HUMANA®

# 2012

## Summary of Benefits
## Extra Services and Programs

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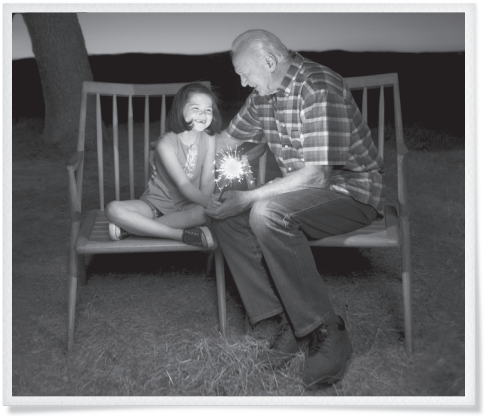

**Humana Gold Choice®**
H8145-061 (PFFS)

# 2012
## Summary of Benefits

## Humana Gold Choice®
H8145-061 (PFFS)

Florida

Select Counties in Florida

HUMANA.

# Section I - Introduction to Summary of Benefits

Thank you for your interest in Humana Gold Choice H8145-061 (PFFS). Our plan is offered by HUMANA INSURANCE COMPANY, a Medicare Advantage Private Fee-for-Service. This Summary of Benefits tells you some features of our plan. It doesn't list every service that we cover or list every limitation or exclusion. To get a complete list of our benefits, please call Humana Gold Choice H8145-061 (PFFS) and ask for the "Evidence of Coverage".

### You Have Choices In Your Health Care

As a Medicare beneficiary, you can choose from different Medicare options. One option is the Original (fee-for-service) Medicare plan. Another option is a Medicare Advantage Private Fee-for-Service plan, like Humana Gold Choice H8145-061 (PFFS). You may have other options too. You make the choice. No matter what you decide, you are still in the Medicare program.

You may join or leave a plan only at certain times. Please call Humana Gold Choice H8145-061 (PFFS) at the telephone number listed at the end of this introduction or 1-800-MEDICARE (1-800-633-4227) for more information. TTY/TDD users should call 1-877-486-2048. You can call this number 24 hours a day, 7 days a week.

### How Can I Compare My Options?

You can compare Humana Gold Choice H8145-061 (PFFS) and the Original Medicare Plan using this Summary of Benefits. The charts in this booklet list some important health benefits. For each benefit, you can see what our plan covers and what the Original Medicare Plan covers.

Our members receive all of the benefits that the Original Medicare Plan offers. We also offer more benefits, which may change from year to year.

### Where Is Humana Gold Choice H8145-061 (PFFS) Available?

The service area for this plan includes: Brevard, Broward, Calhoun, Citrus, Collier, DeSoto, Escambia, Flagler, Glades, Hardee, Hernando, Highlands, Hillsborough, Holmes, Indian River, Jackson, Lee, Levy, Manatee, Marion, Martin, Miami-Dade, Okeechobee, Orange, Osceola, Palm Beach, Pasco, Pinellas, Polk, Putnam, Santa Rosa, Sarasota, Seminole, St. Lucie, Sumter, Volusia Counties, FL. You must live in one of these areas to join the plan.

### Who Is Eligible To Join Humana Gold Choice H8145-061 (PFFS)?

You can join Humana Gold Choice H8145-061 (PFFS) if you are entitled to Medicare Part A and enrolled in Medicare Part B and live in the service area. However, individuals with End-Stage Renal Disease are generally not eligible to enroll in Humana Gold Choice H8145-061 (PFFS) unless they are members of our organization and have been since their dialysis began.

### Where Can I Get My Prescriptions If I Join This Plan?

Humana Gold Choice H8145-061 (PFFS) has formed a network of pharmacies. You must use a network pharmacy to receive plan benefits. We may not pay for your prescriptions if you use an out-of-network pharmacy, except in certain cases.

The pharmacies in our network can change at any time. You can ask for a pharmacy directory or visit us at **http://www.humana.com/Medicare/medicare_prescription_drugs.** Our customer service number is listed at the end of this introduction.

Humana Gold Choice H8145-061 (PFFS) has a list of preferred pharmacies. At these pharmacies, you may get your drugs at a lower copayment or coinsurance. You may go to a non-preferred pharmacy, but you may have to pay more for your prescription drugs.

### How Do I Get Medical Care That Is Covered By The Plan?

You can receive your care from any provider, such as a doctor or hospital, in the United States, if the provider is eligible to be paid by Medicare and agrees to accept our plan's terms and conditions of payment before providing services to you. A provider can decide at every visit to accept our plan's terms and conditions, and thus treat you.

