled services; and • Indicates the length of time the services are needed. <p>Note: See <i>You need prior plan approval for certain services</i> in Section 3.</p>	<p>CDHP</p> <p>Participating: \$60 copay per visit to a specialist</p> <p>Non-participating: 40% of our plan allowance and any difference between our allowance and the billed amount</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Long-term rehabilitative therapy</i> • <i>Exercise programs</i> 	<p><i>All charges</i></p>
Speech therapy	
<p>60 visits per condition per year for the service of the following:</p> <ul style="list-style-type: none"> • Speech therapists <p>Note: See <i>You need prior plan approval for certain services</i> in Section 3.</p>	<p>CDHP</p> <p>Participating: \$60 copay per visit to a specialist</p> <p>Non-participating: 40% of our plan allowance and any difference between our allowance and the billed amount</p>
Hearing services (testing, treatment, and supplies)	
<ul style="list-style-type: none"> • For treatment related to illness or injury, including evaluation and diagnostic hearing tests performed by an M.D., D.O., or audiologist • Cochlear Implants <ul style="list-style-type: none"> - Note: For benefits for the devices, see Section 5(a) <i>Orthopedic and prosthetic devices</i> 	<p>CDHP</p> <p>Participating: 10% coinsurance</p> <p>Non-participating: 40% of our plan allowance and any difference between our allowance and the billed amount</p>
<ul style="list-style-type: none"> • Hearing screening performed during a child's preventive care visit, see Section 5(a) - <i>Preventive care, children.</i> 	<p>Participating: Nothing</p> <p>Non-participating: 40% of our plan allowance and any difference between our allowance and the billed amount</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Hearing services that are not shown as covered</i> 	<p><i>All charges</i></p>
Vision services (testing, treatment, and supplies)	
<ul style="list-style-type: none"> • Diagnosis and treatment of diseases of the eye 	<p>CDHP</p> <p>Participating: \$40 copay per office visit to a primary care physician; \$60 copay per office visit to a specialist (no deductible)</p> <p>Non-participating: 40% of our plan allowance and any difference between our allowance and the billed amount</p>

Vision services (testing, treatment, and supplies) - continued on next page

Benefit Description	You pay After the calendar year deductible...
Vision services (testing, treatment, and supplies) (cont.)	
<ul style="list-style-type: none"> Eye exam to determine the need for vision correction for children through age 17 <p>Note: See <i>Preventive care, children</i> for eye exams for children.</p>	<p>Participating: Nothing</p> <p>Non-participating: 40% of our plan allowance and any difference between our allowance and the billed amount</p>
<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) 	<p>Participating: 10% coinsurance</p> <p>Non-participating: 40% of our plan allowance and any difference between our allowance and the billed amount</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <i>Eyeglasses or contact lenses except as shown above</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>Note: See <i>Orthopedic and prosthetic devices</i> for information on podiatric shoe inserts.</p>	<p>Participating: \$40 copay per office visit to a primary care physician; \$60 copay per office visit to a specialist (no deductible)</p> <p>Non-participating: 40% of our plan allowance and any difference between our allowance and the billed amount</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <i>Cutting, trimming or removal of corns, calluses, or the free edge of toenails, and similar routine treatment of conditions of the foot, except as stated above</i> <i>Treatment of weak, strained or flat feet or bunions or spurs; and of any instability, imbalance or subluxation of the foot (unless the treatment is by open cutting surgery)</i> 	<p><i>All charges</i></p>
Orthopedic and prosthetic devices	
<ul style="list-style-type: none"> Artificial limbs and eyes Prosthetic sleeve or sock Externally worn breast prostheses and surgical bras, including necessary replacements following a mastectomy Corrective orthopedic appliances for non-dental treatment of temporomandibular joint (TMJ) pain dysfunction syndrome. Internal prosthetic devices, such as artificial joints, pacemakers, cochlear implants, and surgically implanted breast implant following mastectomy. <p>Note: For information on the professional charges for the surgery to insert an implant, see Section 5(b) <i>Surgical procedures</i>. For information on the hospital and/or ambulatory surgery center benefits, see Section 5 (c) <i>Services provided by a hospital or other facility, and ambulance services</i>.</p>	<p>Participating: 10% coinsurance</p> <p>Non-participating: 40% of our plan allowance and any difference between our allowance and the billed amount</p>

Orthopedic and prosthetic devices - continued on next page

Benefit Description	You pay After the calendar year deductible...
Orthopedic and prosthetic devices (cont.)	CDHP
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • Orthopedic and corrective shoes, heel pads and heel cups, corsets, trusses • Arch supports, foot orthotics except for diabetes and hammer toe • Elastic stockings, support hose, and other supportive devices not custom made • Prosthetic replacements except as required by growth or change in medical condition, or in the case where the medically necessary repair exceeds the cost replacement or normal wear and tear renders the device nonfunctional and non-repairable 	<p><i>All charges</i></p>
Durable medical equipment (DME)	CDHP
<p>We cover rental or purchase, of durable medical equipment, at our option, including repair and maintenance of purchased medical equipment.</p> <p>Covered items include:</p> <ul style="list-style-type: none"> • Oxygen • Dialysis equipment • Hospital beds • Wheelchairs • Crutches • Walkers • Insulin pumps and supplies • Blood glucose monitors • Communication devices <p>Note: Communication devices are covered when there has been surgical removal of the larynx or a diagnosis of permanent lack of function of the larynx, additional criteria may need to be met.</p> <p>Note: Preauthorization is necessary for items over \$750. See <i>You need prior plan approval for certain services</i> in Section 3.</p> <p>Note: Call us at 1-800-4HUMANA as soon as your Plan physician prescribes this equipment. We will arrange with a healthcare provider to rent or sell you durable medical equipment at discounted rates and will tell you more about this service when you call.</p>	<p>Participating: 10% coinsurance</p> <p>Non-participating: 40% of our plan allowance and any difference between our allowance and the billed amount</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • Equipment such as exercise equipment, air cleaners, heating pads or lights and bed lifts, hearing aids, personnel hygiene equipment • Communication devices, except after surgical removal of the larynx or a diagnosis of permanent lack of function of the larynx, additional criteria may need to be met. 	<p><i>All charges</i></p>

Benefit Description	You pay After the calendar year deductible...
Home health services	
<ul style="list-style-type: none"> Home healthcare ordered by a Plan physician and provided by a registered nurse (R.N.), licensed practical nurse (L.P.N.), licensed vocational nurse (L.V.N.), or home health aide. Services include oxygen therapy, intravenous therapy and medications. <p>Note: See <i>You need prior plan approval for certain services</i> in Section 3.</p>	<p>CDHP</p> <p>Participating: 10% coinsurance</p> <p>Non-participating: 40% of our plan allowance and any difference between our allowance and the billed amount</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <i>Nursing care requested by, or for the convenience of, the patient or the patient's family.</i> <i>Home care primarily for personal assistance that does not include a medical component and is not diagnostic, therapeutic, or rehabilitative.</i> <i>Private duty nurse</i> 	<p><i>All charges</i></p>
Chiropractic	
<ul style="list-style-type: none"> Manipulation of the spine and extremities <p><i>Adjunctive procedures such as ultrasound, electrical muscle stimulation, vibratory therapy, and cold pack application</i></p> <p>Note: See <i>You need prior plan approval for certain services</i> in Section 3.</p>	<p>CDHP</p> <p>Participating: \$60 copay per office visit (no deductible) to a specialist</p> <p>Non-participating: 40% of our plan allowance and any difference between our allowance and the billed amount</p>
Alternative treatments	
<p>Acupuncture – by a licensed acupuncturist for:</p> <ul style="list-style-type: none"> anesthesia pain relief <p>Note: See <i>You need prior plan approval for certain services</i> in Section 3.</p>	<p>CDHP</p> <p>Participating: \$60 copay per office visit (no deductible) to a specialist</p> <p>Non-participating: 40% of our plan allowance and any difference between our allowance and the billed amount</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <i>Naturopathic services</i> <i>Hypnotherapy</i> <i>Biofeedback</i> 	<p><i>All charges</i></p>
Educational classes and programs	
<p>Coverage is provided for:</p> <ul style="list-style-type: none"> Tobacco Cessation program, including individual/group/telephone counseling, over-the-counter (OTC) and prescription drugs approved by the FDA to treat tobacco dependence Childhood obesity education 	<p>CDHP</p> <p>Participating: Nothing for counseling for up to two (2) quit attempts per year with up to four (4) tobacco cessation counseling sessions per quit attempt</p> <p>Nothing for OTC and prescription drugs approved by the FDA to treat tobacco dependence</p> <p>Non-participating: 40% of our plan allowance and any difference between our allowance and the billed amount</p>

Educational classes and programs - continued on next page

Benefit Description	You pay After the calendar year deductible...
Educational classes and programs (cont.)	CDHP
<ul style="list-style-type: none"> Diabetes self management training 	<p>Participating: \$40 copay per office visit to a primary care physician; \$60 copay per office visit to a specialist (no deductible)</p> <p>Non-participating: 40% of our plan allowance and any difference between our allowance and the billed amount</p>

Section 5(b). Surgical and Anesthesia Services Provided by Physicians and Other Healthcare Professionals

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- The calendar year deductible is:
 - Participating providers - You do not have to meet a deductible until your \$1,000 benefit allowance is depleted. The calendar year deductible is \$1,500 for Self Only, (\$3,000 for Self Plus One or Self and Family.) The calendar year deductible applies to almost all benefits in this Section. We added “(No deductible)” to show when the calendar year deductible does not apply.
 - Non-participating providers - The \$1,000 benefit allowance does not apply. The calendar year deductible is \$3,500 for Self Only, (\$7,000 for Self Plus One or Self and Family.) The calendar year deductible applies to almost all benefits in this Section. We added “(No deductible)” to show when the calendar year deductible does not apply.
- After you have satisfied your deductible, your Traditional medical coverage begins.
- Under your Traditional medical coverage, you will be responsible for your coinsurance amounts or copayments for eligible medical expenses and prescriptions.
- Be sure to read Section 4, *Your cost 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 services listed below are for the charges billed by a physician or other healthcare professional for your surgical care. See Section 5(c) for charges associated with a facility (i.e. hospital, surgical center, etc.).
- **YOUR PHYSICIAN MUST GET PRECERTIFICATION FOR SOME SURGICAL PROCEDURES.** Please refer to the precertification information shown in Section 3 to be sure which services require precertification and identify which surgeries require precertification.
- Humana will not waive the medical copayments, coinsurance, and deductibles for member when original Medicare is the primary payor. Members must enroll in the Humana Value Plan code associated within the service areas listed on the Value Plan brochure and the Humana Medicare Advantage Plan to receive waivers for medical copayments, coinsurance, and deductibles. See the Value Plan brochure (RI 73-829) for more details.

Benefit Description	You pay After the calendar year deductible...
<p>Note: The calendar year deductible applies to almost all benefits in this Section. We say “(No deductible)” when it does not apply.</p>	
Surgical procedures	CDHP
<p>A comprehensive range of services, such as:</p> <ul style="list-style-type: none"> • Operative procedures • Treatment of fractures, including casting • Normal pre- and post-operative care by the surgeon • Correction of amblyopia and strabismus • Endoscopy procedures • Biopsy procedures • Removal of tumors and cysts 	<p>Participating: 10% coinsurance</p> <p>Non-participating: 40% of our plan allowance and any difference between our allowance and the billed amount</p>

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

Benefit Description	You pay After the calendar year deductible...
Surgical procedures (cont.)	
<ul style="list-style-type: none"> • Correction of congenital anomalies (see Reconstructive surgery) • Insertion of internal prosthetic devices. See Section 5(a) - <i>Orthopedic and prosthetic devices</i> for device coverage information • Treatment of burns • Voluntary sterilization (e.g., Tubal ligation, Vasectomy) • Surgical treatment for morbid obesity (bariatric surgery). (Note: See <i>You need prior plan approval for certain services</i> in Section 3.) Some of the requirements that must be met before surgery can be authorized are: <ul style="list-style-type: none"> - Patient is 18 years of age or older - Body Mass Index of >40, or a Body Mass Index of >35 with associated comorbidity such as: <ul style="list-style-type: none"> • Hypertension • Type two diabetes • Life-threatening cardiopulmonary problems - Physician's documentation which indicates that you have had unsuccessful attempt(s) with nonoperative medically supervised weight-reduction program(s) • Esophagogastroduodenoscopy (EGD) (Note: See <i>You need prior plan approval for certain services</i> in Section 3) • Colonoscopy repeat testing (Note: See <i>You need prior plan approval for certain services</i> in Section 3) <p>Note: Generally, we pay for internal prostheses (devices) according to where the procedure is done. For example, we pay Hospital benefits for a pacemaker and Surgery benefits for insertion of the pacemaker.</p>	<p style="text-align: center;">CDHP</p> <p>Participating: 10% coinsurance</p> <p>Non-participating: 40% of our plan allowance and any difference between our allowance and the billed amount</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Reversal of voluntary sterilization</i> • <i>Radial keratotomy and other refractive surgery</i> • <i>Routine treatment of conditions of the foot: (See Foot care in Section 5(a))</i> 	<p><i>All charges</i></p>
Reconstructive surgery	
<ul style="list-style-type: none"> • Surgery to correct a functional defect • Surgery to correct a condition caused by injury or illness if: <ul style="list-style-type: none"> - the condition produced a major effect on the member's appearance and - the condition can reasonably be expected to be corrected by such surgery • Surgery to correct a condition that existed at or from birth and that is a significant deviation from the common form or norm. Examples of congenital anomalies are: protruding ear deformities; cleft lip; cleft palate; birth marks; webbed fingers and toes. 	<p style="text-align: center;">CDHP</p> <p>Participating: 10% coinsurance</p> <p>Non-participating: 40% of our plan allowance and any difference between our allowance and the billed amount</p>

Reconstructive surgery - continued on next page

Benefit Description	You pay After the calendar year deductible...
Reconstructive surgery (cont.)	
<ul style="list-style-type: none"> • All stages of breast reconstruction surgery following a mastectomy, such as: <ul style="list-style-type: none"> - surgery to produce a symmetrical appearance of breasts; - treatment of any physical complications, such as lymphedemas; - breast prostheses and surgical bras and replacements (see Orthopedic and Prosthetic devices) <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> <ul style="list-style-type: none"> • Gender reassignment surgery performed to change primary and/or secondary sex characteristics <ul style="list-style-type: none"> - Surgical treatment for gender reassignment is limited to the following: <ul style="list-style-type: none"> • For female to male surgery: mastectomy, hysterectomy, vaginectomy, salpingo-oophorectomy • For male to female surgery: penectomy, orchiectomy <p>Note: You must be 18 years or older to be considered for genital reconstruction surgery. There are pre-surgical requirements for members considering gender reassignment surgery including but not limited to: a documented diagnosis of gender dysphoria, 12 months of hormone therapy as appropriate to the individual gender goals, and referral letters from a mental health specialist.</p>	<p style="text-align: center;">CDHP</p> <p>Participating: 10% coinsurance</p> <p>Non-participating: 40% of our plan allowance and any difference between our allowance and the billed amount</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <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 (Note: See You need prior plan approval for certain services in Section 3)</i> • <i>Any surgical procedure for gender reassignment not listed above</i> 	<p><i>All charges</i></p>
Oral and maxillofacial surgery	
<p>Oral surgical procedures, limited to:</p> <ul style="list-style-type: none"> • Reduction of fractures of the jaws or facial bones; • Surgical correction of cleft lip, cleft palate or severe functional malocclusion; • Removal of stones from salivary ducts; • Excision of leukoplakia or malignancies; • Excision of cysts and incision of abscesses when done as independent procedures; • Excision of partially or completely impacted teeth; and • Other surgical procedures that do not involve the teeth or their supporting structures. 	<p style="text-align: center;">CDHP</p> <p>Participating: 10% coinsurance</p> <p>Non-participating: 40% of our plan allowance and any difference between our allowance and the billed amount</p>

Oral and maxillofacial surgery - continued on next page

Benefit Description	You pay After the calendar year deductible...
<p>Oral and maxillofacial surgery (cont.)</p> <p><i>Not covered:</i></p> <ul style="list-style-type: none"> • Dental work related to treatment of temporomandibular joint syndrome (TMJ) • Oral implants and transplants • Procedures that involve the teeth or their supporting structures (such as the periodontal membrane, gingiva, and alveolar bone) 	<p>CDHP</p> <p><i>All charges</i></p>
<p>Organ/tissue transplants</p> <p>These solid organ transplants are subject to medical necessity and experimental/investigational review by the Plan. See <i>Other services</i> under <i>You need prior Plan approval for certain services</i> on page 21. These solid organ transplants are covered. Solid organ transplants are limited to:</p> <ul style="list-style-type: none"> • Autologous pancreas islet cell transplant (as an adjunct to total or near total pancreatectomy) only for patients with chronic pancreatitis • Cornea • Heart • Heart/lung • Intestinal transplants <ul style="list-style-type: none"> - Isolated small intestine - Small intestine with the liver - Small intestine with multiple organs, such as the liver, stomach, and pancreas • Kidney • Kidney-pancreas • Liver • Lung: single/bilateral/lobar • Pancreas 	<p>CDHP</p> <p>Participating: 10% coinsurance</p> <p>Non-participating: 40% of our plan allowance and any difference between our allowance and the billed amount</p> <p>Non-participating transplant services do not apply toward the maximum out-of-pocket expense limit.</p>
<p>These tandem blood or marrow stem cell transplants for covered transplants are subject to medical necessity review by the Plan. Refer to <i>Other services</i> in Section 3 for prior authorization procedures.</p> <ul style="list-style-type: none"> • Autologous tandem transplants for <ul style="list-style-type: none"> - AL Amyloidosis - Multiple myeloma (de novo and treated) - Recurrent germ cell tumors (including testicular cancer) 	<p>Participating: 10% coinsurance</p> <p>Non-participating: 40% of our plan allowance and any difference between our allowance and the billed amount</p> <p>Non-participating transplant services do not apply toward the maximum out-of-pocket expense limit.</p>
<p>Blood or marrow stem cell transplants</p> <p>The Plan extends coverage for the diagnoses as indicated below.</p> <ul style="list-style-type: none"> • Allogeneic transplants for <ul style="list-style-type: none"> - Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia - Acute myeloid leukemia 	<p>Participating: 10% coinsurance</p> <p>Non-participating: 40% of our plan allowance and any difference between our allowance and the billed amount</p> <p>Non-participating transplant services do not apply toward the maximum out-of-pocket expense limit.</p>

Organ/tissue transplants - continued on next page

Benefit Description	You pay After the calendar year deductible...
<p>Organ/tissue transplants (cont.)</p> <ul style="list-style-type: none"> - Advanced Hodgkin’s lymphoma with recurrence (relapsed) - Advanced Myeloproliferative Disorders (MPDs) - Advanced neuroblastoma - Advanced non-Hodgkin’s lymphoma with recurrence (relapsed) - Amyloidosis - Chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL) - Hemoglobinopathy - Infantile malignant osteopetrosis - Kostmann’s syndrome - Leukocyte adhesion deficiencies - Marrow failure and related disorders (i.e., Fanconi’s, Paroxysmal Nocturnal Hemoglobinuria, Pure Red Cell Aplasia) - Mucopolysaccharidosis (e.g., Gaucher’s disease, metachromatic leukodystrophy, adrenoleukodystrophy) - Mucopolysaccharidosis (e.g., Hunter’s syndrome, Hurler’s syndrome, Sanfillippo’s syndrome, Maroteaux-Lamy syndrome variants) - Myelodysplasia/Myelodysplastic syndromes - Paroxysmal Nocturnal Hemoglobinuria - Phagocytic/Hemophagocytic deficiency diseases (e.g., Wiskott-Aldrich syndrome) - Severe combined immunodeficiency - Severe or very severe aplastic anemia - Sickle cell anemia - X-linked lymphoproliferative syndrome • Autologous transplants for <ul style="list-style-type: none"> - Acute lymphocytic or nonlymphocytic (i.e., myelogenous) leukemia - Advanced Hodgkin’s lymphoma with recurrence (relapsed) - Advanced non-Hodgkin’s lymphoma with recurrence (relapsed) - Amyloidosis - Breast Cancer - Ependyoblastoma - Epithelial ovarian cancer - Ewing’s sarcoma - Medulloblastoma - Multiple myeloma - Neuroblastoma - Pineoblastoma 	<p style="text-align: center;">CDHP</p> <p>Participating: 10% coinsurance</p> <p>Non-participating: 40% of our plan allowance and any difference between our allowance and the billed amount</p> <p>Non-participating transplant services do not apply toward the maximum out-of-pocket expense limit.</p>

Organ/tissue transplants - continued on next page

Benefit Description	You pay After the calendar year deductible...
<p>Organ/tissue transplants (cont.)</p> <ul style="list-style-type: none"> - Testicular, Mediastinal, Retroperitoneal, and Ovarian germ cell tumors 	<p align="center">CDHP</p> <p>Participating: 10% coinsurance</p> <p>Non-participating: 40% of our plan allowance and any difference between our allowance and the billed amount</p> <p>Non-participating transplant services do not apply toward the maximum out-of-pocket expense limit.</p>
<p>Mini-transplants performed in a clinical trial setting (non-myeloablative, reduced intensity conditioning or RIC) for members with a diagnosis listed below are subject to medical necessity review by the Plan.</p> <p>Refer to <i>Other services</i> in Section 3 for prior authorization procedures:</p> <ul style="list-style-type: none"> • Allogeneic transplants for <ul style="list-style-type: none"> - Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia - Acute myeloid leukemia - Advanced Hodgkin’s lymphoma with recurrence (relapsed) - Advanced Myeloproliferative Disorders (MPDs) - Advanced non-Hodgkin’s lymphoma with recurrence (relapsed) - Amyloidosis - Chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL) - Hemoglobinopathy - Marrow failure and related disorders (i.e., Fanconi’s, PNH, Pure Red Cell Aplasia) - Myelodysplasia/Myelodysplastic syndromes - Paroxysmal Nocturnal Hemoglobinuria - Severe combined immunodeficiency - Severe or very severe aplastic anemia • Autologous transplants for <ul style="list-style-type: none"> - Acute lymphocytic or nonlymphocytic (i.e., myelogenous) leukemia - Advanced Hodgkin’s lymphoma with recurrence (relapsed) - Advanced non-Hodgkin’s lymphoma with recurrence (relapsed) - Amyloidosis - Neuroblastoma 	<p>Participating: 10% coinsurance</p> <p>Non-participating: 40% of our plan allowance and any difference between our allowance and the billed amount</p> <p>Non-participating transplant services do not apply toward the maximum out-of-pocket expense limit.</p>
<p>These blood or marrow stem cell transplants are covered only in a National Cancer Institute or National Institutes of Health approved clinical trial or a Plan-designated center of excellence if approved by the Plan’s medical director in accordance with the Plan’s protocols.</p>	<p>Participating: 10% coinsurance</p> <p>Non-participating: 40% of our plan allowance and any difference between our allowance and the billed amount</p>