Not all providers accept our plan's terms and conditions of payment or agree to treat you. If a provider from whom you seek care decides not to accept our plan's terms and conditions of payment or refuses to treat you, then you will need to find another provider that will accept our plan's terms and conditions of payment. A provider that decides not to accept our plan's terms and conditions of payment should not provide services to you, except in emergencies. If you need emergency care, it is covered whether a provider agrees to accept our plan's payment terms or not.

Our plan has signed contracts with some providers. These providers are our network providers. We have network providers for all services covered under Medicare. You can still receive services from non-network providers who do not have a signed contract with us, as long as those providers agree to accept our plan's terms and conditions of payment (as described above). However, you may pay more for seeing a provider who is not one of our network providers. For more information, please call the customer service number listed at the end of this introduction.

### Does My Plan Cover Medicare Part B Or Part D Drugs?

Humana Gold Choice H8145-061 (PFFS) does cover both Medicare Part B prescription drugs and Medicare Part D prescription drugs.

### What Is A Prescription Drug Formulary?

Humana Gold Choice H8145-061 (PFFS) uses a formulary. A formulary is a list of drugs covered by your plan to meet patient needs. We may periodically add, remove, or make changes to coverage limitations on certain drugs or change how much you pay for a drug. If we make any formulary change that limits our members' ability to fill their prescriptions, we will notify the affected enrollees before the change is made. We will send a formulary to you and you can see our complete formulary on our Web site at **http://www.humana.com/members/tools/prescription_tools/medicare_drug_list.asp.**

If you are currently taking a drug that is not on our formulary or subject to additional requirements or limits, you may be able to get a temporary supply of the drug. You can contact us to request an exception or switch to an alternative drug listed on our formulary with your physician's help. Call us to see if you can get a temporary supply of the drug or for more details about our drug transition policy.

### How Can I Get Extra Help With My Prescription Drug Plan Costs Or Get Extra Help With Other Medicare Costs?

You may be able to get extra help to pay for your prescription drug premiums and costs as well as get help with other Medicare costs. To see if you qualify for getting extra help, call:

- 1-800-MEDICARE (1-800-633-4227). TTY/TDD users should call 1-877-486-2048, 24 hours a day/7 days a week and see www.medicare.gov 'Programs for People with Limited Income and Resources' in the publication Medicare & You.
- The Social Security Administration at 1-800-772-1213 between 7 a.m. and 7 p.m., Monday through Friday. TTY/TDD users should call 1-800-325-0778 or
- Your State Medicaid Office.

### What Are My Protections In This Plan?

All Medicare Advantage Plans agree to stay in the program for a full calendar year at a time. Plan benefits and cost-sharing may change from calendar year to calendar year. Each year, plans can decide whether to continue to participate with Medicare Advantage. A plan may continue in their entire service area (geographic area where the plan accepts members) or choose to continue only in certain areas. Also, Medicare may decide to end a contract with a plan. Even if your Medicare Advantage Plan leaves the program, you will not lose Medicare coverage. If a plan decides not to continue for an additional calendar year, it must send you a letter at least 90 days before your coverage will end. The letter will explain your options for Medicare coverage in your area.

As a member of Humana Gold Choice H8145-061 (PFFS), you have the right to request an organization determination, which includes the right to file an appeal if we deny coverage for an item or service, and the right to file a grievance. You have the right to request an organization determination if you want us to provide or pay for an item or service that you believe should be covered. If we deny coverage for your requested item or service, you have the right to appeal and ask us to review our decision. You may ask us for an expedited (fast) coverage determination or appeal if you believe that waiting for a decision could seriously put your life or health at risk, or affect your ability to regain maximum function. If your doctor makes or supports the expedited request, we must expedite our decision. Finally, you have the right to file a grievance with us if you have any type of problem with us or one of our network providers that does not involve coverage for an item or service. If your problem involves quality of care, you also have the right to file a grievance with the Quality Improvement Organization (QIO) for your state. Please refer to the Evidence of Coverage (EOC) for the QIO contact information.