Organ/tissue transplants - continued on next page

Benefit Description	You pay After the calendar year deductible...
Organ/tissue transplants (cont.)	CDHP
<p>If you are a participant in a clinical trial, the Plan will provide benefits for related routine care that is medically necessary (such as doctor visits, lab tests, X-rays and scans, and hospitalization related to treating the patient’s condition) if it is not provided by the clinical trial. Section 9 has additional information on costs related to clinical trials. We encourage you to contact the Plan to discuss specific services if you participate in a clinical trial.</p> <ul style="list-style-type: none"> • Allogeneic transplants for <ul style="list-style-type: none"> - Advanced Hodgkin’s lymphoma - Advanced non-Hodgkin’s lymphoma - Beta Thalassemia Major - Chronic inflammatory demyelination polyneuropathy (CIDP) - Early stage (indolent or non-advanced) small cell lymphocytic lymphoma - Multiple myeloma - Multiple sclerosis - Sickle cell anemia • Mini-transplants (non-myeloablative allogeneic, reduced intensity conditioning or RIC) for <ul style="list-style-type: none"> - Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia - Advanced Hodgkin’s lymphoma - Advanced non-Hodgkin’s lymphoma - Breast cancer - Chronic lymphocytic leukemia - Chronic lymphocytic lymphoma/small lymphocytic lymphoma (CLL/SLL) - Chronic myelogenous leukemia - Colon cancer - Early stage (indolent or non-advanced) small cell lymphocytic lymphoma - Multiple myeloma - Multiple sclerosis - Myeloproliferative disorders (MPDs) - Non-small cell lung cancer - Ovarian cancer - Prostate cancer - Renal cell carcinoma - Sarcomas - Sickle cell anemia • Autologous Transplants for <ul style="list-style-type: none"> - Advanced childhood kidney cancers 	<p>Participating: 10% coinsurance</p> <p>Non-participating: 40% of our plan allowance and any difference between our allowance and the billed amount</p> <p>Non-participating transplant services do not apply toward the maximum out-of-pocket expense limit.</p>

Benefit Description	You pay After the calendar year deductible...
<p>Organ/tissue transplants (cont.)</p> <ul style="list-style-type: none"> - Advanced Ewing sarcoma - Advanced Hodgkin’s lymphoma - Advanced non-Hodgkin’s lymphoma - Aggressive non-Hodgkin’s lymphoma - Breast cancer - Childhood rhabdomyosarcoma - Chronic lymphocytic lymphoma/small lymphocytic lymphoma (CLL/SLL) - Chronic myelogenous leukemia - Early stage (indolent or non-advanced) small cell lymphocytic lymphoma - Epithelial ovarian cancer - Mantle cell (non-Hodgkin lymphoma) - Multiple sclerosis - Small cell lung cancer - Systemic lupus erythematosus - Systemic sclerosis <p>Benefits are available for Allogeneic and Autologous blood or marrow stem cell transplants utilizing a phase two or higher protocol.</p> <p>National Transplant Program (NTP) - All services are determined and authorized through our transplant department, utilizing our National Transplant Network.</p> <p>Note: We cover related medical and hospital expenses of the donor when we cover the recipient. We cover donor testing for the actual solid organ donor or up to four bone marrow/stem cell transplant donors in addition to the testing of family members.</p> <p>Note: See <i>You need prior plan approval for certain services</i> in Section 3.</p>	<p>CDHP</p> <p>Participating: 10% coinsurance</p> <p>Non-participating: 40% of our plan allowance and any difference between our allowance and the billed amount</p> <p>Non-participating transplant services do not apply toward the maximum out-of-pocket expense limit.</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • Donor screening tests and donor search expenses, except as shown above • Implants of artificial organs • Transplants not listed as covered 	<p><i>All charges</i></p>
<p>Anesthesia</p> <p>Professional services provided in –</p> <ul style="list-style-type: none"> • Hospital (inpatient) • Hospital outpatient department • Skilled nursing facility • Ambulatory surgical center • Office 	<p>CDHP</p> <p>Participating: 10% coinsurance</p> <p>Non-participating: 40% of our plan allowance and any difference between our allowance and the billed amount</p>

Section 5(c). Services Provided by a Hospital or Other Facility, and Ambulance Services

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- The calendar year deductible is:
 - Participating providers – You do not have to meet a deductible until your \$1,000 benefit allowance is depleted. The calendar year deductible is \$1,500 for Self Only, (\$3,000 for Self Plus One or Self and Family.) The calendar year deductible applies to almost all benefits in this Section. We added “(No deductible)” to show when the calendar year deductible does not apply.
 - Non-participating providers – The \$1,000 benefit allowance does not apply. The calendar year deductible is \$3,500 for Self Only, (\$7,000 for Self Plus One or Self and Family.) The calendar year deductible applies to almost all benefits in this Section. We added “(No deductible)” to show when the calendar year deductible does not apply.
- After you have satisfied your deductible, your Traditional medical coverage begins.
- Under your Traditional medical coverage, you will be responsible for your coinsurance amounts or copayments for eligible medical expenses and prescriptions.
- Be sure to read Section 4, *Your cost 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 in Sections 5(a) or (b).
- **YOUR PHYSICIAN MUST GET PRECERTIFICATION FOR HOSPITAL STAYS.** Please refer to Section 3 to be sure which services require precertification.
- **Observation Care:** Your share for hospital observation care that exceeds 24 hours is the same as inpatient hospital care. Observation Care below 24 hours is the same as the Emergency Room benefit/copy.
- Humana will not waive the medical copayments, coinsurance, and deductibles for member when original Medicare is the primary payor. Members must enroll in the Humana Value Plan code associated within the service areas listed on the Value Plan brochure and the Humana Medicare Advantage Plan to receive waivers for medical copayments, coinsurance, and deductibles. See the Value Plan brochure (RI 73-829) for more details.

Benefit Description	You pay After the calendar year deductible...
Note: The calendar year deductible applies to almost all benefits in this Section. We say “(No deductible)” when it does not apply.	
Inpatient hospital	CDHP
Room and board, such as: <ul style="list-style-type: none"> • Ward, semiprivate, or intensive care accommodations • General nursing care • 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> Other hospital services and supplies, such as:	Participating: 10% coinsurance Non-participating: 40% of our plan allowance and any difference between our allowance and the billed amount

Benefit Description	You pay After the calendar year deductible...
Inpatient hospital (cont.)	
<ul style="list-style-type: none"> • Operating, recovery, maternity, and other treatment rooms • Prescribed drugs and medications • Diagnostic laboratory tests and X-rays • Dressings, splints, casts, and sterile tray services • Medical supplies and equipment, including oxygen • Anesthetics, including nurse anesthetist services • Take-home items • Medical supplies, appliances, medical equipment, and any covered items billed by a hospital for use at home (Note: calendar year deductible applies) 	<p>Participating: 10% coinsurance</p> <p>Non-participating: 40% of our plan allowance and any difference between our allowance and the billed amount</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • Custodial care • Non-covered facilities, such as nursing homes, schools • Personal comfort items, such as phone, television, barber services, guest meals and beds • Blood and blood components if not replaced 	<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 medications • Diagnostic laboratory tests, X-rays, and pathology services • Administration of blood, blood plasma, and other biologicals • Pre-surgical testing • Dressings, casts, and sterile tray services • Medical supplies, including oxygen • Anesthetics and anesthesia service • Outpatient Hospital Services such as: MRI, MRA, CAT, PET, and SPECT both at a Hospital and Free Standing Facility (Note: See <i>You need prior plan approval for certain services</i> in Section 3) • Other outpatient non-surgical care such as mammograms, laboratory tests and X-rays <p>Note: We cover hospital services and supplies related to dental procedures when necessitated by a non-dental physical impairment. We do not cover the dental procedures.</p>	<p>Participating: 10% coinsurance</p> <p>Non-participating: 40% of our plan allowance and any difference between our allowance and the billed amount</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • Blood and blood derivatives not replaced by the member. 	<p><i>All charges</i></p>

Benefit Description	You pay After the calendar year deductible...
Extended care benefits/Skilled nursing care facility benefits	
<p>Extended care benefit:</p> <p>Up to 60 days per calendar year, including:</p> <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>Participating: 10% coinsurance</p> <p>Non-participating: 40% of our plan allowance and any difference between our allowance and the billed amount</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Custodial care</i> 	<p><i>All charges</i></p>
Hospice care	
<p>Supportive and palliative care for a terminally ill member is covered in the home or hospice facility. Includes:</p> <ul style="list-style-type: none"> • Inpatient and outpatient services and supplies <p>Note: These services must be described in a Hospice Care program that has been approved by us.</p> <p>See <i>You need prior plan approval for certain services</i> in Section 3.</p>	<p>Participating: 10% coinsurance</p> <p>Non-participating: 40% of our plan allowance and any difference between our allowance and the billed amount</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Independent nursing; homemaker services</i> 	<p><i>All charges</i></p>
End of life care	
<p>Personal Nurse provides the following end-of-life support:</p> <ul style="list-style-type: none"> • Hospice coordination • Education and support services • Humana At Home Coordination 	<p>Nothing</p>
Ambulance	
<p>Local professional ambulance service when medically appropriate</p>	<p>10% coinsurance</p>

Section 5(d). Emergency Services/Accidents

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- The calendar year deductible is:
 - Participating providers – You do not have to meet a deductible until your \$1,000 benefit allowance is depleted. The calendar year deductible is \$1,500 for Self Only, (\$3,000 for Self Plus One or Self and Family.) The calendar year deductible applies to almost all benefits in this Section. We added “(No deductible)” to show when the calendar year deductible does not apply.
 - Non-participating providers – The \$1,000 benefit allowance does not apply. The calendar year deductible is \$3,500 for Self Only, (\$7,000 for Self Plus One or Self and Family.) The calendar year deductible applies to almost all benefits in this Section. We added “(No deductible)” to show when the calendar year deductible does not apply.
- After you have satisfied your deductible, your Traditional medical coverage begins.
- Under your Traditional medical coverage, you will be responsible for your coinsurance amounts or copayments for eligible medical expenses and prescriptions.
- Be sure to read Section 4, *Your cost for covered services*, for valuable information about how cost-sharing works. Also, read Section 9 about coordinating benefits with other coverage, including with Medicare.
- **Observation Care:** Your share for hospital observation care that exceeds 24 hours is the same as inpatient hospital care. Observation Care below 24 hours is the same as the Emergency Room benefit/copy.
- Humana will not waive the medical copayments, coinsurance, and deductibles for member when original Medicare is the primary payor. Members must enroll in the Humana Value Plan code associated within the service areas listed on the Value Plan brochure and the Humana Medicare Advantage Plan to receive waivers for medical copayments, coinsurance, and deductibles. See the Value Plan brochure (RI 73-829) for more details.

What is a medical emergency?

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

What to do in case of emergency:

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

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 phone 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 a 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	You pay After the calendar year deductible...
Note: The calendar year deductible applies to almost all benefits in this Section. We say “(No deductible)” when it does not apply.	
Emergency within our service area	CDHP
<ul style="list-style-type: none"> Emergency care at a doctor’s office 	\$40 copay at a primary care physician’s office; \$60 copay at a specialist’s office (no deductible)
<ul style="list-style-type: none"> Emergency care at an urgent care center 	\$60 copay (no deductible)
<ul style="list-style-type: none"> Emergency care as an outpatient at a hospital, including doctors’ services <p>Note: We waive the ER copay if you are admitted to the hospital.</p>	\$250 copay 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>
Emergency outside our service area	CDHP
<ul style="list-style-type: none"> Emergency care at a doctor’s office 	\$40 copay at a primary care physician’s office; \$60 copay at a specialist’s office (no deductible)
<ul style="list-style-type: none"> Emergency care at an urgent care center 	\$60 copay (no deductible)
<ul style="list-style-type: none"> Emergency care as an outpatient at a hospital, including doctors’ services <p>Note: We waive the ER copay if you are admitted to the hospital.</p>	\$250 copay per visit

Emergency outside our service area - continued on next page

Benefit Description	You pay After the calendar year deductible...
Emergency outside our service area (cont.)	CDHP
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Elective care or non-emergency care and follow-up care recommended by non-Plan providers that has not been approved by the Plan or provided by Plan providers</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>
Telehealth services	CDHP
<p>Telemedicine (also known as “telehealth,” “virtual visits” or “video visits”) uses information technology and telecommunications to provide virtual clinical care to patients. Patients can interact with Network Primary/Specialty Care providers through video and app technology by using smartphones, tablets, and laptops.</p> <p>With Humana's telemedicine benefit delivered by Doctor On Demand, you can:</p> <ul style="list-style-type: none"> • Connect with a physician from one of Doctor On Demand’s U.S. board-certified doctors • Immediately see a doctor 24 hours a day, 7 days a week from any location • Your primary care physician can access your telemedicine visit at your request • If medically necessary, the telemedicine doctor can send a prescription to a preferred pharmacy <p>Note: In addition to using Doctor On Demand for telehealth visits, you can talk to other providers to see if they are offering video chat or phone-only visits at normal cost-share.</p>	\$40 copay per visit
Ambulance	CDHP
<p>Professional ambulance service when medically appropriate</p> <p>See Section 5(c) for non-emergency service.</p>	10% coinsurance
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Air ambulance</i> 	All charges

Section 5(e). Mental Health and Substance Use Disorder Benefits

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Copays and coinsurance applies, even after you meet your deductible.
- The calendar year deductible or, for facility care, the inpatient deductible applies to almost all benefits in this Section.
- The calendar year deductible is:
 - Participating providers – You do not have to meet a deductible until your \$1,000 benefit allowance is depleted. The calendar year deductible is \$1,500 for Self Only, (\$3,000 for Self Plus One or Self and Family.) The calendar year deductible applies to almost all benefits in this Section. We added “(No deductible)” to show when the calendar year deductible does not apply.
 - Non-participating providers – The \$1,000 benefit allowance does not apply. The calendar year deductible is \$3,500 for Self Only, (\$7,000 for Self Plus One or Self and Family.) The calendar year deductible applies to almost all benefits in this Section. We added “(No deductible)” to show when the calendar year deductible does not apply.
- Be sure to read Section 4, *Your cost for covered services*, for valuable information about how cost-sharing works. Also, read Section 9 about coordinating benefits with other coverage, including with Medicare.
- **YOUR MENTAL HEALTH PROFESSIONAL MUST GET CERTIFICATION FOR SOME MENTAL HEALTH VISITS AND SERVICES.** Please refer to the precertification information shown in Section 3 to be sure which services require precertification and identify which surgeries require precertification.
- We will provide medical review criteria or reasons for treatment plan denials to enrollees, members or providers upon request or as otherwise required.
- 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.
- Humana will not waive the medical copayments, coinsurance, and deductibles for member when original Medicare is the primary payor. Members must enroll in the Humana Value Plan code associated within the service areas listed on the Value Plan brochure and the Humana Medicare Advantage Plan to receive waivers for medical copayments, coinsurance, and deductibles. See the Value Plan brochure (RI 73-829) for more details.

Benefit Description	You pay After the calendar year deductible...
<p>Note: The calendar year deductible applies to almost all benefits in this Section. We say “(No deductible)” when it does not apply.</p>	
Professional services	CDHP
<p>When part of a treatment plan we approve, we cover professional services by licensed professional mental health and substance use disorder treatment practitioners when acting within the scope of their license, such as psychiatrists, psychologists, clinical social workers, licensed professional counselors, or marriage and family therapists.</p>	<p>Your cost-sharing responsibilities are no greater than for other illnesses or conditions; the cost amount may be determined by the place of service.</p>

Professional services - continued on next page

Benefit Description	You pay After the calendar year deductible...
Professional services (cont.)	CDHP
<p>Diagnosis and treatment of psychiatric conditions, mental illness, or mental disorders. Services include:</p> <ul style="list-style-type: none"> • Diagnostic evaluation • Crisis intervention and stabilization for acute episodes • Medication evaluation and management (pharmacotherapy) • Psychological and neuropsychological testing necessary to determine the appropriate psychiatric treatment • Treatment and counseling (including individual or group therapy visits) • Diagnosis and treatment of substance use disorders, including detoxification, treatment and counseling • Professional charges for intensive outpatient treatment in a provider’s office or other professional setting • Electroconvulsive therapy 	<p>Participating: \$40 copay per visit (no deductible) to a primary care physician</p> <p>Non-participating: 40% of our plan allowance and any difference between our allowance and the billed amount</p>
Diagnostics	CDHP
<ul style="list-style-type: none"> • Outpatient diagnostic tests provided and billed by a licensed mental health and substance use disorder treatment practitioner • Outpatient diagnostic tests provided and billed by a laboratory, hospital or other covered facility • Inpatient diagnostic tests provided and billed by a hospital or other covered facility • Outpatient services, such as: MRI, MRA, CT, PET, and SPECT • Other outpatient non-surgical services 	<p>Participating: 10% coinsurance</p> <p>Non-participating: 40% of our plan allowance and any difference between our allowance and the billed amount</p>
Inpatient hospital or other covered facility	CDHP
<p>Inpatient services provided and billed by a hospital or other covered facility, including residential facilities</p> <ul style="list-style-type: none"> • Room and board, such as semiprivate or intensive accommodations, general nursing care, meals and special diets, and other hospital services, including telemedicine 	<p>Participating: 10% coinsurance</p> <p>Non-participating: 40% of our plan allowance and any difference between our allowance and the billed amount</p>
Outpatient hospital or other covered facility	CDHP
<p>Outpatient services provided and billed by a hospital or other covered facility</p> <ul style="list-style-type: none"> • Services in approved treatment programs, such as partial hospitalization or full-day hospitalization 	<p>Participating: 10% coinsurance</p> <p>Non-participating: 40% of our plan allowance and any difference between our allowance and the billed amount</p>
<ul style="list-style-type: none"> • Facility-based intensive outpatient treatment 	<p>Participating: Nothing</p> <p>Non-participating: 40% of our plan allowance and any difference between our allowance and the billed amount</p>
<p>Telemedicine (also known as “telehealth” or “video visits”) uses information technology and telecommunications to provide virtual clinical care to patients. Patients can interact with providers through video and app technology by using smartphones, tablets, and laptops.</p>	<p>\$40 copay per visit (no deductible)</p>

Outpatient hospital or other covered facility - continued on next page

Benefit Description	You pay After the calendar year deductible...
Outpatient hospital or other covered facility (cont.)	CDHP
<p>With Humana's telemedicine benefit delivered by Doctor On Demand, you can:</p> <ul style="list-style-type: none"> • Connect with a physician from one of Doctor On Demand's U.S. board-certified doctors • Immediately see a doctor 24 hours a day, 7 days a week from any location • Your primary care physician can access your telemedicine visit at your request • If medically necessary, the telemedicine doctor can send a prescription to a preferred pharmacy 	\$40 copay per visit (no deductible)
Applied behavior analysis (ABA) therapy	CDHP
<p>Applied behavior analysis (ABA) therapy for Autism Spectrum Disorder</p>	<p>Participating: \$40 copay per visit (no deductible) to a primary care physician</p> <p>Non-participating: 40% of our plan allowance and any difference between our allowance and the billed amount</p>
Other Services	CDHP
<ul style="list-style-type: none"> • Urgent Care • Physical, Occupational, Speech and Habilitative therapies for Mental Health (Note: See <i>You need prior plan approval for certain services</i> in Section 3) 	<p>\$40 copay (no deductible) to a primary care physician</p> <p>Non-participating: 40% of our plan allowance and any difference between our allowance and the billed amount</p>

Section 5(f). Prescription Drug Benefits

Important things you should keep in mind about these benefits:

- We cover prescribed drugs and medications, as described in the chart beginning on the next page.
- Prescription copayments and coinsurance amounts do not apply to the benefit allowance or the deductibles when using participating pharmacies.
- Please remember that all benefits are subject to the definitions, limitations and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Members must make sure their prescribers obtain prior approval/authorizations for certain prescription drugs and supplies before coverage applies. Prior approval/authorizations must be renewed periodically.
- Federal law prevents the pharmacy from accepting unused medications.
- Be sure to read Section 4, *Your cost for covered services*, for valuable information about how cost-sharing works. Also, read Section 9 about coordinating benefits with other coverage, including with Medicare.
- Humana will not waive the medical copayments, coinsurance, and deductibles for member when original Medicare is the primary payor. Members must enroll in the Humana Value Plan code associated within the service areas listed on the Value Plan brochure and the Humana Medicare Advantage Plan to receive waivers for medical copayments, coinsurance, and deductibles. See the Value Plan brochure (RI 73-829) for more details.

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

- **Who can write your prescription.** A licensed physician or dentist, and in states allowing it, licensed/certified providers with prescriptive authority prescribing within their scope of practice.
- **Where you can obtain them.** You must fill the prescription at a plan pharmacy, or by mail for a prescribed maintenance medication. Maintenance medications are drugs that are generally prescribed for the treatment of long term chronic sicknesses or injuries. Members can also fill their maintenance medications for 90 days at a retail pharmacy for their appropriate copayment.
- **We use a formulary.** We cover non-formulary drugs prescribed by a Plan doctor.
- **The Rx5 Plan** allows members access to appropriate drugs which are used to treat conditions the medical plan covers. Thousands of drugs have been placed in levels based on their a) efficacy, b) safety, c) possible side effects, d) drug interactions, and e) cost compared to similar drugs. New drugs are continually reviewed for level placement, dispensing limits, step therapy and prior authorization requirements that represent the current clinical judgment of our Pharmacy and Therapeutics Committee. Some medications are considered non-formulary because there are other lower cost therapeutic alternatives available on the formulary.

Level One contains/covers Preferred generic and lowest cost generic drugs.

Level Two contains/covers non-Preferred generic and low cost generic drugs.

Level Three contains/covers Preferred brand and higher cost generic drugs.

Level Four contains/covers non-preferred brand and some non-preferred higher cost generic drugs

Level Five contains specialty drugs and includes most self administered injectable medications and high technology drugs that are often newly approved by the U.S. Food and Drug Administration. For some specialty drugs, see *You need prior plan approval for certain services* in Section 3.

With **Rx5** the member takes on more of the cost share for the drug. In return, members receive access to more drugs to treat their conditions and have more choices, along with their physicians, to decide which drug to take. Members receive letters offering guidance in changing medications to those with a lower copayment. We use internal data to identify members for whom a less expensive prescription drug option may be available. We communicate the information to the member to enable them, along with their physician, to make an informed choice regarding prescription drug copayment options.

- **Prior Authorization** – Some medications need special monitoring and may require prior authorization. These drugs have different approval criteria based on indication, safety and appropriate use. Prior authorization (PA) requires a physician to obtain pre-approval in order to provide coverage for a drug prescribed to a member. Visit <http://feds.humana.com> to view the annual drug list for medications that require prior authorization.
- **Step Therapy:** Step Therapy directs therapy to the most cost-effective and safest drug available to be used prior to moving to a more costly or risky therapy. Step Therapy is an automated process and requires the member to try alternative medications before the more costly medications are considered.
- **These are the dispensing limitations.** Prescription drugs dispensed at a Plan pharmacy will be dispensed for up to a 30-day supply. You may receive up to a 90-day supply of a prescribed maintenance medication through our mail-order program or at one of our retail pharmacies. Specialty drugs may be limited to a 30-day supply. You must use dispensing limitations as directed, unless provider instructs otherwise.
- **Why use generic drugs?** Generic medications have the same benefits, ingredients and safety as brand-name medications but without the high dollar cost. With the price of prescription medicine rising, it's nice to find where you can save money without compromising on quality.
- **When you do have to file a claim?** For out of network claims, please contact Humana's customer service for reimbursement.

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

- **Non-formulary.** Medicine(s) are not in your plan's drug list (which means you pay the full cost of the prescription.) Your doctor can ask Humana to make an exception to cover your non-formulary medicine if he or she believes the alternative covered drugs won't be as effective in treating your health condition and/or would cause a bad reaction.
- **A generic equivalent will be dispensed if it is available.** When brand name drugs are purchased and a generic is available, you must pay the difference between the brand name and generic cost plus any applicable brand copay, unless the physician writes "dispense as written" on the prescription. The physician must write "dispense as written" on the prescription for you to receive a brand name drug and only pay the brand name copay, if a generic is available.

You can visit our web site at <http://feds.humana.com> to check the copayment for your prescription drug coverage before you get your prescription filled. You can also find out more about possible drug alternatives and the locations of participating pharmacies.

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

You pay 100% of the dispensing pharmacy charges and file a claim with Humana. The claim is paid at 60% of charges, after the applicable copay.

Benefit Description	You pay
<p>Note: The calendar year deductible applies to almost all benefits in this Section. We say “(No deductible)” when it does not apply.</p>	
Covered medications and supplies	CDHP
<p>We cover the following medications and supplies prescribed by a Plan physician and obtained from a Plan pharmacy or through our mail order program:</p> <ul style="list-style-type: none"> • Drugs and medicines that by Federal law of the United States require a physician’s prescription for their purchase, except those listed as <i>Not covered</i>. • Insulin • Diabetes supplies including testing agents, lancet devices, alcohol swabs, glucose elevating agents, insulin delivery devices, approved blood glucose monitors and disposable needles and syringes for the administration of covered medications • Self administered injectable drugs • Oral fertility drugs • Oral chemo medications • Growth hormone • Drugs for sexual dysfunction • Drugs or drug therapies for the treatment of gender dysphoria supported by FDA approved prescribing information and/or clinical treatment guidelines • Weight loss drugs <p>Note: Blood Glucose Monitors are also covered under Durable Medical Equipment. (See Section 5(a), page 42.)</p> <p>Note: Your cost share for covered orally administered anticancer medications for the treatment of cancer will not exceed \$50 per month supply.</p> <p>Note: Drugs to treat sexual dysfunction are limited. Contact the Plan for dosage limits. You pay the applicable drug copay up to the dosage limits, and all charges after that.</p>	<p>At participating pharmacies:</p> <ul style="list-style-type: none"> \$10 copay for Level One drugs \$45 copay for Level Two drugs \$65 copay for Level Three drugs \$100 copay for Level Four drugs 25% coinsurance for Level Five drugs (specialty drugs may be limited to a 30-day supply) 2.5 applicable copays for a 90-day supply of prescribed maintenance drugs when ordered through our mail-order program <p>At non-participating pharmacies:</p> <ul style="list-style-type: none"> 40% of charges plus applicable copay
<ul style="list-style-type: none"> • Women's contraceptive drugs and devices, including the "morning after pill" • Tobacco Cessation drugs <p>Note: The above over-the-counter drugs and devices approved by the FDA require a written prescription by an approved provider. Some restrictions apply.</p>	<p>Nothing</p>

Covered medications and supplies - continued on next page

Benefit Description	You pay
Covered medications and supplies (cont.)	CDHP
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Drugs and supplies for cosmetic purposes</i> • <i>Drugs to enhance athletic performance</i> • <i>Drugs obtained at a non-Plan pharmacy; except for out-of-area emergencies</i> • <i>Nonprescription medications/medicines</i> <p><i>Note: Over-the-counter and appropriate prescription drugs approved by the FDA to treat tobacco dependence are covered under the Tobacco Cessation program benefits. (See page 43.)</i></p>	<p><i>All charges</i></p>
Preventive care medications	CDHP
<p>The following are covered:</p> <ul style="list-style-type: none"> • Aspirin (81 mg) for men age 45-79 and women age 55-79 and women of childbearing age • Folic acid supplements for women of childbearing age 400 & 800 mcg • Prenatal vitamins for pregnant women • Fluoride tablets, solution (not toothpaste, rinses) for children age 0-6 • Statin Medications for ages 40 years old and older generic forms of atorvastatin, lovastatin and simvastatin • Breast cancer risk reduction medications for women with increased risk for breast cancer • Colonoscopy bowel preparation medications for Adults age 50 to 75 • Prevention of Human Immunodeficiency virus (HIV) Infection – Pre Exposure Prophylaxis (HIV PreP) • Preventive vaccines for children and adults as recommended by the Advisory Committee on Immunization Practices (ACIP) <p>Note: The drugs and supplements listed above are covered without cost-share, even if over-the-counter, are prescribed by a healthcare professional and filled at a network pharmacy.</p> <p>Note: Preventive Medications with a USPSTF recommendation of A or B are covered without cost-share when prescribed by a healthcare professional and filled by a network pharmacy. These may include some over-the-counter vitamins, nicotine replacement medications, and low dose aspirin for certain patients. For current recommendations go to www.uspreventiveservicestaskforce.org/BrowseRec/Index/browse-recommendation</p>	<p>Nothing</p>

Preventive care medications - continued on next page

Benefit Description	You pay
Preventive care medications (cont.)	CDHP
<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, except as listed above</i> • <i>Drugs and supplies for cosmetic purposes (such as Rogaine)</i> • <i>Vitamins, nutrients and food supplements not listed as a covered benefit even if a physician prescribes or administers them, except as listed above</i> • <i>Drugs to enhance athletic performance</i> • <i>Medical supplies such as dressings and antiseptics</i> <p><i>Note: Over-the-counter and appropriate prescription drugs approved by the FDA to treat tobacco dependence are covered under the Tobacco Cessation program benefits. (See page 43)</i></p>	<p><i>All charges</i></p>

Section 5(g). Dental Benefits

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary
- If you are enrolled in a Federal Employee Dental Vision Insurance Program (FEDVIP) Dental Plan, your FEHB plan will be primary payor of any Benefit payments and your FEDVIP Plan is secondary to your FEHB plan. See Section 9 *Coordinating benefits with Medicare and other coverage*.
- Plan dentists must provide or arrange your care.
- The calendar year deductible is:
 - Participating providers – You do not have to meet a deductible until your \$1,000 benefit allowance is depleted. The calendar year deductible is \$1,500 for Self Only, (\$3,000 for Self Plus One or Self and Family.) The calendar year deductible applies to almost all benefits in this Section.
 - Non-participating providers – The \$1,000 benefit allowance does not apply. The calendar year deductible is \$3,500 for Self Only, or (\$7,000 for Self Plus One or Self and Family.) The calendar year deductible applies to almost all benefits in this Section. We added “(No deductible)” to show when the calendar year deductible does not apply.
- After you have satisfied your deductible, your Traditional medical coverage begins.
- Under your Traditional medical coverage, you will be responsible for your coinsurance amounts or copayments for eligible medical expenses and prescriptions.
- We cover hospitalization for dental procedures only when a non-dental physical impairment exists which makes hospitalization necessary to safeguard the health of the patient. See Section 5(c) for *Inpatient hospital* benefits. We do not cover the dental procedure unless it is described below.
- Be sure to read Section 4, *Your cost for covered services*, for valuable information about how cost-sharing works. Also, read Section 9 about *Coordinating benefits with Medicare and other coverage*, including with Medicare.
- Humana will not waive the medical copayments, coinsurance, and deductibles for member when original Medicare is the primary payor. Members must enroll in the Humana Value Plan code associated within the service areas listed on the Value Plan brochure and the Humana Medicare Advantage Plan to receive waivers for medical copayments, coinsurance, and deductibles. See the Value Plan brochure (RI 73-829) for more details.

Benefit Description	You Pay
Accidental injury benefit	CDHP
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.	10% coinsurance after deductible
Dental benefits	CDHP
We have no other dental benefits.	<i>All charges</i>

Section 5. Value Plan Benefits

See page 17 for how our benefits changed this year. Page 131 is the benefits summary. Make sure that you review the benefits that are available under the option in which you are enrolled.

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Section 5. Value Plan Benefits Overview

This Plan offers a Value Plan. The Value Plan benefit package is described in Section 5. Make sure that you review the benefits that are available under the option in which you are enrolled.

The Value Plan Section 5 is divided into subsections. Please read *Important things you should keep in mind* at the beginning of the subsections. Also read the general exclusions in Section 6; they apply to the benefits in the following subsections. To obtain claim forms, claims filing advice, or more information about Value Plan benefits, contact us at 800-4HUMANA or on our website at <https://feds.humana.com/>.

Network Availability

Humana contracts with both private office physicians and with physician groups. Referrals are not required for participating providers. The Value Plan will utilize the National Point of Service (NPOS) network.

Pharmacy

Your pharmacy plan is an Rx5 Plan, which allows members access to appropriate drugs used to treat conditions the medical plan covers. See drug levels listed below:

- **Level One** – preferred generic and lowest-cost generic
- **Level Two** – non-preferred generic and low-cost generic
- **Level Three** – preferred brand and higher-cost generic
- **Level Four** – non-preferred brand and some non-preferred higher-cost generics
- **Level Five** – most self-administered injectable medications and high-technology drugs that are often newly approved by the U.S. Food and Drug Administration.

Check your pharmacy and drug coverage details at MyHumana.com.

[feds.Humana.com](https://feds.humana.com)

Online tools include:

- Newly hired employees can easily navigate their plan choices
- Ability to view benefits and rates available to you based on service area ZIP code
- Learn “What’s New” about Humana’s plan offerings and other health topics
- Enroll in medical plans online
- Educate yourself about Humana’s health and wellness programs
- Find in-network doctors, hospitals and pharmacies near you
- Search Humana’s Drug List for prescription drugs and their estimated retail prices

Medicare Advantage Plan Highlights

If you are a retiree and enroll in the Value Plan and the Medicare Advantage Plan, you will receive a Medicare Part B Premium Reduction.

Medicare Coordination of Benefits: We will reduce the Part B premium that you pay to the Social Security Administration by \$100 per month. If you pay your Part B premium on a monthly basis, you will see this dollar amount credited in your Social Security check. If you pay your Part B premium quarterly, you will see an amount equaling three months of reductions credited on your quarterly Part B premium statement. It may take a few months to see these reductions credited to either your Social Security check or premium statement, but you will be reimbursed for any credits you did not receive during this waiting period.

Medicare Advantage Plan Benefits**Benefit Description: Deductible**

You pay No deductible for this Medicare plan.

Benefit Description: Provider visits

- Primary Care Physician (PCP) visit: You pay \$0 copayment
- Specialist visit: You pay \$0 copayment
- Routine annual physical: You pay \$0 copayment
- Virtual doctor visits: You pay \$0 copayment
- Outpatient Rehabilitation - physical, occupational or speech/language therapy: You pay \$0 copayment
- Urgent care center: You pay \$0 copayment

Benefit Description: Hospital services

- Inpatient hospital: You pay \$0 copayment
- Inpatient mental health: You pay \$0 copayment
- Skilled Nursing Facility: You pay \$0 copayment per day for days 1-20; \$0 copayment per additional day up to 100 days
- Emergency Room: You pay \$0 copayment
- Ambulance: You pay \$0 copayment

Benefit Description: Diagnostic Services

You pay \$0 copayment.

Benefit Description: Hearing Aids

Not covered

Benefit Description: Pharmacy benefits

- 30-day supply: You pay for Tier 1 - \$10; Tier 2 - \$45; Tier 3 - \$65; Tier 4 - \$100; Tier 5 - 25%
- 90-day supply at mail order: You pay for Tier 1 - \$25; Tier 2 - \$112.50; Tier 3 - \$162.50; Tier 4 - \$250; Tier 5 - 25%

SilverSneakers®

An overall wellness program that may help members improve their health and live the life they want. The program gives members access to exercise equipment, classes, and fun social activities at thousands of locations nationwide.

Note: You must have Medicare Part A and Part B, and Medicare must be primary for you to enroll in the Humana Medicare Advantage Plan. This plan reduces your costs by eliminating your cost sharing for covered medical services. Please see Section 9 in this brochure for additional information on how to enroll in this plan and for details on a reimbursement of \$100 of your Medicare Part B premium. You need to retain enrollment in this FEHB plan to be enrolled in the Medicare Advantage Plan.

Section 5(a). Medical Services and Supplies Provided by Physicians and Other Healthcare Professionals

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Copays and coinsurance applies, even after you meet your deductible.
- A facility copay applies to services that appear in this section but are performed in an ambulatory surgical center or the outpatient department of a hospital.
- The calendar year deductible is:
 - Participating providers – The calendar year deductible is \$1,500 for Self Only, (\$3,000 for Self Plus One or Self and Family.) The calendar year deductible applies to almost all benefits in this Section. We added “(No deductible)” to show when the calendar year deductible does not apply.
 - Non-participating providers – The calendar year deductible is \$3,500 for Self Only, (\$7,000 for Self Plus One or Self and Family.) The calendar year deductible applies to almost all benefits in this Section. We added “(No deductible)” to show when the calendar year deductible does not apply.
- Be sure to read Section 4, *Your cost for covered services*, for valuable information about how cost-sharing works. Also, read Section 9 about coordinating benefits with other coverage, including with Medicare.
- Humana will not waive the medical copayments, coinsurance, and deductibles for member when original Medicare is the primary payor. Members must enroll in the Humana Value Plan code associated within the service areas listed on the Value Plan brochure and the Humana Medicare Advantage Plan to receive waivers for medical copayments, coinsurance, and deductibles. See the Value Plan brochure (RI 73-829) for more details.

Benefit Description	You pay After the calendar year deductible...
<p>Note: The calendar year deductible applies to almost all benefits in this Section. We say “(No deductible)” when it does not apply.</p>	
Diagnostic and treatment services	Value Plan
Professional services of physicians <ul style="list-style-type: none"> • In physician’s office • Office medical consultations • At home • Second surgical opinion • Advance care planning 	Participating: \$50 copay per office visit to a primary care physician; \$70 copay per office visit to a specialist (no deductible) Non-participating: 50% of our plan allowance and any difference between our allowance and the billed amount
In an urgent care center	Participating: \$70 copay (no deductible) Non-participating: 50% of our plan allowance and any difference between our allowance and the billed amount
<ul style="list-style-type: none"> • During a hospital stay • In a skilled nursing facility 	Participating: 20% coinsurance Non-participating: 50% of our plan allowance and any difference between our allowance and the billed amount

Benefit Description	You pay After the calendar year deductible...
Telehealth Services	Value Plan
<p>Telemedicine (also known as “telehealth,” “virtual visits” or “video visits”) uses information technology and telecommunications to provide virtual clinical care to patients. Patients can interact with Network Primary/Specialty Care providers through video and app technology by using smartphones, tablets, and laptops.</p> <p>With Humana's telemedicine benefit delivered by Doctor On Demand, you can:</p> <ul style="list-style-type: none"> • Connect with a physician from one of Doctor On Demand’s U.S. board-certified doctors • Immediately see a doctor 24 hours a day, 7 days a week from any location • Your primary care physician can access your telemedicine visit at your request • If medically necessary, the telemedicine doctor can send a prescription to a preferred pharmacy <p>Note: In addition to using Doctor On Demand for telehealth visits, you can talk to other providers to see if they are offering video chat or phone-only visits at normal cost-share.</p>	\$50 copay per visit
Lab, X-ray and other diagnostic tests	Value Plan
<p>Tests, such as:</p> <ul style="list-style-type: none"> • Blood tests • Urinalysis • Non-routine pap test • Pathology • X-ray • Non-routine mammogram • Ultrasound • Electrocardiogram and EEG • Coronary angiography (Note: See You need prior plan approval for certain services in Section 3) 	<p>Participating: 20% coinsurance</p> <p>Non-participating: 50% of our plan allowance and any difference between our allowance and the billed amount</p>
<p>Other tests:</p> <ul style="list-style-type: none"> • Genetic counseling and Genetic testing when medically necessary. (Note: See <i>You need prior plan approval for certain services in Section 3</i>) 	<p>Participating: 20% coinsurance</p> <p>Non-participating: 50% of our plan allowance and any difference between our allowance and the billed amount</p>

Benefit Description	You pay After the calendar year deductible...
<p>Preventive care, adult</p>	<p>Value Plan</p>
<p>Routine physical every year</p> <p>The following preventive services are covered at the time interval recommended at each of the links below:</p> <ul style="list-style-type: none"> • Immunizations such as Pneumococcal, influenza, shingles, tetanus/DTaP, and human papillomavirus (HPV). For a complete list of immunizations go to the Centers for Disease Control (CDC) website at https://www.cdc.gov/vaccines/schedules/ • Screenings such as cancer, osteoporosis, depression, diabetes, high blood pressure, total blood cholesterol, HIV, and colorectal cancer screening. For a complete list of screenings go to the U.S. Preventive Services Task Force (USPSTF) website at https://www.uspreventiveservicestaskforce.org • Individual counseling on prevention and reducing health risks • Well woman care such as Pap smears, gonorrhea prophylactic medication to protect newborns, annual counseling for sexually transmitted infections, contraceptive methods, and screening for interpersonal and domestic violence. For a complete list of Well Women preventive care services please visit the Health and Human Services (HHS) website at https://www.healthcare.gov/preventive-care-women/ • To build your personalized list of preventive services go to https://health.gov/myhealthfinder 	<p>Participating: Nothing</p> <p>Non-participating: 50% of our plan allowance and any difference between our allowance and the billed amount</p>
<ul style="list-style-type: none"> • Routine mammogram – covered for women 	<p>Participating: Nothing</p> <p>Non-participating: 50% of our plan allowance and any difference between our allowance and the billed amount</p>
<ul style="list-style-type: none"> • Adult immunizations endorsed by the Centers for Disease Control and Prevention (CDC): based on the Advisory Committee on Immunization Practices (ACIP) schedule. <p>Note: Any procedure, injection, diagnostic service, laboratory, or X-ray service done in conjunction with a routine examination and is not included in the preventive recommended listing of services will be subject to the applicable member copayments, coinsurance, and deductible.</p>	<p>Participating: Nothing</p> <p>Non-participating: 50% of our plan allowance and any difference between our allowance and the billed amount</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Physical exams required for obtaining or continuing employment or insurance, attending schools or camp, athletic exams or travel.</i> • <i>Immunizations, boosters, and medications for travel or work-related exposure.</i> 	<p><i>All charges</i></p>

Benefit Description	You pay After the calendar year deductible...
<p>Preventive care, children</p> <ul style="list-style-type: none"> Well-child visits, examinations, and other preventive services as described in the Bright Future Guidelines provided by the American Academy of Pediatrics. For a complete list of the American Academy of Pediatrics Bright Futures Guidelines go to https://brightfutures.aap.org Immunizations such as DTaP, Polio, Measles, Mumps, and Rubella (MMR), and Varicella. For a complete list of immunizations go to the Centers for Disease Control (CDC) website at https://www.cdc.gov/vaccines/schedules/index.html You can also find a complete list of preventive care services recommended under the U.S. Preventive Services Task Force (USPSTF) online at https://www.uspreventiveservicestaskforce.org \ <p>Note: Any procedure, injection, diagnostic service, laboratory, or X-ray service done in conjunction with a routine examination and is not included in the preventive recommended listing of services will be subject to the applicable member copayments, coinsurance, and deductible.</p>	<p>Value Plan</p> <p>Participating: Nothing</p> <p>Non-participating: 50% of our plan allowance and any difference between our allowance and the billed amount</p>
<p>Maternity care</p> <p>Complete maternity (obstetrical) care, such as:</p> <ul style="list-style-type: none"> Prenatal care Screening for gestational diabetes for pregnant women Delivery Postnatal care <p>Breastfeeding support, supplies and counseling for each birth</p> <p>Note: Here are some things to keep in mind:</p> <ul style="list-style-type: none"> You do not need to precertify your vaginal delivery; see page 24 for other circumstances, such as extended stays for you or your baby. You may remain in the hospital up to 48 hours after a vaginal delivery and 96 hours after a cesarean delivery. We will extend your inpatient stay for you and/or your baby if medically necessary. We cover routine nursery care of the newborn child during the covered portion of the mother’s maternity stay. We will cover other care of an infant who requires non-routine treatment only if we cover the infant under a Self Plus One or Self and Family enrollment. Surgical benefits, not maternity benefits, apply to circumcision. We pay hospitalization and surgeon services for non-maternity care the same as for illness and injury. Hospital services are covered under Section 5(c) and Surgical benefits Section 5(b). 	<p>Value Plan</p> <p>Participating: Nothing</p> <p>Non-participating: 50% of our plan allowance and any difference between our allowance and the billed amount</p> <p>Facility coinsurance and deductible applies to delivery</p> <p>Participating: Nothing</p> <p>Non-participating: 50% of our plan allowance and any difference between our allowance and the billed amount</p>

Maternity care - continued on next page

Benefit Description	You pay After the calendar year deductible...
Value Plan	
<p>Maternity care (cont.)</p> <p>Note: When a newborn requires definitive treatment during or after the mother’s confinement, the newborn is considered a patient in their own right. If the newborn is eligible for coverage, regular medical or surgical benefits apply rather than maternity benefits.</p> <p>Note: We offer Humana<i>Beginnings</i>. See <i>Special features</i> in Section 5(h).</p>	<p>Participating: Nothing</p> <p>Non-participating: 50% of our plan allowance and any difference between our allowance and the billed amount</p>
Value Plan	
<p>Family planning</p> <p>Contraceptive counseling on an annual basis</p>	<p>Nothing</p>
<p>A range of voluntary family planning services, limited to:</p> <ul style="list-style-type: none"> • Voluntary sterilization (See <i>Surgical procedures</i>, Section 5(b)) • Surgically implanted contraceptives • Injectable contraceptive drugs (such as Depo-Provera) • Intrauterine devices (IUDs) • Diaphragms <p>Note: We cover oral contraceptives under the prescription drug benefit.</p>	<p>Participating: Nothing</p> <p>Non-participating: 50% of our plan allowance and any difference between our allowance and the billed amount</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Reversal of voluntary surgical sterilization</i> 	<p><i>All charges</i></p>
Value Plan	
<p>Infertility services</p> <p>Infertility is the condition of an individual who is unable to conceive or produce conception during a period of 1 year if the female is age 35 or younger or during a period of 6 months if the female is over the age of 35. For women without male partners or exposure to sperm, infertility is the inability to conceive after six cycles of artificial insemination or intrauterine insemination performed by a qualified specialist using normal quality donor sperm. These 6 cycles (including donor sperm) are not covered by the plan as a diagnosis of infertility is not established until the cycles have been completed.</p> <p>Covered benefits including evaluation and treatment:</p> <p>Females - ovulation evaluation, tubal patency, hormonal evaluation, and cervical factor evaluation.</p> <p>Males – includes sperm analysis, hormonal analysis, sperm functioning and medical imaging. Treatment would include correction of any defect found in the evaluation of both male and female partners.</p> <p>Diagnosis and treatment of infertility, such as:</p> <ul style="list-style-type: none"> • Artificial insemination: <ul style="list-style-type: none"> - Intrauterine insemination (IUI) - Intrauterine insemination (IUI) - Intrauterine insemination (IUI) • Fertility drugs 	<p>Participating: 50% of charges</p> <p>Non-participating: 50% up to \$5,000 limit per plan year, of our plan allowance and any difference between our allowance and the billed amount</p>

Infertility services - continued on next page

Benefit Description	You pay After the calendar year deductible...
Value Plan	
<p>Infertility services (cont.)</p> <p>Note: We cover Self-Injectable and oral fertility drugs under the prescription drug benefit. (See <i>You need prior plan approval for certain services</i> in Section 3).</p>	<p>Participating: 50% of charges</p> <p>Non-participating: 50% up to \$5,000 limit per plan year, of our plan allowance and any difference between our allowance and the billed amount</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Assisted reproductive technology (ART) procedures, such as:</i> <ul style="list-style-type: none"> - <i>In vitro fertilization (IVF)</i> - <i>Embryo transfer, gamete intra-fallopian transfer (GIFT) and zygote intra-fallopian transfer (ZIFT)</i> • <i>Services and supplies related to excluded ART procedures</i> • <i>Cost of donor sperm</i> • <i>Cost of donor egg</i> 	<p><i>All charges</i></p>
Value Plan	
<p>Allergy care</p> <p>Testing and treatment</p>	<p>Participating: \$50 copay per office visit to a primary care physician; \$70 copay per office visit to a specialist (no deductible when received in physician’s office)</p> <p>Non-participating: 50% of our plan allowance and any difference between our allowance and the billed amount</p>
<p>Allergy injection</p>	<p>Participating: \$5 copay per visit (no deductible)</p> <p>Non-participating: 50% of our plan allowance and any difference between our allowance and the billed amount</p>
<p>Allergy serum</p>	<p>Participating: Nothing</p> <p>Non-participating: 50% of our plan allowance and any difference between our allowance and the billed amount</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Provocative food testing</i> • <i>Sublingual allergy desensitization</i> 	<p><i>All charges</i></p>
Value Plan	
<p>Treatment therapies</p> <ul style="list-style-type: none"> • <i>Chemotherapy and radiation therapy (Note: See <i>You need prior plan approval for certain services</i> in Section 3)</i> <p>Note: High dose chemotherapy in association with autologous bone marrow transplants is limited to those transplants listed under <i>Organ/ Tissue Transplants</i> on page 86.</p> <p>Note: Oral chemotherapy medications are covered under the Pharmacy benefit. (See Section 5(f) for details)</p>	<p>Participating: 20% coinsurance</p> <p>Non-participating: 50% of our plan allowance and any difference between our allowance and the billed amount</p>

Treatment therapies - continued on next page

Benefit Description	You pay After the calendar year deductible...
Treatment therapies (cont.)	Value Plan
<ul style="list-style-type: none"> • Respiratory and inhalation therapy • Cardiac rehabilitation following qualifying event/condition is provided. No visit limitations apply • Dialysis – hemodialysis and peritoneal dialysis • Intravenous (IV)/Infusion Therapy – Home IV and antibiotic therapy (Note: See <i>You need prior plan approval for certain services</i> in Section 3) • Growth hormone therapy (GHT) <p>Note: Growth hormone is covered under the Prescription Drug benefit.</p> <p>Note: We only cover GHT when we preauthorize the treatment.</p> <p>We will ask you to submit information that establishes that the GHT is medically necessary. Your Plan Physician will ask us to authorize GHT before you begin treatment. We will only cover GHT services and related services and supplies that we determine are medically necessary. See <i>Other services</i> under <i>You need prior Plan approval for certain services</i> on page 21.</p> <p>Note: Applied Behavior Analysis (ABA) children with Autism Spectrum Disorder is described in Section 5(e).</p>	<p>Participating: 20% coinsurance</p> <p>Non-participating: 50% of our plan allowance and any difference between our allowance and the billed amount</p>
Physical, occupational and cardiac therapies	Value Plan
<p>60 visits per condition per year for the services of each of the following:</p> <ul style="list-style-type: none"> • Qualified physical therapists • Occupational therapists <p>Note: We only cover therapy when a physician:</p> <ul style="list-style-type: none"> • orders the care • identifies the specific professional skills the patient requires and the medical necessity for skilled services; and • indicates the length of time the services are needed. <p>Note: See <i>You need prior plan approval for certain services</i> in Section 3.</p>	<p>Participating: \$70 copay per visit to a specialist</p> <p>Non-participating: 50% of our plan allowance and any difference between our allowance and the billed amount</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Long-term rehabilitative therapy</i> • <i>Exercise programs</i> 	<p><i>All charges</i></p>
Speech therapy	Value Plan
<p>60 visits per condition per year for the service of the following:</p> <ul style="list-style-type: none"> • Speech therapists <p>Note: See <i>You need prior plan approval for certain services</i> in Section 3.</p>	<p>Participating: \$70 copay per visit to a specialist</p> <p>Non-participating: 50% of our plan allowance and any difference between our allowance and the billed amount</p>

Benefit Description	You pay After the calendar year deductible...
Hearing services (testing, treatment, and supplies)	
<ul style="list-style-type: none"> For treatment related to illness or injury, including evaluation and diagnostic hearing tests performed by an M.D., D.O., or audiologist Cochlear Implants <ul style="list-style-type: none"> Note: For benefits for the devices, see Section 5(a) - <i>Orthopedic and prosthetic devices</i> 	<p>Value Plan</p> <p>Participating: 20% coinsurance</p> <p>Non-participating: 50% of our plan allowance and any difference between our allowance and the billed amount</p>
<ul style="list-style-type: none"> Hearing screening performed during a child's preventive care visit, see <i>Preventive care, children</i> 	<p>Participating: Nothing</p> <p>Non-participating: 50% of our plan allowance and any difference between our allowance and the billed amount</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> Hearing services that are not shown as covered 	<p><i>All charges</i></p>
Vision services (testing, treatment, and supplies)	
<ul style="list-style-type: none"> Diagnosis and treatment of diseases of the eye 	<p>Participating: \$50 copay per office visit to a primary care physician; \$70 copay per office visit to a specialist (no deductible)</p> <p>Non-participating: 50% of our plan allowance and any difference between our allowance and the billed amount</p>
<ul style="list-style-type: none"> Eye exam to determine the need for vision correction for children through age 17, see Section 5(a) - <i>Preventive care, children</i> 	<p>Participating: Nothing</p> <p>Non-participating: 50% of our plan allowance and any difference between our allowance and the billed amount</p>
<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) 	<p>Participating: 20% coinsurance</p> <p>Non-participating: 50% of our plan allowance and any difference between our allowance and the billed amount</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> Eyeglasses or contact lenses, except as shown above Eye exercises and orthoptics Radial keratotomy and other refractive surgery 	<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>Note: See <i>Orthopedic and prosthetic devices</i> for information on podiatric shoe inserts.</p>	<p>Participating: \$50 copay per office visit to a primary care physician; \$70 copay per office visit to a specialist (no deductible)</p> <p>Non-participating: 50% of our plan allowance and any difference between our allowance and the billed amount</p>

Foot care - continued on next page

Benefit Description	You pay After the calendar year deductible...
Foot care (cont.)	Value Plan
<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, except as stated above</i> • <i>Treatment of weak, strained or flat feet or bunions or spurs; and of any instability, imbalance or subluxation of the foot (unless the treatment is by open cutting surgery)</i> 	<p><i>All charges</i></p>
Orthopedic and prosthetic devices	Value Plan
<ul style="list-style-type: none"> • Artificial limbs and eyes • Prosthetic sleeve or sock • Externally worn breast prostheses and surgical bras, including necessary replacements following a mastectomy • Corrective orthopedic appliances for non-dental treatment of temporomandibular joint (TMJ) pain dysfunction syndrome. • Internal prosthetic devices, such as artificial joints, pacemakers, and surgically implanted breast implant following mastectomy. <p>Note: For information on the professional charges for the surgery to insert an implant, see Section 5(b) <i>Surgical procedures</i>. For information on the hospital and/or ambulatory surgery center benefits, see Section 5 (c) <i>Services provided by a hospital or other facility, and ambulance services</i>.</p>	<p>Participating: 20% coinsurance</p> <p>Non-participating: 50% of our plan allowance and any difference between our allowance and the billed amount</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Orthopedic and corrective shoes, heel pads and heel cups, corsets, trusses</i> • <i>Arch supports, foot orthotics except for diabetes and hammer toe</i> • <i>Elastic stockings, support hose, and other supportive devices not custom made</i> • <i>Prosthetic replacements except as required by growth or change in medical condition, or in the case where the medically necessary repair exceeds the cost replacement or normal wear and tear renders the device nonfunctional and non-repairable</i> 	<p><i>All charges</i></p>
Durable medical equipment (DME)	Value Plan
<p>We cover rental or purchase of durable medical equipment, at our option, including repair and adjustment of purchased medical equipment. Covered items include:</p> <ul style="list-style-type: none"> • Oxygen • Dialysis equipment • Hospital beds • Wheelchairs • Crutches • Walkers • Insulin pumps and supplies 	<p>Participating: 20% coinsurance</p> <p>Non-participating: 50% of our plan allowance and any difference between our allowance and the billed amount</p>

Durable medical equipment (DME) - continued on next page

Benefit Description	You pay After the calendar year deductible...
Value Plan	
<p>Durable medical equipment (DME) (cont.)</p> <ul style="list-style-type: none"> Blood glucose monitors Communication devices <p>Note: Communication devices are covered when there has been surgical removal of the larynx or a diagnosis of permanent lack of function of the larynx, additional criteria may need to be met.</p> <p>Note: Preauthorization is necessary for items over \$750. See <i>You need prior plan approval for certain services</i> in Section 3.</p> <p>Note: Call customer service at 1-800-4HUMANA as soon as your Plan physician prescribes this equipment. We will arrange with a healthcare provider to rent or sell you durable medical equipment at discounted rates and will tell you more about this service when you call.</p>	<p>Participating: 20% coinsurance</p> <p>Non-participating: 50% of our plan allowance and any difference between our allowance and the billed amount</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> Equipment such as exercise equipment, air cleaners, heating pads or lights and bed lifts, hearing aids, personnel hygiene equipment Communication devices, except after surgical removal of the larynx or a diagnosis of permanent lack of function of the larynx, additional criteria may need to be met. 	<p><i>All charges</i></p>
Value Plan	
<p>Home health services</p> <ul style="list-style-type: none"> Home healthcare ordered by a Plan physician and provided by a registered nurse (R.N.), licensed practical nurse (L.P.N.), licensed vocational nurse (L.V.N.), or home health aide. Services include oxygen therapy, intravenous therapy and medications. <p>Note: See <i>You need prior plan approval for certain services</i> in Section 3.</p>	<p>Participating: 20% coinsurance</p> <p>Non-participating: 50% of our plan allowance and any difference between our allowance and the billed amount</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> Nursing care requested by, or for the convenience of, the patient or the patient's family. Home care primarily for personal assistance that does not include a medical component and is not diagnostic, therapeutic, or rehabilitative. Private duty nurse 	<p><i>All charges</i></p>
Value Plan	
<p>Chiropractic</p> <ul style="list-style-type: none"> Manipulation of the spine and extremities <p><i>Adjunctive procedures such as ultrasound, electrical muscle stimulation, vibratory therapy, and cold pack application</i></p> <p>Note: See <i>You need prior plan approval for certain services</i> in Section 3.</p>	<p>Participating: \$70 copay per office visit (no deductible) to a specialist</p> <p>Non-participating: 50% of our plan allowance and any difference between our allowance and the billed amount</p>

Benefit Description	You pay After the calendar year deductible...
Alternative treatments	Value Plan
<p>Acupuncture – by a licensed acupuncturist for:</p> <ul style="list-style-type: none"> • anesthesia • pain relief <p>Note: See <i>You need prior plan approval for certain services</i> in Section 3.</p>	<p>Participating: \$70 copay per office visit (no deductible) to a specialist</p> <p>Non-participating: 50% of our plan allowance and any difference between our allowance and the billed amount</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Naturopathic services</i> • <i>Hypnotherapy</i> • Biofeedback 	<p>All charges</p>
Educational classes and programs	Value Plan
<p>Coverage is provided for:</p> <ul style="list-style-type: none"> • Tobacco Cessation program, including individual/group/telephone counseling, over-the-counter (OTC) and prescription drugs approved by the FDA to treat tobacco dependence • Childhood obesity education 	<p>Participating: Nothing</p> <p>Nothing for counseling for up to two (2) quit attempts per year with up to four (4) tobacco cessation counseling sessions per quit attempt</p> <p>Nothing for OTC and prescription drugs approved by the FDA to treat tobacco dependence</p> <p>Non-participating: 50% of our plan allowance and any difference between our allowance and the billed amount</p>
<ul style="list-style-type: none"> • Diabetes self management training 	<p>Participating: \$50 copay per office visit to a primary care physician; \$70 copay per office visit to a specialist (no deductible)</p> <p>Non-participating: 50% of our plan allowance and any difference between our allowance and the billed amount</p>

Section 5(b). Surgical and Anesthesia Services Provided by Physicians and Other Healthcare Professionals

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Copays and coinsurance applies, even after you meet your deductible.
- The calendar year deductible is:
 - Participating providers - The calendar year deductible is \$1,500 for Self Only, or (\$3,000 for Self Plus One or Self and Family.) The calendar year deductible applies to almost all benefits in this Section. We added “(No deductible)” to show when the calendar year deductible does not apply.
 - Non-participating providers - The calendar year deductible is \$3,500 for Self Only, or (\$7,000 for Self Plus One or Self and Family.) The calendar year deductible applies to almost all benefits in this Section. We added “(No deductible)” to show when the calendar year deductible does not apply.
- Be sure to read Section 4, *Your cost 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 services listed below are for the charges billed by a physician or other healthcare professional for your surgical care. See Section 5(c) for charges associated with a facility (i.e. hospital, surgical center, etc.).
- **YOUR PHYSICIAN MUST GET PRECERTIFICATION FOR SOME SURGICAL PROCEDURES.** Please refer to the precertification information shown in Section 3 to be sure which services require precertification and identify which surgeries require precertification.
- Humana will not waive the medical copayments, coinsurance, and deductibles for member when original Medicare is the primary payor. Members must enroll in the Humana Value Plan code associated within the service areas listed on the Value Plan brochure and the Humana Medicare Advantage Plan to receive waivers for medical copayments, coinsurance, and deductibles. See the Value Plan brochure (RI 73-829) for more details.

Benefit Description	You pay After the calendar year deductible...
<p>Note: The calendar year deductible applies to almost all benefits in this Section. We say “(No deductible)” when it does not apply.</p>	
Surgical procedures	Value Plan
<p>A comprehensive range of services, such as:</p> <ul style="list-style-type: none"> • Operative procedures • Treatment of fractures, including casting • Normal pre- and post-operative care by the surgeon • Correction of amblyopia and strabismus • Endoscopy procedures • Biopsy procedures • Removal of tumors and cysts • Correction of congenital anomalies (see Reconstructive surgery) • Insertion of internal prosthetic devices. See Section 5(a) Orthopedic and prosthetic devices for device coverage information • Treatment of burns 	<p>Participating: 20% coinsurance</p> <p>Non-participating: 50% of our plan allowance and any difference between our allowance and the billed amount</p>

Benefit Description	You pay After the calendar year deductible...
Surgical procedures (cont.)	
<ul style="list-style-type: none"> • Voluntary sterilization (e.g., Tubal ligation, Vasectomy) • Surgical treatment for morbid obesity (bariatric surgery). (Note: See You need prior plan approval for certain services in Section 3.) Some of the requirements that must be met before surgery can be authorized are: <ul style="list-style-type: none"> - Patient is 18 years of age or older - Body Mass Index of >40, or a Body Mass Index of >35 with associated comorbidity such as: <ul style="list-style-type: none"> • Hypertension • Type two diabetes • Life-threatening cardiopulmonary problems - Physician's documentation which indicates that you have had unsuccessful attempt(s) with nonoperative medically supervised weight-reduction program(s) • Esophagogastroduodenoscopy (EGD) (Note: See You need prior plan approval for certain services in Section 3) • Colonoscopy repeat testing (Note: See You need prior plan approval for certain services in Section 3) <p>Note: Generally, we pay for internal prostheses (devices) according to where the procedure is done. For example, we pay Hospital benefits for a pacemaker and Surgery benefits for insertion of the pacemaker.</p>	<p style="text-align: center;">Value Plan</p> <p>Participating: 20% coinsurance</p> <p>Non-participating: 50% of our plan allowance and any difference between our allowance and the billed amount</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Reversal of voluntary sterilization</i> • <i>Radial keratotomy and other refractive surgery</i> • <i>Routine treatment of conditions of the foot (See 5(a) Foot Care)</i> 	<p><i>All charges</i></p>
Reconstructive surgery	
<ul style="list-style-type: none"> • Surgery to correct a functional defect • Surgery to correct a condition caused by injury or illness if: <ul style="list-style-type: none"> - the condition produced a major effect on the member's appearance and - the condition can reasonably be expected to be corrected by such surgery • Surgery to correct a condition that existed at or from birth and that is a significant deviation from the common form or norm. Examples of congenital anomalies are: protruding ear deformities; cleft lip; cleft palate; birth marks; webbed fingers and webbed toes. • All stages of breast reconstruction surgery following a mastectomy, such as: <ul style="list-style-type: none"> - Surgery to produce a symmetrical appearance of breasts; - Treatment of any physical complications, such as lymphedemas; - Breast prostheses and surgical bras and replacements (see Orthopedic and Prosthetic devices) 	<p style="text-align: center;">Value Plan</p> <p>Participating: 20% coinsurance</p> <p>Non-participating: 50% of our plan allowance and any difference between our allowance and the billed amount</p>

Reconstructive surgery - continued on next page
Value Plan Section 5 (b)

Benefit Description	You pay After the calendar year deductible...
Reconstructive surgery (cont.)	
<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> <ul style="list-style-type: none"> • Gender reassignment surgery performed to change primary and/or secondary sex characteristics <ul style="list-style-type: none"> - Surgical treatment for gender reassignment is limited to the following: <ul style="list-style-type: none"> • For female to male surgery: mastectomy, hysterectomy, vaginectomy, salpingo-oophorectomy • For male to female surgery: penectomy, orchiectomy <p>Note: You must be 18 years or older to be considered for genital reconstruction surgery. There are pre-surgical requirements for members considering gender reassignment surgery including but not limited to: a documented diagnosis of gender dysphoria, 12 months of hormone therapy as appropriate to the individual gender goals, and referral letters from a mental health specialist.</p>	<p>Value Plan</p> <p>Participating: 20% coinsurance</p> <p>Non-participating: 50% of our plan allowance and any difference between our allowance and the billed amount</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <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 (Note: See You need prior plan approval for certain services in Section 3)</i> • <i>Any surgical procedure for gender reassignment not listed above</i> 	<p><i>All charges</i></p>
Oral and maxillofacial surgery	
<p>Oral surgical procedures, limited to:</p> <ul style="list-style-type: none"> • Reduction of fractures of the jaws or facial bones; • Surgical correction of cleft lip, cleft palate or severe functional malocclusion; • Removal of stones from salivary ducts; • Excision of leukoplakia or malignancies; • Excision of cysts and incision of abscesses when done as independent procedures; • Excision of partially or completely impacted teeth; and • Other surgical procedures that do not involve the teeth or their supporting structures. 	<p>Value Plan</p> <p>Participating: 20% coinsurance</p> <p>Non-participating: 50% of our plan allowance and any difference between our allowance and the billed amount</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Dental work related to treatment of temporomandibular joint syndrome (TMJ)</i> • <i>Oral implants and transplants</i> • <i>Procedures that involve the teeth or their supporting structures (such as the periodontal membrane, gingiva, and alveolar bone)</i> 	<p><i>All charges</i></p>

Benefit Description	You pay After the calendar year deductible...
<p>Organ/tissue transplants</p> <p>These solid organ transplants are covered. Solid organ transplants are limited to:</p> <ul style="list-style-type: none"> • Autologous pancreas islet cell transplant (as an adjunct to total or near total pancreatectomy) only for patients with chronic pancreatitis • Cornea • Heart • Heart/lung • Intestinal transplants <ul style="list-style-type: none"> - Isolated small intestine - Small intestine with the liver - Small intestine with multiple organs, such as the liver, stomach, and pancreas • Kidney • Kidney-pancreas • Liver • Lung: single/bilateral/lobar • Pancreas 	<p>Value Plan</p> <p>Participating: 20% coinsurance</p> <p>Non-participating: 50% of our plan allowance and any difference between our allowance and the billed amount</p> <p>Non-participating transplant services do not apply toward the maximum out-of-pocket expense limit.</p>
<p>These tandem blood or marrow stem cell transplants for covered transplants are subject to medical necessity review by the Plan. Refer to <i>Other services</i> in Section 3 for prior authorization procedures.</p> <ul style="list-style-type: none"> • Autologous tandem transplants for <ul style="list-style-type: none"> - AL Amyloidosis - Multiple myeloma (de novo and treated) - Recurrent germ cell tumors (including testicular cancer) 	<p>Participating: 20% coinsurance</p> <p>Non-participating: 50% of our plan allowance and any difference between our allowance and the billed amount</p> <p>Non-participating transplant services do not apply toward the maximum out-of-pocket expense limit.</p>
<p>Blood or marrow stem cell transplants</p> <p>The Plan extends coverage for the diagnoses as indicated below.</p> <ul style="list-style-type: none"> • Allogeneic transplants for <ul style="list-style-type: none"> - Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia - Acute myeloid leukemia - Advanced Hodgkin’s lymphoma with recurrence (relapsed) - Advanced Myeloproliferative Disorders (MPDs) - Advanced neuroblastoma - Advanced non-Hodgkin’s lymphoma with recurrence (relapsed) - Amyloidosis - Chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL) - Hemoglobinopathy - Infantile malignant osteopetrosis - Kostmann’s syndrome 	<p>Participating: 20% coinsurance</p> <p>Non-participating: 50% of our plan allowance and any difference between our allowance and the billed amount</p> <p>Non-participating transplant services do not apply toward the maximum out-of-pocket expense limit.</p>

Organ/tissue transplants - continued on next page

Benefit Description	You pay After the calendar year deductible...
<p>Organ/tissue transplants (cont.)</p> <ul style="list-style-type: none"> - Leukocyte adhesion deficiencies - Marrow failure and related disorders (i.e., Fanconi’s, Paroxysmal Nocturnal Hemoglobinuria, Pure Red Cell Aplasia) - Mucopolysaccharidosis (e.g., Gaucher’s disease, metachromatic leukodystrophy, adrenoleukodystrophy) - Mucopolysaccharidosis (e.g., Hunter’s syndrome, Hurler’s syndrome, Sanfillippo’s syndrome, Maroteaux-Lamy syndrome variants) - Myelodysplasia/Myelodysplastic syndromes - Paroxysmal Nocturnal Hemoglobinuria - Phagocytic/Hemophagocytic deficiency diseases (e.g., Wiskott-Aldrich syndrome) - Severe combined immunodeficiency - Severe or very severe aplastic anemia - Sickle cell anemia - X-linked lymphoproliferative syndrome • Autologous transplants for <ul style="list-style-type: none"> - Acute lymphocytic or nonlymphocytic (i.e., myelogenous) leukemia - Advanced Hodgkin’s lymphoma with recurrence (relapsed) - Advanced non-Hodgkin’s lymphoma with recurrence (relapsed) - Amyloidosis - Breast Cancer - Ependyblastoma - Epithelial ovarian cancer - Ewing’s sarcoma - Medulloblastoma - Multiple myeloma - Neuroblastoma - Pineoblastoma - Testicular, Mediastinal, Retroperitoneal, and Ovarian germ cell tumors 	<p>Value Plan</p> <p>Participating: 20% coinsurance</p> <p>Non-participating: 50% of our plan allowance and any difference between our allowance and the billed amount</p> <p>Non-participating transplant services do not apply toward the maximum out-of-pocket expense limit.</p>
<p>Mini-transplants performed in a clinical trial setting (non-myeloablative, reduced intensity conditioning or RIC) for members with a diagnosis listed below are subject to medical necessity review by the Plan.</p> <p>Refer to <i>Other services</i> in Section 3 for prior authorization procedures:</p> <ul style="list-style-type: none"> • Allogeneic transplants for <ul style="list-style-type: none"> - Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia - Advanced Hodgkin’s lymphoma with recurrence (relapsed) 	<p>Participating: 20% coinsurance</p> <p>Non-participating: 50% of our plan allowance and any difference between our allowance and the billed amount</p> <p>Non-participating transplant services do not apply toward the maximum out-of-pocket expense limit.</p>

Organ/tissue transplants - continued on next page

Benefit Description	You pay After the calendar year deductible...
<p>Organ/tissue transplants (cont.)</p> <ul style="list-style-type: none"> - Advanced non-Hodgkin’s lymphoma with recurrence (relapsed) - Acute myeloid leukemia - Advanced Myeloproliferative Disorders (MPDs) - Amyloidosis - Chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL) - Hemoglobinopathy - Marrow failure and related disorders (i.e., Fanconi’s, Paroxysmal Nocturnal Hemoglobinuria, Pure Red Cell Aplasia) - Myelodysplasia/Myelodysplastic syndromes - Paroxysmal Nocturnal Hemoglobinuria - Severe combined immunodeficiency - Severe or very severe aplastic anemia • Autologous transplants for <ul style="list-style-type: none"> - Acute lymphocytic or nonlymphocytic (i.e., myelogenous) leukemia - Advanced Hodgkin’s lymphoma with recurrence (relapsed) - Advanced non-Hodgkin’s lymphoma with recurrence (relapsed) - Amyloidosis - Neuroblastoma 	<p>Value Plan</p> <p>Participating: 20% coinsurance</p> <p>Non-participating: 50% of our plan allowance and any difference between our allowance and the billed amount</p> <p>Non-participating transplant services do not apply toward the maximum out-of-pocket expense limit.</p>
<p>These blood or marrow stem cell transplants are covered only in a National Cancer Institute or National Institutes of Health approved clinical trial or a Plan-designated center of excellence if approved by the Plan's medical director in accordance with the Plan's protocol.</p> <p>If you are a participant in a clinical trial, the Plan will provide benefits for related routine care that is medically necessary (such as doctor visits, lab tests, X-rays and scans, and hospitalization related to treating the patient’s condition) if it is not provided by the clinical trial. Section 9 has additional information on costs related to clinical trials. We encourage you to contact the Plan to discuss specific services if you participate in a clinical trial.</p> <ul style="list-style-type: none"> • Allogeneic transplants for <ul style="list-style-type: none"> - Advanced Hodgkin’s lymphoma - Advanced non-Hodgkin’s lymphoma - Beta Thalassemia Major - Chronic inflammatory demyelination polyneuropathy (CIDP) - Early stage (indolent or non-advanced) small cell lymphocytic lymphoma - Multiple myeloma - Multiple sclerosis - Sickle cell anemia 	<p>Participating: 20% coinsurance</p> <p>Non-participating: 50% of our plan allowance and any difference between our allowance and the billed amount</p> <p>Non-participating transplant services do not apply toward the maximum out-of-pocket expense limit.</p>

Organ/tissue transplants - continued on next page

Benefit Description	You pay After the calendar year deductible...
Organ/tissue transplants (cont.)	Value Plan
<ul style="list-style-type: none"> • Mini-transplants (non-myeloablative allogeneic, reduced intensity conditioning or RIC) for <ul style="list-style-type: none"> - Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia - Advanced Hodgkin’s lymphoma - Advanced non-Hodgkin’s lymphoma - Breast cancer - Chronic lymphocytic leukemia - Chronic lymphocytic lymphoma/small lymphocytic lymphoma (CLL/SLL) - Chronic myelogenous leukemia - Colon cancer - Early stage (indolent or non-advanced) small cell lymphocytic lymphoma - Multiple myeloma - Multiple sclerosis - Myelodysplasia/Myelodysplastic Syndromes - Myeloproliferative disorders (MPDs) - Non-small cell lung cancer - Ovarian cancer - Prostate cancer - Renal cell carcinoma - Sarcomas - Sickle cell anemia • Autologous Transplants for <ul style="list-style-type: none"> - Advanced childhood kidney cancers - Advanced Ewing sarcoma - Advanced Hodgkin’s lymphoma - Advanced non-Hodgkin’s lymphoma - Aggressive non-Hodgkin’s lymphoma - Breast cancer - Childhood rhabdomyosarcoma - Chronic lymphocytic lymphoma/small lymphocytic lymphoma (CLL/SLL) - Chronic myelogenous leukemia - Early stage (indolent or non-advanced) small cell lymphocytic lymphoma - Epithelial ovarian cancer - Mantle cell (non-Hodgkin lymphoma) - Multiple sclerosis 	<p>Participating: 20% coinsurance</p> <p>Non-participating: 50% of our plan allowance and any difference between our allowance and the billed amount</p> <p>Non-participating transplant services do not apply toward the maximum out-of-pocket expense limit.</p>

Organ/tissue transplants - continued on next page

Benefit Description	You pay After the calendar year deductible...
<p>Organ/tissue transplants (cont.)</p> <ul style="list-style-type: none"> - Small cell lung cancer - Systemic lupus erythematosus - Systemic sclerosis <p>Benefits are available for Allogeneic and Autologous blood or marrow stem cell transplants utilizing a phase two or higher protocol.</p> <p>National Transplant Program (NTP) - all services are determined and authorized through our transplant department, utilizing our National Transplant Network.</p> <p>Note: We cover related medical and hospital expenses of the donor when we cover the recipient. We cover donor testing for the actual solid organ donor or up to four bone marrow/stem cell transplant donors in addition to the testing of family members.</p> <p>Note: See <i>You need prior plan approval for certain services</i> in Section 3.</p>	<p>Value Plan</p> <p>Participating: 20% coinsurance</p> <p>Non-participating: 50% of our plan allowance and any difference between our allowance and the billed amount</p> <p>Non-participating transplant services do not apply toward the maximum out-of-pocket expense limit.</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • Donor screening tests and donor search expenses, except as shown above • Implants of artificial organs • Transplants not listed as covered 	<p><i>All charges</i></p>
<p>Anesthesia</p> <p>Professional services provided in –</p> <ul style="list-style-type: none"> • Hospital (inpatient) • Hospital outpatient department • Skilled nursing facility • Ambulatory surgical center • Office 	<p>Value Plan</p> <p>Participating: 20% coinsurance</p> <p>Non-participating: 50% of our plan allowance and any difference between our allowance and the billed amount</p>

Section 5(c). Services Provided by a Hospital or Other Facility, and Ambulance Services

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Copays and coinsurance applies, even after you meet your deductible.
- The calendar year deductible is:
 - Participating providers – The calendar year deductible is \$1,500 for Self Only, (\$3,000 for Self Plus One or Self and Family.) The calendar year deductible applies to almost all benefits in this Section. We added “(No deductible)” to show when the calendar year deductible does not apply.
 - Non-participating providers – The calendar year deductible is \$3,500 for Self Only, (\$7,000 for Self Plus One or Self and Family.) The calendar year deductible applies to almost all benefits in this Section. We added “(No deductible)” to show when the calendar year deductible does not apply.
- Be sure to read Section 4, *Your cost 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 in Sections 5(a) or (b).
- **YOUR PHYSICIAN MUST GET PRECERTIFICATION FOR HOSPITAL STAYS.** Please refer to Section 3 to be sure which services require precertification.
- **Observation Care:** Your share for hospital observation care that exceeds 24 hours is the same as inpatient hospital care. Observation Care below 24 hours is the same as the Emergency Room benefit/copy.
- Humana will not waive the medical copayments, coinsurance, and deductibles for member when original Medicare is the primary payor. Members must enroll in the Humana Value Plan code associated within the service areas listed on the Value Plan brochure and the Humana Medicare Advantage Plan to receive waivers for medical copayments, coinsurance, and deductibles. See the Value Plan brochure (RI 73-829) for more details.

Benefit Description	You pay After the calendar year deductible...
NOTE: The calendar year deductible applies to almost all benefits in this section. We say "no deductible" when the deductible does not apply.	
Inpatient hospital	Value Plan
Room and board, such as <ul style="list-style-type: none"> • Ward, semiprivate, or intensive care accommodations • General nursing care • Meals and special diets Note: If you want a private room when it is not medically necessary, you pay the additional charge above the semiprivate room rate. Other hospital services and supplies, such as: <ul style="list-style-type: none"> • Operating, recovery, maternity, and other treatment rooms • Prescribed drugs and medications • Diagnostic laboratory tests and X-rays 	Participating: 20% coinsurance Non-participating: 50% of our plan allowance and any difference between our allowance and the billed amount

Inpatient hospital - continued on next page
Value Plan Section 5(c)

Benefit Description	You pay After the calendar year deductible...
Inpatient hospital (cont.)	
<ul style="list-style-type: none"> • 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. 	<p>Participating: 20% coinsurance</p> <p>Non-participating: 50% of our plan allowance and any difference between our allowance and the billed amount</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • Custodial care • Non-covered facilities, such as nursing homes, schools • Personal comfort items, such as phone, television, barber services, guest meals and beds • Blood and blood components not replaced 	<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 medications • Diagnostic laboratory tests, X-rays, and pathology services • Administration of blood, blood plasma, and other biologicals • Pre-surgical testing • Dressings, casts, and sterile tray services • Medical supplies, including oxygen • Anesthetics and anesthesia service • Outpatient Hospital Services such as: MRI, MRA, CAT, PET, and SPECT both at a Hospital and Free Standing Facility (Note: See <i>You need prior plan approval for certain services</i> in Section 3) • Other outpatient non-surgical care such as mammograms, laboratory tests and X-rays <p>Note: We cover hospital services and supplies related to dental procedures when necessitated by a non-dental physical impairment. We do not cover the dental procedures.</p>	<p>Participating: 20% coinsurance</p> <p>Non-participating: 50% of our plan allowance and any difference between our allowance and the billed amount</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • Blood and Blood derivatives not replaced by the member. 	<p><i>All charges</i></p>
Extended care benefits/Skilled nursing care facility benefits	
<p>Extended care benefit:</p> <p>Up to 60 days per calendar year, including:</p> <ul style="list-style-type: none"> • Bed and board • General nursing care • Drugs, biologicals, supplies and equipment provided by the facility 	<p>Participating: 20% coinsurance</p> <p>Non-participating: 50% of our plan allowance and any difference between our allowance and the billed amount</p>

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

Benefit Description	You pay After the calendar year deductible...
Extended care benefits/Skilled nursing care facility benefits (cont.)	Value Plan
<p>Note: Coverage is provided when full-time skilled nursing care is necessary and confinement in a skilled nursing facility is medically appropriate as determined by a Plan doctor and approved by the Plan.</p>	<p>Participating: 20% coinsurance</p> <p>Non-participating: 50% of our plan allowance and any difference between our allowance and the billed amount</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Custodial care</i> 	<p><i>All charges</i></p>
Hospice care	Value Plan
<p>Supportive and palliative care for a terminally ill member is covered in the home or hospice facility. Includes:</p> <ul style="list-style-type: none"> • Inpatient and outpatient services and supplies <p>Note: These services must be described in a Hospice Care program that has been approved by us.</p> <p>See <i>You need prior plan approval for certain services</i> in Section 3.</p>	<p>Participating: 20% coinsurance</p> <p>Non-participating: 50% of our plan allowance and any difference between our allowance and the billed amount</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Independent nursing, homemaker services</i> 	<p><i>All charges</i></p>
End of life care	Value Plan
<p>Personal Nurse provides the following end-of-life support:</p> <ul style="list-style-type: none"> • Hospice coordination • Education and support services • Humana At Home Coordination 	<p>Nothing</p>
Ambulance	Value Plan
<p>Local professional ambulance service when medically appropriate</p>	<p>20% coinsurance</p>

Section 5(d). Emergency Services/Accidents

Important things to keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Copays and coinsurance applies, even after you meet your deductible.
- The calendar year deductible is:
 - Participating providers – The calendar year deductible is \$1,500 for Self Only, (\$3,000 for Self Plus One or Self and Family.) The calendar year deductible applies to almost all benefits in this Section. We added “(No deductible)” to show when the calendar year deductible does not apply.
 - Non-participating providers – The calendar year deductible is \$3,500 for Self Only, (\$7,000 for Self Plus One or Self and Family.) The calendar year deductible applies to almost all benefits in this Section. We added “(No deductible)” to show when the calendar year deductible does not apply.
- Be sure to read Section 4, *Your cost for covered services*, for valuable information about how cost-sharing works. Also, read Section 9 about coordinating benefits with other coverage, including with Medicare.
- **Observation Care:** Your share for hospital observation care that exceeds 24 hours is the same as inpatient hospital care. Observation Care below 24 hours is the same as the Emergency Room benefit/copay.
- Humana will not waive the medical copayments, coinsurance, and deductibles for member when original Medicare is the primary payor. Members must enroll in the Humana Value Plan code associated within the service areas listed on the Value Plan brochure and the Humana Medicare Advantage Plan to receive waivers for medical copayments, coinsurance, and deductibles. See the Value Plan brochure (RI 73-829) for more details.

What is a medical emergency?

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

What to do in case of emergency:

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

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 phone 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 a 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	You pay After the calendar year deductible...
NOTE: The calendar year deductible applies to almost all benefits in this section. We say "no deductible" when the deductible does not apply.	
Emergency within our service area	Value Plan
<ul style="list-style-type: none"> Emergency care at a doctor’s office 	\$50 copay at a primary care physician’s office; \$70 copay at a specialist’s office (no deductible)
<ul style="list-style-type: none"> Emergency care at an urgent care center 	\$70 copay (no deductible)
<ul style="list-style-type: none"> Emergency care as an outpatient at a hospital, including doctors’ services <p>Note: We waive the ER copay if you are admitted to the hospital.</p>	\$350 copay 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>
Emergency outside our service area	Value Plan
<ul style="list-style-type: none"> Emergency care at a doctor’s office 	\$50 copay at a primary care physician’s office; \$70 copay at a specialist’s office (no deductible)
<ul style="list-style-type: none"> Emergency care at an urgent care center 	\$70 copay (no deductible)
<ul style="list-style-type: none"> Emergency care as an outpatient at a hospital, including doctors’ services <p>Note: We waive the ER copay if you are admitted to the hospital.</p>	\$350 copay per visit

Emergency outside our service area - continued on next page

Benefit Description	You pay After the calendar year deductible...
Value Plan	
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Elective care or non-emergency care and follow-up care recommended by non-Plan providers that has not been approved by the Plan or provided by Plan providers</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> 	<p><i>All charges</i></p>
Value Plan	
<p>Telehealth services</p> <p>Telemedicine (also known as “telehealth,” “virtual visits” or “video visits”) uses information technology and telecommunications to provide virtual clinical care to patients. Patients can interact with Network Primary/Specialty Care providers through video and app technology by using smartphones, tablets, and laptops.</p> <p>With Humana's telemedicine benefit delivered by Doctor On Demand, you can:</p> <ul style="list-style-type: none"> • Connect with a physician from one of Doctor On Demand’s U.S. board-certified doctors • Immediately see a doctor 24 hours a day, 7 days a week from any location • Your primary care physician can access your telemedicine visit at your request • If medically necessary, the telemedicine doctor can send a prescription to a preferred pharmacy <p>Note: In addition to using Doctor On Demand for telehealth visits, you can talk to other providers to see if they are offering video chat or phone-only visits at normal cost-share.</p>	<p>\$50 copay per visit</p>
Value Plan	
<p>Ambulance</p> <p>Professional ambulance service when medically appropriate</p> <p>Note: See Section 5(c) for non-emergency service.</p>	<p>20% coinsurance</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Air ambulance</i> 	<p>All charges</p>

Section 5(e). Mental Health and Substance Use Disorder Benefits

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Copays and coinsurance applies, even after you meet your deductible.
- The calendar year deductible or, for facility care, the inpatient deductible applies to almost all benefits in this Section.
- The calendar year deductible is:
 - Participating providers – The calendar year deductible is \$1,500 for Self Only, (\$3,000 for Self Plus One or Self and Family.) The calendar year deductible applies to almost all benefits in this Section. We added “(No deductible)” to show when the calendar year deductible does not apply.
 - Non-participating providers – The calendar year deductible is \$3,500 for Self Only, (\$7,000 for Self Plus One or Self and Family.) The calendar year deductible applies to almost all benefits in this Section. We added “(No deductible)” to show when the calendar year deductible does not apply.
- Be sure to read Section 4, *Your cost for covered services*, for valuable information about how cost-sharing works. Also, read Section 9 about coordinating benefits with other coverage, including with Medicare.
- **YOUR MENTAL HEALTH PROFESSIONAL MUST GET CERTIFICATION FOR SOME MENTAL HEALTH VISITS AND SERVICES.** Please refer to the precertification information shown in Section 3 to be sure which services require precertification and identify which surgeries require precertification.
- We will provide medical review criteria or reasons for treatment plan denials to enrollees, members or providers upon request or as otherwise required.
- 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.
- Humana will not waive the medical copayments, coinsurance, and deductibles for member when original Medicare is the primary payor. Members must enroll in the Humana Value Plan code associated within the service areas listed on the Value Plan brochure and the Humana Medicare Advantage Plan to receive waivers for medical copayments, coinsurance, and deductibles. See the Value Plan brochure (RI 73-829) for more details.

Benefit Description	You pay After the calendar year deductible...
<p>Note: The calendar year deductible applies to almost all benefits in this Section. We say “(No deductible)” when it does not apply.</p>	
Professional services	Value Plan
<p>When part of a treatment plan we approve, we cover professional services by licensed professional mental health and substance use disorder treatment practitioners when acting within the scope of their license, such as psychiatrists, psychologists, clinical social workers, licensed professional counselors, or marriage and family therapists.</p>	<p>Your cost-sharing responsibilities are no greater than for other illnesses or conditions: the cost amount may be determined by the place of service.</p>

Professional services - continued on next page

Benefit Description	You pay After the calendar year deductible...
Professional services (cont.)	Value Plan
<p>Diagnosis and treatment of psychiatric conditions, mental illness, or mental disorders. Services include:</p> <ul style="list-style-type: none"> • Diagnostic evaluation • Crisis intervention and stabilization for acute episodes • Medication evaluation and management (pharmacotherapy) • Psychological and neuropsychological testing necessary to determine the appropriate psychiatric treatment • Treatment and counseling (including individual or group therapy visits) • Diagnosis and treatment of substance use disorders, including detoxification, treatment and counseling • Professional charges for intensive outpatient treatment in a provider's office or other professional setting • Electroconvulsive therapy 	<p>Participating: \$50 copay per visit (no deductible) to a primary care physician</p> <p>Non-participating: 50% of our plan allowance and any difference between our allowance and the billed amount</p>
Diagnostics	Value Plan
<ul style="list-style-type: none"> • Outpatient diagnostic tests provided and billed by a licensed mental health and substance use disorder treatment practitioner • Outpatient diagnostic tests provided and billed by a laboratory, hospital or other covered facility • Inpatient diagnostic tests provided and billed by a hospital or other covered facility • Outpatient services, such as: MRI, MRA, CT, PET, and SPECT • Other outpatient non-surgical services 	<p>Participating: 20% coinsurance</p> <p>Non-participating: 50% of our plan allowance and any difference between our allowance and the billed amount</p>
Inpatient hospital or other covered facility	Value Plan
<p>Inpatient services provided and billed by a hospital or other covered facility, including residential facilities</p> <ul style="list-style-type: none"> • Room and board, such as semiprivate or intensive accommodations, general nursing care, meals and special diets, and other hospital services, including telemedicine 	<p>Participating: 20% coinsurance</p> <p>Non-participating: 50% of our plan allowance and any difference between our allowance and the billed amount</p>
Outpatient hospital or other covered facility	Value Plan
<p>Outpatient services provided and billed by a hospital or other covered facility</p> <ul style="list-style-type: none"> • Services in approved treatment programs, such as partial hospitalization or full-day hospitalization 	<p>Participating: 20% coinsurance</p> <p>Non-participating: 50% of our plan allowance and any difference between our allowance and the billed amount</p>
<ul style="list-style-type: none"> • Facility-based intensive outpatient treatment 	<p>Participating: Nothing</p> <p>Non-participating: 50% of our plan allowance and any difference between our allowance and the billed amount</p>

Outpatient hospital or other covered facility - continued on next page

Benefit Description	You pay After the calendar year deductible...
Outpatient hospital or other covered facility (cont.)	Value Plan
<p>Telemedicine (also known as “telehealth” or “video visits”) uses information technology and telecommunications to provide virtual clinical care to patients. Patients can interact with providers through video and app technology by using smartphones, tablets, and laptops.</p> <p>With Humana's telemedicine benefit delivered by Doctor On Demand, you can:</p> <ul style="list-style-type: none"> • Connect with a physician from one of Doctor On Demand’s U.S. board-certified doctors • Immediately see a doctor 24 hours a day, 7 days a week from any location • Your primary care physician can access your telemedicine visit at your request • If medically necessary, the telemedicine doctor can send a prescription to a preferred pharmacy 	\$50 copay per visit (no deductible)
Applied behavior analysis (ABA) therapy	Value Plan
<p>Applied behavior analysis (ABA) therapy for Autism Spectrum Disorder</p>	<p>Participating: \$50 copay per visit (no deductible) to a primary care physician</p> <p>Non-participating: 50% of our plan allowance and any difference between our allowance and the billed amount</p>
Other Services	Value Plan
<ul style="list-style-type: none"> • Urgent Care • Physical, Occupational, Speech and Habilitative therapies for Mental Health (Note: See <i>You need prior plan approval for certain services</i> in Section 3) 	<p>Participating: \$50 copay (no deductible) to a primary care physician</p> <p>Non-Participating: 50% of our plan allowance and any difference between our allowance and the billed amount</p>

Section 5(f). Prescription Drug Benefits

Important things you should keep in mind about these benefits:

- We cover prescribed drugs and medications, as described in the chart beginning on the next page.
- Prescription copayments and coinsurance amounts do not apply to the deductible when using participating pharmacies.
- Please remember that all benefits are subject to the definitions, limitations and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Members must make sure their prescribers obtain prior approval/authorizations for certain prescription drugs and supplies before coverage applies. Prior approval/authorizations must be renewed periodically.
- Federal law prevents the pharmacy from accepting unused medications.
- Be sure to read Section 4, *Your cost for covered services*, for valuable information about how cost-sharing works. Also, read Section 9 about coordinating benefits with other coverage, including with Medicare.
- Humana will not waive the medical copayments, coinsurance, and deductibles for member when original Medicare is the primary payor. Members must enroll in the Humana Value Plan code associated within the service areas listed on the Value Plan brochure and the Humana Medicare Advantage Plan to receive waivers for medical copayments, coinsurance, and deductibles. See the Value Plan brochure (RI 73-829) for more details.

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

- **Who can write your prescription.** A licensed physician or dentist, and in states allowing it, licensed/certified providers with prescriptive authority prescribing within their scope of practice must prescribe your medication.
- **Where you can obtain them.** You must fill the prescription at a Plan pharmacy, or by mail for a prescribed maintenance medication. Maintenance medications are drugs that are generally prescribed for the treatment of long term chronic sicknesses or injuries. Members can also fill their maintenance medications for 90 days at a retail pharmacy for their appropriate copayment.
- **We use a formulary.** We cover non-formulary drugs prescribed by a Plan doctor.
- **The Rx5 Plan** allows members access to appropriate drugs which are used to treat conditions the medical plan covers. Thousands of drugs have been placed in levels based on their a) efficacy, b) safety, c) possible side effects, d) drug interactions, and e) cost compared to similar drugs. New drugs are continually reviewed for level placement, dispensing limits, step therapy and prior authorization requirements that represent the current clinical judgment of our Pharmacy and Therapeutics Committee. Some medications are considered non-formulary because there are other lower cost therapeutic alternatives available on the formulary.

Level One contains/covers Preferred generic and lowest cost generic drugs.

Level Two contains/covers non-Preferred generic and low cost generic drugs.

Level Three contains/covers Preferred brand and higher cost generic drugs.

Level Four contains/covers non-preferred brand and some non-preferred higher cost generics drugs.

Level Five contains specialty drugs and most self administered injectable medications and high technology drugs that are often newly approved by the U.S. Food and Drug Administration. For some specialty drugs, see *You need prior plan approval for certain services* in Section 3.

With **Rx5** the member takes on more of the cost share for the drug. In return, members receive access to more drugs to treat their conditions and have more choices, along with their physicians, to decide which drug to take. Members receive letters offering guidance in changing medications to those with a lower copayment. We use internal data to identify members for whom a less expensive prescription drug option may be available. We communicate the information to the member to enable them, along with their physician, to make an informed choice regarding prescription drug copayment options.

- **Prior Authorization** – Some medications need special monitoring and may require prior authorization. These drugs have different approval criteria based on indication, safety and appropriate use. Prior authorization (PA) requires a physician to obtain pre-approval in order to provide coverage for a drug prescribed to a member. Visit feds.humana to view the annual drug list for medications that require prior authorization.
- **Step Therapy:** Step Therapy directs therapy to the most cost-effective and safest drug available to be used prior to moving to a more costly or risky therapy. Step Therapy is an automated process and requires the member to try alternative medications before the more costly medications are considered.
- **These are the dispensing limitations.** Prescription drugs dispensed at a Plan pharmacy will be dispensed for up to a 30-day supply. You may receive up to a 90-day supply of a prescribed maintenance medication through our mail-order program or at one of our retail pharmacies. Specialty drugs may be limited to a 30-day supply. You must use dispensing limitations as directed, unless provider instructs otherwise.
- **Why use generic drugs?** Generic medications have the same benefits, ingredients and safety as brand-name medications but without the high dollar cost. With the price of prescription medicine rising, it's nice to find where you can save money without compromising on quality.
- **When you do have to file a claim?** For out of network claims, please contact Humana's customer service for reimbursement.

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

- **Non-formulary.** Medicine(s) are not in your plan's drug list (which means you pay the full cost of the prescription.) Your doctor can ask Humana to make an exception to cover your non-formulary medicine if he or she believes the alternative covered drugs won't be as effective in treating your health condition and/or would cause a bad reaction.
- **A generic equivalent will be dispensed if it is available.** When brand name drugs are purchased and a generic is available, you must pay the difference between the brand name and generic cost plus any applicable brand copay, unless the physician writes "dispense as written" on the prescription. The physician must write "dispense as written" on the prescription for you to receive a brand name drug and only pay the brand name copay, if a generic is available.

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

You can visit our web site at <http://feds.humana.com> to check the copayment for your prescription drug coverage before you get your prescription filled. You can also find out more about possible drug alternatives and the locations of participating pharmacies.

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

You pay 100% of the dispensing pharmacy charges and file a claim with Humana. The claim is paid at 50% of charges, after the applicable copay.

Benefit Description	You pay
<p>Covered medications and supplies</p> <p>We cover the following medications and supplies prescribed by a plan physician and obtained from a Plan pharmacy or through our mail order program:</p> <ul style="list-style-type: none"> • Drugs and medicines that by Federal law of the United States require a physician’s prescription for their purchase, except those listed as <i>Not covered</i>. • Insulin • Diabetes supplies including testing agents, lancet devices, alcohol swabs, glucose elevating agents, insulin delivery devices and approved blood glucose monitors and disposable needles and syringes for the administration of covered medications • Self administered injectable drugs • Oral fertility drugs • Oral chemo medications • Growth hormone • Drugs for sexual dysfunction • Drugs or drug therapies for the treatment of gender dysphoria supported by FDA approved prescribing information and/or clinical treatment guidelines • Weight loss drugs <p>Note: Blood Glucose Monitors are also covered under Durable Medical Equipment. (See Section 5(a), page 80.)</p> <p>Note: Your cost share for covered orally administered anticancer medications for the treatment of cancer will not exceed \$50 per month supply.</p> <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>Value Plan</p> <p>At participating pharmacies:</p> <p>\$10 copay for Level One drugs</p> <p>\$45 copay for Level Two drugs</p> <p>\$65 copay for Level Three drugs</p> <p>\$100 copay for Level Four drugs</p> <p>25% coinsurance for Level Five drugs (specialty drugs may be limited to a 30-day supply)</p> <p>2.5 applicable copays for a 90-day supply of prescribed maintenance drugs when ordered through our mail-order program</p> <p>At non-participating pharmacies:</p> <p>50% of charges plus applicable copay</p>
<ul style="list-style-type: none"> • Women's contraceptive drugs and devices, including the "morning after pill" • Tobacco Cessation drugs <p>Note: The above over-the-counter drugs and devices approved by the FDA require a written prescription by an approved provider. Some restrictions apply.</p>	<p>Nothing</p>

Covered medications and supplies - continued on next page

Benefit Description	You pay
Covered medications and supplies (cont.)	Value Plan
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Drugs and supplies for cosmetic purposes</i> • <i>Drugs to enhance athletic performance</i> • <i>Drugs obtained at a non-Plan pharmacy; except for out-of-area emergencies</i> • <i>Nonprescription medications/medicines</i> <p><i>Note: Over-the-counter and appropriate prescription drugs approved by the FDA to treat tobacco dependence are covered under the Tobacco Cessation program benefits. (See page 82.)</i></p>	<p><i>All charges</i></p>
Preventive care medications	Value Plan
<p>The following are covered:</p> <ul style="list-style-type: none"> • Aspirin (81 mg) for men age 45-79 and women age 55-79 and women of childbearing age • Folic acid supplements for women of childbearing age 400 & 800 mcg • Prenatal vitamins for pregnant women • Fluoride tablets, solution (not toothpaste, rinses) for children age 0-6 • Statin Medications for ages 40 years old or older: generic forms of atorvastatin, lovastatin and simvastatin • Breast cancer risk reduction medications for women with increased risk for breast cancer • Colonoscopy bowel preparation medications for Adults age 50 to 75 • Prevention of Human Immunodeficiency virus (HIV) Infection – Pre Exposure Prophylaxis (HIV PreP) • Preventive vaccines for children and adults as recommended by the Advisory Committee on Immunization Practices (ACIP) <p>Note: The drugs and supplements listed above are covered without cost-share, even if over-the-counter, are prescribed by a healthcare professional and filled at a network pharmacy.</p> <p>Note: Preventive Medications with a USPSTF recommendation of A or B are covered without cost-share when prescribed by a healthcare professional and filled by a network pharmacy. These may include some over-the- counter vitamins, nicotine replacement medications, and low dose aspirin for certain patients. For current recommendations go to www.uspreventiveservicestaskforce.org/BrowseRec/Index/browse-recommendation</p>	<p>Nothing</p>

Preventive care medications - continued on next page

Benefit Description	You pay
Preventive care medications (cont.)	Value Plan
<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, except as listed above</i> • <i>Drugs and supplies for cosmetic purposes (such as Rogaine)</i> • <i>Vitamins, nutrients and food supplements not listed as a covered benefit even if a physician prescribes or administers them, except as listed above</i> • <i>Drugs to enhance athletic performance</i> • <i>Medical supplies such as dressings and antiseptics</i> <p><i>Note: Over-the-counter and appropriate prescription drugs approved by the FDA to treat tobacco dependence are covered under the Tobacco Cessation program benefits. (See page 82.)</i></p>	<p><i>All charges</i></p>

Section 5(g). Dental Benefits

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary
- If you are enrolled in a Federal Employee Dental Vision Insurance Program (FEDVIP) Dental Plan, your FEHB plan will be primary payor of any Benefit payments and your FEDVIP Plan is secondary to your FEHB plan. See Section 9 *Coordinating benefits with Medicare and other coverage*.
- Plan dentists must provide or arrange your care.
- The calendar year deductible is:
 - Participating providers – The calendar year deductible is \$1,500 for Self Only, (\$3,000 for Self Plus One or Self and Family.) The calendar year deductible applies to almost all benefits in this Section. We added “(No deductible)” to show when the calendar year deductible does not apply.
 - Non-participating providers – The calendar year deductible is \$3,500 for Self Only, (\$7,000 for Self Plus One or Self and Family.) The calendar year deductible applies to almost all benefits in this Section. We added “(No deductible)” to show when the calendar year deductible does not apply.
- We cover hospitalization for dental procedures only when a non-dental physical impairment exists which makes hospitalization necessary to safeguard the health of the patient. See Section 5(c) for *Inpatient hospital* benefits. We do not cover the dental procedure unless it is described below.
- Be sure to read Section 4, *Your cost for covered services*, for valuable information about how cost-sharing works. Also, read Section 9 about *Coordinating benefits with Medicare and other coverage*, including with Medicare.
- Humana will not waive the medical copayments, coinsurance, and deductibles for member when original Medicare is the primary payor. Members must enroll in the Humana Value Plan code associated within the service areas listed on the Value Plan brochure and the Humana Medicare Advantage Plan to receive waivers for medical copayments, coinsurance, and deductibles. See the Value Plan brochure (RI 73-829) for more details.

Benefit Description	You pay
Accidental injury benefit	Value Plan
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	20% coinsurance
Dental benefits	Value Plan
We have no other dental benefits.	<i>All charges</i>

Section 5(h). Wellness and Other Special Features

Feature	Description
Flexible benefits option	<p>Under the flexible benefits option: we determine the most effective way to provide services.</p> <ul style="list-style-type: none"> • We may identify medically appropriate alternatives to regular contract benefits as a less costly alternative. If we identify a less costly alternative, we will ask you to sign an alternative benefit agreement that will include all of the following terms in addition to other terms as necessary. Until you sign and return the agreement regular contract benefits will continue. • Alternative benefits will be made available for a limited time period and are subject to our ongoing review. You must cooperate with the review process. • By approving an alternative benefit, we do not guarantee you will get it in the future. • The decision to offer an alternative benefit is solely ours, and except as expressly provided in the agreement, we may withdraw it at any time and resume regular contract benefits. • If you sign the agreement, we will provide the agreed-upon alternative benefits for the stated time period (unless circumstances change). You may request an extension of the time period, but regular contract benefits will resume if we do not approve your request. • Our decision to offer or withdraw alternative benefits is not subject to OPM review under the disputed claims process. However, if at the time we make a decision regarding alternative benefits, we also decide that regular contract benefits are not payable, then you may dispute our regular contract benefits decision under the OPM disputed claim process (see Section 8).
Wellness Benefit	<p>Health Assessment:</p> <p>Members can benefit from completing an Health Assessment annually and using the information to guide their personal health goals; Health Assessments ask about your medical history, health status, and lifestyle to identify health risks and opportunities to improve health behavior.</p> <p>Biometric Screenings:</p> <p>A biometric screening is easy to complete and gives you this true picture of your health. You'll not only know your numbers, but you'll be able to understand them, so you can take charge of your health. It's an empowering way towards living happier and healthier...and being your best.</p> <p>For more information, visit our website, https://feds.humana.com/.</p>
MyHumana(Humana.com)	<p>Once you've taken your Health Assessment, check out MyHumana for resources and information to help you improve your overall health. You'll also find shop-and-compare tools to help you choose hospitals and doctors, as well as health encyclopedias and practical information about health conditions, prescription drugs, and other health issues. The site also has video and audio health libraries, discounts and coupons for health-related programs.</p>
Wellness Reminders	<p>You may receive messages by telephone, mail or e-mail on topics such as mammograms, immunizations, and more.</p>
Humana Pharmacy	<p>Humana Pharmacy, a prescription home delivery service, is a wholly owned subsidiary of Humana that gives members convenience, savings, guidance, and excellent Customer Service. Humana Pharmacy is a fast and easy alternative to retail pharmacies. Depending on your location and benefits, you may be able to use Humana Pharmacy.</p>

Feature	Description
Humana Beginnings[®]	Registered nurses offer education and support to mothers throughout pregnancy and the baby's first months.
Case Management	Nurses provide assistance for those facing a crisis or major medical procedure - includes support for parents during neonatal intensive care.
Transplant Management	This specialized team helps transplant recipients coordinate benefits, facilitate services, and follow their treatment plans.
Maximize Your Benefit (MYB)	The Maximize Your Benefit (MYB) program, available to Humana members, offers guidance in helping you control the rising cost of prescription drugs with information about generics, lower cost alternatives and prescription home delivery service.
Personal Nurse[®]	Registered nurses assist those who are following treatment plans or who need continued guidance in reaching their long-term health goals.
Chronic Condition Management	Programs that focus on: asthma, cancer, chronic obstructive pulmonary disease, congestive heart failure, coronary artery disease, diabetes, depression, chronic kidney disease, end-stage renal disease, cystic fibrosis, hypertension, mental illness, multiple sclerosis, Parkinson's disease, and other conditions.
Services for deaf and hearing impaired	Humana offers telecommunication devices for the deaf (TDD) and Teletype (TTY) phone lines for the hearing impaired. Call 1-800-432-7482 to access the service.
Humana Health Coaching	Humana's Health Coaching offers you personalized action plans and assistance from certified health coaches. Your health coaches are specially trained experts who will educate, motivate, and support you to address: Weight management, Physical activity, Back care, Nutrition, Stress management, and Tobacco Cessation. With Humana's health coaching model, our virtual well-being coaching partners offer digital programs that are available 24 hours a day, seven days a week throughout the year. Find out more under "Wellness" in the Health & Wellness section on www.MyHumana.com .
Employee Assistance Program (EAP)	Life, relationships, work, money, legal, family and everyday issues, all can be challenging. Sometimes you need help and guidance to come up with the answers and practical solutions. Your Employee Assistance (EAP) any day, anytime, as often as you need it. Best of all, this is a completely confidential service at no cost to you. Find out more at www.humana.com/eap or by calling 1-866-440-6556.

For more information regarding these programs, call customer service at the number on the back of your ID card.

Non-FEHB benefits Available to Plan members

The benefits on this page are not insurance or insured benefits, nor part of the FEHB contract and premium; they are not eligible as part of the FEHB disputed claim process. Fees you pay for these services do not count toward FEHB deductibles or catastrophic protection out-of-pocket maximums. This program is subject to change at any time and not available where prohibited by law. For additional information, contact us at 1-800-4-HUMANA or visit our website at <http://feds.humana.com>.

Humana's Lifestyle Discount Program is designed to help you achieve lifelong well-being with valuable discounts and exclusive deals on popular health and wellness services. As a Humana member, you have access to this valuable program (program eligibility varies based on your service area).

Weight loss	Members will receive a 50% discount off every Nutrisystem plan, seven free high-protein shakes, and free shipping on all orders. To get started, sign in to Humana.com/LifestyleDiscounts and select the link to Nutrisystem. If you prefer, call Nutrisystem at 1-866-430-8647 .
Lasik	With nearly 600 locations nationwide, members may choose any in-network provider and receive these discounts: 15% off standard prices or 5% off promotional prices. Extra member value: Special set prices, free Lasik exam, affordable financing options, multiple technologies, 100% bladeless procedures, free enhancements for life on most procedures. To get started, sign in to Humana.com/LifestyleDiscounts and select the link to Lasik. If you prefer, call 1-855-645-2020 .
Teeth whitening	Humana teamed up with ProSmileUSATM to offer up to 70% off teeth whitening. ProSmileUSA specializes in Hi-IntensityTM, competitive strength, professional teeth bleaching. To order a teeth whitening kit, sign in to Humana.com/LifestyleDiscounts and select the link to ProSmileUSA.
Identity monitoring and protection services	Protect yourself with identity monitoring and protection services provided by CyberScout®. This benefit provides expert support to help detect fraud, monitor credit activity, and resolve any identity-related issues. To get started or to review a complete list of services and savings, sign in to Humana.com/LifestyleDiscounts and select CyberScout (MyIDManager.com/LifestyleDiscounts).
Alternative medicine	You'll get on-the-spot discounts of up to 30% when you receive services from the WholeHealth Network providers. Choose from: Chiropractic, Massage therapy, Acupuncture. It's easy to get your savings from more than 37,000 WholeHealth Network providers. To get started, sign in to Humana.com/LifestyleDiscounts . To find a provider in your area, visit the WholeHealth Choices website at Humana.wholehealthmd.com . If you prefer, call WholeHealth at 1-866-430-8647 .
Hearing aids	Humana provides you access to the TruHearing® program, which may save you 30%–60% on hearing aids. TruHearing provides hearing solutions for virtually every type of hearing loss, care from a local professional in your area, and a worry-free purchase with a 45-day trial and 3-year warranty. To learn more, visit TruHearing.com today or call 1-888-403-3937 .
Vision Discount	Humana medical and dental members receive our Vision Discount program at no cost. The program offers access to more than 119,000 vision provider locations (access points) including LensCrafters, Pearle Vision, and Target Optical. To locate a network provider, members can call 1-866-995-9316 or via the following method: Go to Humana.com > Member Resources > Find a Doctor > Vision care
Humana Individual Plans	Humana offers individual Dental and Vision products. Go to Humana.com for more information.

Section 6. General Exclusions – Services, Drugs and Supplies We Do not Cover

The exclusions in this section apply to all benefits. There may be other exclusions and limitations listed in Section 5 of this brochure. **Although we may list a specific service as a benefit, we will not cover it unless it is medically necessary to prevent, diagnose, or treat your illness, disease, injury, or condition. For information on obtaining prior approval for specific services, such as transplants, see Section 3 *You need prior Plan approval for certain services.***

We do not cover the following:

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

Section 7. Filing a Claim for Covered Services

This Section primarily deals with post-service claims (claims for services, drugs or supplies you have already received). See Section 3 for information on pre-service claims procedures (services, drugs or supplies requiring prior Plan approval), including urgent care claims procedures. When you see Plan providers, receive services at Plan hospitals and facilities, or obtain your prescription drugs at Plan pharmacies, you will not have to file claims. Just present your identification card and pay your copayment, coinsurance, or deductible.

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

If you need to file the claim, here is the process:

Medical and hospital benefits

In most cases, providers and facilities file claims for you. Provider must file on the form CMS-1500, Health Insurance Claim Form. Your facility will file on the UB-04 form. For claims questions and assistance, call us at 1-800-4HUMANA or 1-800-448-6262 or at our website at <https://feds.humana.com>.

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

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

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

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

Prescription drugs and other supplies or services

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

Deadline for filing your claim

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

Post-service claims procedures

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

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

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

Authorized Representative

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

Notice Requirements

If you live in a county where at least 10 percent of the population is literate only in a non-English language (as determined by the Secretary of Health and Human Services), we will provide language assistance in that non-English language. You can request a copy of your Explanation of Benefits (EOB) statement, related correspondence, oral language services (such as phone customer assistance), and help with filing claims and appeals (including external reviews) in the applicable non-English language. The English versions of your EOBs and related correspondence will include information in the non-English language about how to access language services in that non-English language.

Any notice of an adverse benefit determination or correspondence from us confirming an adverse benefit determination will include information sufficient to identify the claim involved (including the date of service, the healthcare provider, and the claim amount, if applicable), and a statement describing the availability, upon request, of the diagnosis and procedure codes.

Section 8. The Disputed Claims Process

You may appeal directly to the Office of Personnel Management (OPM) if we do not follow required claims processes. For more information or to make an inquiry about situations in which you are entitled to immediately appeal to OPM, including additional requirements not listed in Sections 3, 7 and 8 of this brochure, please call your plan's customer service representative at the phone number found on your enrollment card, plan brochure, or plan website.

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

To help you prepare your appeal, you may arrange with us to review and copy, free of charge, all relevant materials and Plan documents under our control relating to your claim, including those that involve any expert review(s) of your claim. To make your request, please contact our Customer Service Department by writing Humana Claims Office, P.O. Box 14546, Lexington KY 40512-4601 or calling 1-800-4HUMANA or 1-800-448-6262.

Our reconsideration will take into account all comments, documents, records, and other information submitted by you relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination.

When our initial decision is based (in whole or in part) on a medical judgment (i.e., medical necessity, experimental/investigational), we will consult with a healthcare professional who has appropriate training and experience in the field of medicine involved in the medical judgment and who was not involved in making the initial decision.

Our reconsideration will not take into account the initial decision. The review will not be conducted by the same person, or their subordinate, who made the initial decision.

We will not make our decisions regarding hiring, compensation, termination, promotion, or other similar matters with respect to any individual (such as a claims adjudicator or medical expert) based upon the likelihood that the individual will support the denial of benefits.

Step	Description
1	<p>Ask us in writing to reconsider our initial decision. You must:</p> <ul style="list-style-type: none">a) Write to us within 6 months from the date of our decision; andb) Send your request to us at: Humana Claims Office, Attn: Grievance and Appeals, P.O. Box 14546, Lexington, KY 40512-4601; andc) Include a statement about why you believe our initial decision was wrong, based on specific benefit provisions in this brochure; andd) Include copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms.e) Include your email address (optional for member), if you would like to receive our decision via email. Please note that by giving us your email, we may be able to provide our decision more quickly. <p>We will provide you, free of charge and in a timely manner, with any new or additional evidence considered, relied upon, or generated by us or at our direction in connection with your claim and any new rationale for our claim decision. We will provide you with this information sufficiently in advance of the date that we are required to provide you with our reconsideration decision to allow you a reasonable opportunity to respond to us before that date. However, our failure to provide you with new evidence or rationale in sufficient time to allow you to timely respond shall not invalidate our decision on reconsideration. You may respond to that new evidence or rationale at the OPM review stage described in step 4.</p>

Step	Description
2	<p>In the case of a post-service claim, we have 30 days from the date we receive your request to:</p> <ul style="list-style-type: none"> a) Pay the claim or b) Write to you and maintain our denial or c) Ask you or your provider for more information <p>You or your provider must send the information so that we receive it within 60 days of our request. We will then decide within 30 more days.</p> <p>If we do not receive the information within 60 days we will decide within 30 days of the date the information was due. We will base our decision on the information we already have. We will write to you with our decision.</p>
3	<p>If you do not agree with our decision, you may ask OPM to review it.</p> <p>You must write to OPM within:</p> <ul style="list-style-type: none"> • 90 days after the date of our letter upholding our initial decision; or • 120 days after you first wrote to us - if we did not answer that request in some way within 30 days; or • 120 days after we asked for additional information. <p>Write to OPM at: United States Office of Personnel Management, Healthcare and Insurance, Federal Employee Insurance Operations, Health Insurance 3, 1900 E Street, NW, Washington, DC 20415-3630.</p> <p>Send OPM the following information:</p> <ul style="list-style-type: none"> • A statement about why you believe our decision was wrong, based on specific benefit provisions in this brochure; • Copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms; • Copies of all letters you sent to us about the claim; • Copies of all letters we sent to you about the claim; and • Your daytime phone number and the best time to call. • Your email address, if you would like to receive OPM's decision via email. Please note that by providing your email address, you may receive OPM's decision more quickly. <p>Note: If you want OPM to review more than one claim, you must clearly identify which documents apply to which claim.</p> <p>Note: You are the only person who has a right to file a disputed claim with OPM. Parties acting as your representative, such as medical providers, must include a copy of your specific written consent with the review request. However, for urgent care claims, a healthcare professional with knowledge of your medical condition may act as your authorized representative without your express consent.</p> <p>Note: The above deadlines may be extended if you show that you were unable to meet the deadline because of reasons beyond your control.</p>
4	<p>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.</p> <p>If you do not agree with OPM's decision, your only recourse is to sue. If you decide to file a lawsuit, you must file the suit against OPM in Federal court by December 31 of the third year after the year in which you received the disputed services, drugs, or supplies or from the year in which you were denied precertification or prior approval. This is the only deadline that may not be extended.</p>

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 file a lawsuit until you have completed the disputed claims process. Further, Federal law governs your lawsuit, benefits, and payment of benefits. The Federal court will base its review on the record that was before OPM when OPM decided to uphold or overturn our decision. You may recover only the amount of benefits in dispute.

Note: **If you have a serious or life threatening condition** (one that may cause permanent loss of bodily functions or death if not treated as soon as possible), and you did not indicate that your claim was a claim for urgent care, then call us at 1-800-523-0023. We will expedite our review (if we have not yet responded to your claim); or we will inform OPM so they can quickly review your claim on appeal. You may call OPM's Health Insurance 3 at 1-(202) 606-0737 between 8 a.m. and 5 p.m. Eastern Time.

Please remember that we do not make decisions about plan eligibility issues. For example, we do not determine whether you or a dependent is covered under this plan. You must raise eligibility issues with your Agency personnel/payroll office if you are an employee, your retirement system if you are an annuitant or the Office of Workers' Compensation Programs if you are receiving Workers' Compensation benefits.

Section 9. Coordinating Benefits with Medicare and Other Coverage

When you have other health coverage

You must tell us if you or a covered family member has coverage under any other health plan or has automobile insurance that pays healthcare expenses without regard to fault. This is called "double coverage".

When you have double coverage, one plan normally pays its benefits in full as the primary payor and the other plan pays a reduced benefit as the secondary payor. We, like other insurers, determine which coverage is primary according to the National Association of Insurance Commissioners' (NAIC) guidelines. For more information on NAIC rules regarding the coordinating of benefits, visit our website at <https://feds.humana.com/>.

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

- **TRICARE and CHAMPVA**

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

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

- **Workers' Compensation**

We do not cover services that:

- You (or a covered family member) need because of a workplace-related illness or injury that the Office of Workers' Compensation Programs (OWCP) or a similar federal or state agency determines they must provide; or
- OWCP or a worker's compensation carrier 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 pays its maximum benefits for your treatment, we will cover your care. You must use our providers.

- **Medicaid**

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

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

When other Government agencies are responsible for your care

We do not cover services and supplies when a local, state, or federal government agency directly or indirectly pays for them.

When others are responsible for injuries

By accepting benefits under this plan you agree to the following conditions and limitations on the nature of benefits or benefit payments when another person causes an injury or illness or when you are entitled to recover from any other insurance or source of funds that may be available to pay for the injury or illness.

Humana is entitled to recover the full value of the benefits we have paid or provided in connection with your injury or illness. However, when benefits are otherwise provided by this plan we will cover the cost of treatment that exceeds the amount of the payment you received. You and all covered persons agree to promptly notify us that you have asked anyone other than us to make payment for your injuries and to fully cooperate with our efforts to secure our recovery rights. You and your representative also agree to obtain our consent before releasing any party from liability for payment of medical expenses and before disbursing any funds paid by other parties.

When benefits are provided under the Plan in relation to the illness or injury, Humana may, at its option:

- Subrogate, that is, take over your right to pursue recovery from any other parties, insurance carriers or sources of funds that you may have a right to pursue; or
- Enforce a right to reimbursement from any payment(s) you or your representative may obtain from other parties, settlements or insurance coverage.

Our right to recover the full value of the benefits we have paid or provided for shall take first priority (before any of the rights of any other parties are honored) and are not impacted by how the judgment, settlement, or other recovery is characterized, designated, or apportioned. The amount we are entitled to recovery is not subject to reduction based on attorney fees or costs under the “common fund” or similar rules and is fully enforceable regardless of whether you are “made whole” or compensated for the full amount of damages you may have incurred.

Our recovery rights shall apply only to the extent of the full value of benefits provided for the injury or illness. We will provide benefits to cover the cost of treatment that exceeds amounts that are recoverable other insurance coverage or sources of funds.

If you, a covered person or your representative fails to cooperate with the enforcement of our recovery rights we may delay or deny future benefits until cooperation is provided or we are reimbursed.

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

Some FEHB plans already cover some dental and vision services. When you are covered by more than one vision/dental plan, coverage provided under your FEHB plan remains as your primary coverage. FEDVIP coverage pays secondary to that coverage. When you enroll in a dental and/or vision plan on www.BENEFEDS.com or by phone at 1-877-888-3337, TTY 1-877-889-5680, you will be asked to provide information on your FEHB plan so that your plans can coordinate benefits. Providing your FEHB information may reduce your out-of-pocket cost.

Clinical trials

An approved clinical trial includes a phase I, phase II, phase III, or phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition and is either Federally funded; conducted under an investigational new drug application reviewed by the Food and Drug Administration; or is a drug trial that is exempt from the requirement of an investigational new drug application.

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

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

When you have Medicare

For more detailed information on “What is Medicare?” and “Should I Enroll in Medicare?” please contact Medicare at 800-MEDICARE (1-800-633-4227), (TTY 1-877-486-2048) or at www.medicare.gov.

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

The Original Medicare Plan (Original Medicare) is available everywhere in the United States. It is the way everyone used to get Medicare benefits and is the way most people get their Medicare Part A and Part B benefits now. You may go to any doctor, specialist, or hospital that accepts Medicare. The Original Medicare Plan pays its share and you pay your share.

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

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

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

When we are the primary payor, we process the claim first.

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

Humana will not waive the medical copayments, coinsurance, and deductibles for member when original Medicare is the primary payor. Members must enroll in the Humana Value Plan code associated within the service areas listed on the Value Plan brochure and the Humana Medicare Advantage Plan to receive waivers for medical copayments, coinsurance, and deductibles. See the Value Plan brochure (RI 73-829) for more details.

Please review the following table it illustrates your cost share if you are enrolled in Medicare Part A and B. Members must use providers who accept Medicare’s assignment.

CDHP: In-network example

Benefit Description: Deductible

CDHP Option You pay without Medicare: \$1,500 Self Only/\$3,000 Self Plus One or Self and Family

CDHP Option You pay with Medicare Parts A and B (primary): \$1,500 Self Only/\$3,000 Self Plus One or Self and Family

Benefit Description: Out of Pocket Maximum

CDHP Option You pay without Medicare: \$8,150 Self Only/\$16,300 Self Plus One or Self and Family

CDHP Option You pay with Medicare Parts A and B (primary):\$8,150 Self Only/\$16,300 Self Plus One or Self and Family

Benefit Description: Part B Premium Reimbursement Offered

CDHP Option You pay without Medicare: N/A

CDHP Option You pay with Medicare Parts A and B (primary): N/A

Benefit Description: Primary Care Physician

CDHP Option You pay without Medicare: \$40

CDHP Option You pay with Medicare Parts A and B (primary): \$40

Benefit Description: Specialist

CDHP Option You pay without Medicare: \$60

CDHP Option You pay with Medicare Parts A and B (primary): \$60

Benefit Description: In-Patient Hospital

CDHP Option You pay without Medicare: 10% after deductible

CDHP Option You pay with Medicare Parts A and B (primary): 10% after deductible

Benefit Description: Out-Patient Hospital

CDHP Option You pay without Medicare: 10% after deductible

CDHP Option You pay with Medicare Parts A and B (primary): 10% after deductible

Benefit Description: Incentives Offered

CDHP Option You pay without Medicare: N/A

CDHP Option You pay with Medicare Parts A and B (primary): N/A

Value Plan: In-network example

Benefit Description: Deductible

Value Plan You pay without Medicare: \$1,500 Self Only/\$3,000 Self Plus One or Self and Family

Value Plan You pay with Medicare Parts A and B (primary): \$1,500 Self Only/\$3,000 Self Plus One or Self and Family

Value Plan You pay with Medicare Parts A and B, Value Plan and Medicare Advantage: \$0

Benefit Description: Out of Pocket Maximum

Value Plan You pay without Medicare: \$8,150 Self Only/\$16,300 Self Plus One or Self and Family

Value Plan You pay with Medicare Parts A and B (primary): \$8,150 Self Only/\$16,300 Self Plus One or Self and Family

Value Plan You pay with Medicare Parts A and B, Value Plan and Medicare Advantage: \$8,150 Self Only/\$16,300 Self Plus One or Self and Family

Benefit Description: Part B Premium Reimbursement Offered

Value Plan You pay without Medicare: N/A

Value Plan You pay with Medicare Parts A and B (primary): N/A

Value Plan with Medicare Parts A and B and our Medicare Advantage Plan are eligible for a Medicare Part B reimbursement of \$100

Benefit Description: Primary Care Physician

Value Plan You pay without Medicare: \$50
Value Plan You pay with Medicare Parts A and B (primary): \$50
Value Plan You pay with Medicare Parts A and B, Value Plan and Medicare Advantage: \$0

Benefit Description: Specialist

Value Plan You pay without Medicare: \$70
Value Plan You pay with Medicare Parts A and B (primary): \$70
Value Plan You pay with Medicare Parts A and B, Value Plan and Medicare Advantage: \$0

Benefit Description: In-Patient Hospital

Value Plan You pay without Medicare: 20% after deductible
Value Plan You pay with Medicare Parts A and B (primary): 20% after deductible
Value Plan You pay with Medicare Parts A and B, Value Plan and Medicare Advantage: \$0

Benefit Description: Out-Patient Hospital

Value Plan You pay without Medicare: 20% after deductible
Value Plan You pay with Medicare Parts A and B (primary): 20% after deductible
Value Plan You pay with Medicare Parts A and B, Value Plan and Medicare Advantage: \$0

Benefit Description: Incentives Offered

Value Plan You pay without Medicare: N/A
Value Plan You pay with Medicare Parts A and B (primary): N/A
Value Plan with Medicare Parts A and B and Medicare Advantage: Yes, \$100 Medicare Part B monthly reimbursement

You can find more information about how our plan coordinates benefits with Medicare by calling 1-800-4HUMANA or visit the Medicare website at <https://www.medicare.gov/supplements-other-insurance/how-medicare-works-with-other-insurance>.

• **Tell us about your Medicare coverage**

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

• **Medicare Advantage (Part C)**

If you are eligible for Medicare, you may choose to enroll in and get your Medicare benefits from a Medicare Advantage plan. These are private healthcare choices (like HMOs and regional PPOs) in some areas of the country. To learn more about Medicare Advantage plans, contact Medicare at 1-800-MEDICARE (1-800-633-4227), (TTY 1-877-486-2048) or at www.medicare.gov.

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

This Plan and our Medicare Advantage plan: You may enroll in our Medicare Advantage plan and if you are an annuitant or a former spouse with FEHB coverage and are enrolled in Medicare parts A and B. Our Medicare Advantage plan will enhance your FEHB coverage by lowering or eliminating cost share for services and/or adding benefits at no additional cost. Our Medicare Advantage plan is subject to Medicare rules.

You may enroll in the Humana Medicare Advantage Plan if:

- You are enrolled in the Humana Value Plan and have Medicare parts A & B.
- You are retired and live in our geographic service area
- You are a US Citizen
- You Do Not have End Stage Renal Disease (with limited exceptions)
- You complete a separate enrollment application for the Humana MAPD

Members will receive a reimbursement of \$100 towards your Medicare Part B premium through CMS, which should start the first of the month following your application's approval.

If you enroll in a Medicare Advantage plan, tell us. We will need to know whether you are in the Original Medicare plan or in a Medicare Advantage plan so we can correctly coordinate benefits with Medicare. For information about Medicare Advantage plans offered in your area call 1-866-836-5079.

This Plan and another plan's Medicare Advantage plan: You may enroll in another plan's Medicare Advantage plan and also remain enrolled in our FEHB plan. We will still provide benefits when your Medicare Advantage plan is primary, even out of the Medicare Advantage plan's network and/or service area (if you use our Plan providers).

However, we will not waive any of our copayments, coinsurance, or deductibles. If you enroll in a Medicare Advantage plan, tell us. We will need to know whether you are in the Original Medicare Plan or in a Medicare Advantage plan so we can correctly coordinate benefits with Medicare.

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

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

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

Medicare always makes the final determination as to whether they are the primary payor. The following chart illustrates whether Medicare or this Plan should be the primary payor for you according to your employment status and other factors determined by Medicare. It is critical that you tell us if you or a covered family member has Medicare coverage so we can administer these requirements correctly. **(Having coverage under more than two health plans may change the order of benefits determined on this chart.)**

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

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

Section 10. Definitions of Terms We Use in This Brochure

Benefit Allowance – CoverageFirst only	The Plan pays the first \$1,000 of covered medical services for each person enrolled. We call this your benefit allowance. While using the \$1,000 benefit allowance, you are only responsible for the applicable copayments and coinsurance. The amount the plan deducts from your allowance for a particular service is based on the price Humana has negotiated with the healthcare provider. You do not have to submit receipts for reimbursement. The benefit allowance can only be used to pay for covered medical services from participating providers.
Calendar year	January 1 through December 31 of the same year. For new enrollees, the calendar year begins on the effective date of their enrollment and ends on December 31 of the same year.
Clinical Trials Cost Categories	<p>An approved clinical trial includes a phase I, phase II, phase III, or phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition and is either Federally funded; conducted under an investigational new drug application reviewed by the Food and Drug Administration; or is a drug trial that is exempt from the requirement of an investigational new drug application.</p> <ul style="list-style-type: none">• Routine care costs - costs for routine services such as doctor visits, lab tests, X-rays and scans, and hospitalizations related to treating the patient's condition whether the patient is in a clinical trial or is receiving standard therapy• Extra care costs - costs related to taking part in a clinical trial such as additional tests that a patient may need as part of the trial, but not as part of the patient's routine care• Research costs - costs related to conducting the clinical trial such as research physician and nurse time, analysis of results, and clinical tests performed only for research purposes are generally covered by the clinical trials. This plan does not cover these costs.
Coinsurance	See Section 4, page 26.
Consumer Driven Plan	A plan that gives greater control over your choices of healthcare expenditures. You decide what healthcare services will be reimbursed under the health plan benefit allowance. The benefit allowance is only used for participating providers. If you spend the entire benefit allowance before the end of the year, then you must satisfy your deductible before benefits are payable under the traditional type of insurance covered by your plan.
Copayment	See Section 4, page 26.
Cost-sharing	See Section 4, page 26.
Covered services	Care we provide benefits for, as described in this brochure.
Custodial care	Services provided to you such as assistance with dressing, bathing, preparation and feeding of special diets, walking, supervision of medication which is ordinarily self-administered, getting in and out of bed, and maintaining continence, which are not likely to improve your condition. Custodial care that lasts 90 days or more is sometimes known as long term care.
Deductible	See Section 4, page 26.
Durable Medical Equipment (DME)	<p>Equipment recognized as such by Medicare Part B, that meets all of the following criteria:</p> <ul style="list-style-type: none">• it can stand repeated use; and• it is primarily and customarily used to serve a medical purpose rather than being primarily for comfort or convenience; and• it is usually not useful to a person in the absence of sickness or injury; and• it is appropriate for home use; and• it is related to the patient's physical disorder; and• the equipment must be used in the member's home.

Experimental or investigational services	<p>A drug, biological product, device, medical treatment, or procedure is determined to be experimental or investigational if reliable evidence shows it meets one of the following criteria:</p> <ul style="list-style-type: none"> • when applied to the circumstances of a particular patient is the subject of ongoing phase I, II or III clinical trials, or • when applied to the circumstances of a particular patient is under study with written protocol to determine maximum tolerated dose, toxicity, safety, efficacy, or efficacy in comparison to conventional alternatives, or • is being delivered or should be delivered subject to the approval and supervision of an Institutional Review Board as required and defined by the USFDA or Department of Health and Human Services, or • 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>
Healthcare professional	A physician or other healthcare professional licensed, accredited, or certified to perform specified health services consistent with state law.
Medical necessity	The determination as to whether a medical service is required to treat a condition, illness, or injury. In order to meet the standard of medical necessity the service must be consistent with symptoms, diagnosis, or treatment; consistent with good medical practice; and the most appropriate level of service that can be safely provided.
Morbid obesity	Excess body weight in comparison to set standards. Obesity refers specifically to having an abnormal proportion of body fat. The primary classification of overweight and obesity is based on the assessment of Body Mass Index (BMI).
Oral surgery	Procedures to correct diseases, injuries and defects of the jaw and mouth structures.
Out-of-pocket	The out-of-pocket amount is the limit on total member copayments, deductibles, and coinsurance under a benefit contract.
Participating provider	A hospital, physician, or any other health services provider who has been designated to provide services to covered members under this plan.
Plan allowance	<p>Plan allowance is the amount we use to determine our payment and your coinsurance for covered services. Plans determine their allowances in different ways. We determine our allowance using Humana's fee schedule for similar providers in your service area. The dollar amount over Humana's allowance/fee schedule will be the responsibility of the member.</p> <p>You should also see <i>Important Notice About Surprise Billing – Know Your Rights</i> in Section 4 that describes your protections against surprise billing under the No Surprises Act.</p>
Post-service claims	Any claims that are not pre-service claims. In other words, post-service claims are those claims where treatment has been performed and the claims have been sent to us in order to apply for benefits.
Pre-service claims	Those claims (1) that require precertification, prior approval, or a referral and (2) where failure to obtain precertification, prior approval, or a referral results in a reduction of benefits.
Reimbursement	A carrier's pursuit of a recovery if a covered individual has suffered an illness or injury and has received, in connection with that illness or injury, a payment from any party that may be liable, any applicable insurance policy, or a workers' compensation program or insurance policy, and the terms of the carrier's health benefits plan require the covered individual, as a result of such payment, to reimburse the carrier out of the payment to the extent of the benefits initially paid or provided. The right of reimbursement is cumulative with and not exclusive of the right of subrogation.

Specialist	A specialist is a physician other than a family practitioner, general practitioner, internist or pediatrician.
Subrogation	A carrier's pursuit of a recovery from any party that may be liable, any applicable insurance policy, or a workers' compensation program or insurance policy, as successor to the rights of a covered individual who suffered an illness or injury and has obtained benefits from that carrier's health benefits plan.
Urgent care claims	<p>A claim for medical care or treatment is an urgent care claim if waiting for the regular time limit for non-urgent care claims could have one of the following impacts:</p> <ul style="list-style-type: none"> • Waiting could seriously jeopardize your life or health; • Waiting could seriously jeopardize your ability to regain maximum function; or • In the opinion of a physician with knowledge of your medical condition, waiting would subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim. <p>Urgent care claims usually involve Pre-service claims and not Post-service claims. We will determine whether or not a claim is an urgent care claim by applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine.</p> <p>If you believe your claim qualifies as an urgent care claim, please contact our Customer Service Department at 1-800-4HUMANA. You may also prove that your claim is an urgent care claim by providing evidence that a physician with knowledge of your medical condition has determined that your claim involves urgent care.</p>
Us/We	Us and We refer to Humana Consumer Driven Health Plan and/or Value Plan.
You	You refers to the enrollee and each covered family member.

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

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- Skilled nursing facility care...21-22, 35-36, 52, 55, 72, 90, 92-93
- Social worker.....59-60, 97-98
- Speech therapy.....21-22, 40, 61, 78, 99
- Splints.....53-54, 91-92
- Subrogation.....123-124
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- Reconstructive.....45-47, 83-85
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- Tobacco Cessation...43-44, 64-65, 102-103, 107
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Summary of Benefits for the CDHP - 2022

- **Do not rely on this chart alone.** This is a summary. All benefits are subject to the definitions, limitations, and exclusions in this brochure. Before making a final decision, please read this FEHB brochure. You can also obtain a copy of our Summary of Benefits and Coverage as required by the Affordable Care Act at <https://feds.humana.com/>.
- If you want to enroll or change your enrollment in this Plan, be sure to put the correct enrollment code from the cover on your enrollment form.
- Members have a \$1,000 in-network benefit allowance to use before they must meet a deductible. Once your benefit allowance has been exhausted, you must satisfy your in-network deductible: \$1,500 for Self Only, or \$3,000 for Self Plus One or Self and Family. After the deductible has been met, you are only responsible for your copays or coinsurance.

In-Network Benefits	You Pay	Page
Medical services provided by physicians: <ul style="list-style-type: none"> • Diagnostic and treatment services provided in the office 	\$40 copay primary care; \$60 copay specialist	35
Services provided by a hospital: <ul style="list-style-type: none"> • Inpatient • Outpatient - surgery • Outpatient - MRI, MRA, CT, PET, SPECT • Outpatient - other services 	10% coinsurance after deductible	53
Emergency benefits: <ul style="list-style-type: none"> • At a doctor's office • In and out-of-area (emergency room) 	\$40 copay primary care; \$60 copay specialist \$250 copay	57
Mental health and substance use disorder treatment	Regular cost-sharing	59
Prescription drugs: <ul style="list-style-type: none"> • Level One drugs • Level Two drugs • Level Three drugs • Level Four drugs • Level Five drugs • Maintenance drugs (90-day supply) when ordered through our mail-order program 	\$10 copay \$45 copay \$65 copay \$100 copay 25% coinsurance 2.5 applicable copays	64
Dental care: Accidental injury benefit only	10% coinsurance after deductible	67
Vision care	No benefit	
Special features: Wellness benefit; Personal Nurse; MyHumana; Humana <i>Beginnings</i> ; Chronic Condition management; Transplant management; Case management; Humana Health Coaching; TDD and TTY phone lines		106
Protection against catastrophic medical and prescription drug costs (out-of-pocket maximum).	Nothing after \$8,150 for Self Only, or \$16,300 for Self Plus One or Self and Family including the deductible per contract year.	27

Summary of Benefits for the Value Plan - 2022

- **Do not rely on this chart alone.** This is a summary. All benefits are subject to the definitions, limitations, and exclusions in this brochure. Before making a final decision, please read this FEHB brochure. You can also obtain a copy of our Summary of Benefits and Coverage as required by the Affordable Care Act at <https://feds.humana.com/>.
- 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.
- After the \$1,500 for Self Only, or \$3,000 for Self Plus One or Self and Family in-network deductible has been met, you are only responsible for your copays or coinsurance.

In-Network Benefits	You Pay	Page
Medical services provided by physicians: <ul style="list-style-type: none"> • Diagnostic and treatment services provided in the office 	\$50 copay primary care; \$70 copay specialist	72
Services provided by a hospital: <ul style="list-style-type: none"> • Inpatient • Outpatient - surgery • Outpatient - MRI, MRA, CT, PET, SPECT • Outpatient - other services 	20% coinsurance after deductible	91
Emergency benefits: <ul style="list-style-type: none"> • At a doctor's office • In and out-of-area (emergency room) 	\$50 copay primary care; \$70 copay specialist \$350 copay	95
Mental health and substance use disorder treatment	Regular cost-sharing	97
Prescription drugs: <ul style="list-style-type: none"> • Level One drugs • Level Two drugs • Level Three drugs • Level Four drugs • Level Five drugs • Maintenance drugs (90-day supply) when ordered through our mail-order program 	\$10 copay \$45 copay \$65 copay \$100 copay 25% coinsurance 2.5 applicable copays	102
Dental care: Accidental injury benefit only	20% coinsurance after deductible	105
Vision care	No benefit	
Special features: Wellness benefit; Personal Nurse; MyHumana; Humana <i>Beginnings</i> ; Chronic Condition management; Transplant management; Case management; Humana Health Coaching; TDD and TTY phone lines		106
Protection against catastrophic medical and prescription drug costs (out-of-pocket maximum).	Nothing after \$8,150 for Self Only, or \$16,300 for Self Plus One or Self and Family including the deductible per contract year.	27

2022 Rate Information for Humana CoverageFirst/Humana Value Plan

To compare your FEHB health plan options please go to www.opm.gov/fehcompare.

To review premium rates for all FEHB health plan options please go to www.opm.gov/FEHBpremiums or www.opm.gov/Tribalpremium.

Premiums for Tribal employees are shown under the Monthly Premium Rate column. The amount shown under employee contribution is the maximum you will pay. Your Tribal employer may choose to contribute a higher portion of your premium. Please contact your Tribal Benefits Officer for exact rates.

Type of Enrollment	Enrollment Code	Premium Rate			
		Biweekly		Monthly	
		Gov't Share	Your Share	Gov't Share	Your Share

Arizona: Phoenix

CDHP Option Self Only	R61	\$244.86	\$158.13	\$530.53	\$342.62
CDHP Option Self Plus One	R63	\$524.63	\$341.79	\$1,136.70	\$740.54
CDHP Option Self and Family	R62	\$574.13	\$332.59	\$1,243.95	\$720.61
Value Option Self Only	R64	\$230.35	\$76.78	\$499.09	\$166.36
Value Option Self Plus One	R66	\$495.25	\$165.08	\$1,073.04	\$357.68
Value Option Self and Family	R65	\$518.27	\$172.76	\$1,122.92	\$374.31

Arizona: Tucson

CDHP Option Self Only	R91	\$244.86	\$107.62	\$530.53	\$233.18
CDHP Option Self Plus One	R93	\$524.63	\$233.17	\$1,136.70	\$505.20
CDHP Option Self and Family	R92	\$574.13	\$218.92	\$1,243.95	\$474.33
Value Option Self Only	R94	\$202.58	\$67.52	\$438.92	\$146.30
Value Option Self Plus One	R96	\$435.55	\$145.18	\$943.69	\$314.56
Value Option Self and Family	R95	\$455.79	\$151.93	\$987.55	\$329.18

Type of Enrollment	Enrollment Code	Premium Rate			
		Biweekly		Monthly	
		Gov't Share	Your Share	Gov't Share	Your Share

Florida: Daytona

CDHP Option Self Only	W91	\$244.86	\$90.54	\$530.53	\$196.17
CDHP Option Self Plus One	W93	\$524.63	\$196.47	\$1,136.70	\$425.68
CDHP Option Self and Family	W92	\$565.97	\$188.66	\$1,226.27	\$408.76
Value Option Self Only	W94	\$207.74	\$69.24	\$450.09	\$150.03
Value Option Self Plus One	W96	\$446.63	\$148.87	\$967.69	\$322.56
Value Option Self and Family	W95	\$467.41	\$155.80	\$1,012.72	\$337.57

Florida: Orlando

CDHP Option Self Only	X21	\$218.27	\$72.75	\$472.91	\$157.63
CDHP Option Self Plus One	X23	\$469.29	\$156.43	\$1,016.80	\$338.93
CDHP Option Self and Family	X22	\$491.12	\$163.71	\$1,064.10	\$354.70
Value Option Self Only	X24	\$189.09	\$63.03	\$409.70	\$136.56
Value Option Self Plus One	X26	\$406.54	\$135.51	\$880.83	\$293.61
Value Option Self and Family	X25	\$463.27	\$154.42	\$1,003.75	\$334.58

Florida: South Florida

CDHP Option Self Only	QP1	\$244.86	\$136.47	\$530.53	\$295.69
CDHP Option Self Plus One	QP3	\$524.63	\$296.29	\$1,136.70	\$641.96
CDHP Option Self and Family	QP2	\$574.13	\$284.97	\$1,243.95	\$617.43
Value Option Self Only	QP4	\$190.56	\$63.52	\$412.88	\$137.63
Value Option Self Plus One	QP6	\$409.70	\$136.56	\$887.67	\$295.89
Value Option Self and Family	QP5	\$428.75	\$142.91	\$928.95	\$309.65

Type of Enrollment	Enrollment Code	Premium Rate			
		Biweekly		Monthly	
		Gov't Share	Your Share	Gov't Share	Your Share

Florida: Tampa

CDHP Option Self Only	MJ1	\$244.86	\$246.62	\$530.53	\$534.34
CDHP Option Self Plus One	MJ3	\$524.63	\$532.05	\$1,136.70	\$1,152.77
CDHP Option Self and Family	MJ2	\$574.13	\$531.68	\$1,243.95	\$1,151.97
Value Option Self Only	MJ4	\$194.26	\$64.75	\$420.89	\$140.30
Value Option Self Plus One	MJ6	\$417.65	\$139.22	\$904.91	\$301.64
Value Option Self and Family	MJ5	\$466.22	\$155.41	\$1,010.15	\$336.72

Georgia: Atlanta

CDHP Option Self Only	AD1	\$244.86	\$293.53	\$530.53	\$635.98
CDHP Option Self Plus One	AD3	\$524.63	\$632.90	\$1,136.70	\$1,371.28
CDHP Option Self and Family	AD2	\$574.13	\$637.23	\$1,243.95	\$1,380.66
Value Option Self Only	AD4	\$244.86	\$136.39	\$530.53	\$295.51
Value Option Self Plus One	AD6	\$524.63	\$295.03	\$1,136.70	\$639.23
Value Option Self and Family	AD5	\$574.13	\$283.64	\$1,243.95	\$614.55

Georgia: Columbus

CDHP Option Self Only	S91	\$244.86	\$136.88	\$530.53	\$296.57
CDHP Option Self Plus One	S93	\$524.63	\$296.12	\$1,136.70	\$641.59
CDHP Option Self and Family	S92	\$574.13	\$284.79	\$1,243.95	\$617.04
Value Option Self Only	S94	\$227.96	\$75.99	\$493.92	\$164.64
Value Option Self Plus One	S96	\$490.11	\$163.37	\$1,061.90	\$353.97
Value Option Self and Family	S95	\$512.90	\$170.97	\$1,111.29	\$370.43

Type of Enrollment	Enrollment Code	Premium Rate			
		Biweekly		Monthly	
		Gov't Share	Your Share	Gov't Share	Your Share

Georgia: Macon

CDHP Option Self Only	LM1	\$244.86	\$117.22	\$530.53	\$253.98
CDHP Option Self Plus One	LM3	\$524.63	\$253.84	\$1,136.70	\$549.99
CDHP Option Self and Family	LM2	\$574.13	\$240.55	\$1,243.95	\$521.19
Value Option Self Only	LM4	\$244.86	\$97.66	\$530.53	\$211.60
Value Option Self Plus One	LM6	\$524.63	\$211.80	\$1,136.70	\$458.90
Value Option Self and Family	LM5	\$574.13	\$196.55	\$1,243.95	\$425.86

Illinois: Central Illinois

CDHP Option Self Only	GB1	\$244.86	\$364.29	\$530.53	\$789.30
CDHP Option Self Plus One	GB3	\$524.63	\$785.04	\$1,136.70	\$1,700.92
CDHP Option Self and Family	GB2	\$574.13	\$796.43	\$1,243.95	\$1,725.60
Value Option Self Only	GB4	\$244.86	\$137.25	\$530.53	\$297.38
Value Option Self Plus One	GB6	\$524.63	\$296.87	\$1,136.70	\$643.22
Value Option Self and Family	GB5	\$574.13	\$285.58	\$1,243.95	\$618.76

Illinois: Chicago

CDHP Option Self Only	MW1	\$244.86	\$242.87	\$530.53	\$526.22
CDHP Option Self Plus One	MW3	\$524.63	\$524.02	\$1,136.70	\$1,135.38
CDHP Option Self and Family	MW2	\$574.13	\$523.32	\$1,243.95	\$1,133.86
Value Option Self Only	MW4	\$244.86	\$124.23	\$530.53	\$269.17
Value Option Self Plus One	MW6	\$524.63	\$268.90	\$1,136.70	\$582.62
Value Option Self and Family	MW5	\$574.13	\$256.30	\$1,243.95	\$555.32

Type of Enrollment	Enrollment Code	Premium Rate			
		Biweekly		Monthly	
		Gov't Share	Your Share	Gov't Share	Your Share

Kansas/Missouri: Kansas City

CDHP Option Self Only	PH1	\$244.86	\$105.00	\$530.53	\$227.50
CDHP Option Self Plus One	PH3	\$524.63	\$227.58	\$1,136.70	\$493.09
CDHP Option Self and Family	PH2	\$574.13	\$213.07	\$1,243.95	\$461.65
Value Option Self Only	PH4	\$196.33	\$65.44	\$425.38	\$141.79
Value Option Self Plus One	PH6	\$422.12	\$140.70	\$914.58	\$304.86
Value Option Self and Family	PH5	\$441.74	\$147.25	\$957.11	\$319.04

Kentucky: Lexington

CDHP Option Self Only	6N1	\$244.86	\$146.87	\$530.53	\$318.22
CDHP Option Self Plus One	6N3	\$524.63	\$317.59	\$1,136.70	\$688.11
CDHP Option Self and Family	6N2	\$574.13	\$307.26	\$1,243.95	\$665.73
Value Option Self Only	6N4	\$219.40	\$73.13	\$475.37	\$158.45
Value Option Self Plus One	6N6	\$471.71	\$157.23	\$1,022.03	\$340.67
Value Option Self and Family	6N5	\$493.64	\$164.54	\$1,069.55	\$356.51

Kentucky: Louisville

CDHP Option Self Only	TC1	\$244.86	\$104.55	\$530.53	\$226.53
CDHP Option Self Plus One	TC3	\$524.63	\$226.59	\$1,136.70	\$490.94
CDHP Option Self and Family	TC2	\$574.13	\$212.02	\$1,243.95	\$459.38
Value Option Self Only	TC4	\$200.68	\$66.89	\$434.81	\$144.93
Value Option Self Plus One	TC6	\$431.46	\$143.82	\$934.83	\$311.61
Value Option Self and Family	TC5	\$451.53	\$150.51	\$978.32	\$326.10

Type of Enrollment	Enrollment Code	Premium Rate			
		Biweekly		Monthly	
		Gov't Share	Your Share	Gov't Share	Your Share

Ohio: Cincinnati

CDHP Option Self Only	X31	\$244.86	\$171.62	\$530.53	\$371.84
CDHP Option Self Plus One	X33	\$524.63	\$370.81	\$1,136.70	\$803.42
CDHP Option Self and Family	X32	\$574.13	\$362.95	\$1,243.95	\$786.39
Value Option Self Only	X34	\$240.35	\$80.11	\$520.75	\$173.58
Value Option Self Plus One	X36	\$516.74	\$172.25	\$1,119.61	\$373.20
Value Option Self and Family	X35	\$540.77	\$180.26	\$1,171.67	\$390.56

Tennessee: Knoxville

CDHP Option Self Only	TT1	\$244.86	\$147.12	\$530.53	\$318.76
CDHP Option Self Plus One	TT3	\$524.63	\$318.13	\$1,136.70	\$689.28
CDHP Option Self and Family	TT2	\$574.13	\$307.83	\$1,243.95	\$666.96
Value Option Self Only	TT4	\$244.86	\$97.61	\$530.53	\$211.49
Value Option Self Plus One	TT6	\$524.63	\$211.68	\$1,136.70	\$458.64
Value Option Self and Family	TT5	\$574.13	\$196.42	\$1,243.95	\$425.58

Texas: Austin

CDHP Option Self Only	TV1	\$244.86	\$174.86	\$530.53	\$378.86
CDHP Option Self Plus One	TV3	\$524.63	\$377.79	\$1,136.70	\$818.54
CDHP Option Self and Family	TV2	\$574.13	\$370.26	\$1,243.95	\$802.23
Value Option Self Only	TV4	\$244.86	\$87.11	\$530.53	\$188.74
Value Option Self Plus One	TV6	\$524.63	\$189.13	\$1,136.70	\$409.78
Value Option Self and Family	TV5	\$560.21	\$186.74	\$1,213.79	\$404.60

Type of Enrollment	Enrollment Code	Premium Rate			
		Biweekly		Monthly	
		Gov't Share	Your Share	Gov't Share	Your Share

Texas: Corpus Christi

CDHP Option Self Only	TP1	\$244.86	\$111.51	\$530.53	\$241.61
CDHP Option Self Plus One	TP3	\$524.63	\$241.57	\$1,136.70	\$523.40
CDHP Option Self and Family	TP2	\$574.13	\$227.69	\$1,243.95	\$493.33
Value Option Self Only	TP4	\$168.37	\$56.12	\$364.80	\$121.60
Value Option Self Plus One	TP6	\$362.00	\$120.66	\$784.32	\$261.44
Value Option Self and Family	TP5	\$404.09	\$134.69	\$875.52	\$291.84

Texas: Houston

CDHP Option Self Only	T31	\$244.86	\$157.95	\$530.53	\$342.23
CDHP Option Self Plus One	T33	\$524.63	\$341.41	\$1,136.70	\$739.72
CDHP Option Self and Family	T32	\$574.13	\$332.18	\$1,243.95	\$719.72
Value Option Self Only	T34	\$205.40	\$68.46	\$445.02	\$148.34
Value Option Self Plus One	T36	\$441.62	\$147.20	\$956.84	\$318.94
Value Option Self and Family	T35	\$492.95	\$164.32	\$1,068.07	\$356.02

Texas: San Antonio

CDHP Option Self Only	TU1	\$244.86	\$112.15	\$530.53	\$242.99
CDHP Option Self Plus One	TU3	\$524.63	\$242.96	\$1,136.70	\$526.41
CDHP Option Self and Family	TU2	\$574.13	\$229.16	\$1,243.95	\$496.51
Value Option Self Only	TU4	\$213.11	\$71.03	\$461.73	\$153.91
Value Option Self Plus One	TU6	\$458.20	\$152.73	\$992.76	\$330.92
Value Option Self and Family	TU5	\$479.49	\$159.83	\$1,038.89	\$346.30