As a member of Humana Gold Choice H8145-061 (PFFS), you have the right to request a coverage determination, which includes the right to request an exception, the right to file an appeal if we deny coverage for a prescription drug, and the right to file a grievance. You have the right to request a coverage determination if you want us to cover a Part D drug that you believe should be covered. An exception is a type of coverage determination. You may ask us for an exception if you believe you need a drug that is not on our list of covered drugs or believe you should get a non-preferred drug at a lower out-of-pocket cost. You can also ask for an exception to cost utilization rules, such as a limit on the quantity of a drug. If you think you need an exception, you should contact us before you try to fill your prescription at a pharmacy. Your doctor must provide a statement to support your exception request. If we deny coverage for your prescription drug(s), you have the right to appeal and ask us to review our decision. Finally, you have the right to file a grievance if you have any type of problem with us or one of our network pharmacies that does not involve coverage for a prescription drug. If your problem involves quality of care, you also have the right to file a grievance with the Quality Improvement Organization (QIO) for your state. Please refer to the Evidence of Coverage (EOC) for the QIO contact information.

### What Is A Medication Therapy Management (MTM) Program?

A Medication Therapy Management (MTM) Program is a free service we may offer. You may be invited to participate in a program designed for your specific health and pharmacy needs. You may decide not to participate but it is recommended that you take full advantage of this covered service if you are selected. Contact Humana Gold Choice H8145-061 (PFFS) for more details.

### What Types Of Drugs May Be Covered Under Medicare Part B?

Some outpatient prescription drugs may be covered under Medicare Part B. These may include, but are not limited to, the following types of drugs. Contact Humana Gold Choice H8145-061 (PFFS) for more details.

- **Some Antigens:** If they are prepared by a doctor and administered by a properly instructed person (who could be the patient) under doctor supervision.
- **Osteoporosis Drugs:** Injectable drugs for osteoporosis for certain women with Medicare.
- **Erythropoietin (Epoetin Alfa or Epogen®):** By injection if you have end-stage renal disease (permanent kidney failure requiring either dialysis or transplantation) and need this drug to treat anemia.
- **Hemophilia Clotting Factors:** Self-administered clotting factors if you have hemophilia.
- **Injectable Drugs:** Most injectable drugs administered incident to a physician's service.
- **Immunosuppressive Drugs:** Immunosuppressive drug therapy for transplant patients if the transplant was paid for by Medicare, or paid by a private insurance that paid as a primary payer to your Medicare Part A coverage, in a Medicare-certified facility.
- **Some Oral Cancer Drugs:** If the same drug is available in injectable form.
- **Oral Anti-Nausea Drugs:** If you are part of an anti-cancer chemotherapeutic regimen.
- **Inhalation and Infusion Drugs administered through DME.**

### Where Can I Find Information On Plan Ratings?

The Medicare program rates how well plans perform in different categories (for example, detecting and preventing illness, ratings from patients and customer service). If you have access to the web, you may use the web tools on www.medicare.gov and select "Health and Drug Plans" then "Compare Drug and Health Plans" to compare the plan ratings for Medicare plans in your area. You can also call us directly to obtain a copy of the plan ratings for this plan. Our customer service number is listed below.

Please call Humana Insurance Company for more information about Humana Gold Choice H8145-061 (PFFS).

Visit us at **www.humana-medicare.com** or, call us:
Customer Service Hours: Sunday, Monday, Tuesday, Wednesday, Thursday, Friday, Saturday, 8 a.m. - 8 p.m. Eastern

Current members should call toll-free **(800)-457-4708** for questions related to the Medicare Advantage Program.
**(TTY/TDD 711)**

Prospective members should call toll-free **(800)-833-2364** for questions related to the Medicare Advantage Program.
**(TTY/TDD 711)**

Current members should call locally **(800)-457-4708** for questions related to the Medicare Advantage Program.
**(TTY/TDD 711)**

Prospective members should call locally **(800)-833-2364** for questions related to the Medicare Advantage Program.
**(TTY/TDD 711)**

Current members should call toll-free **(800)-457-4708** for questions related to the Medicare Part D Prescription Drug program.
**(TTY/TDD 711)**

Prospective members should call toll-free **(800)-833-2364** for questions related to the Medicare Part D Prescription Drug program.
**(TTY/TDD 711)**

Current members should call locally **(800)-457-4708** for questions related to the Medicare Part D Prescription Drug program.
**(TTY/TDD 711)**

Prospective members should call locally **(800)-833-2364** for questions related to the Medicare Part D Prescription Drug program.
**(TTY/TDD 711)**

For more information about Medicare, please call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. You can call 24 hours a day, 7 days a week. Or, visit www.medicare.gov on the web.This document may be available in other formats such as Braille, large print or other alternate formats.

This document may be available in a non-English language. For additional information, call customer service at the phone number listed above.

Este documento podría estar disponible en un idioma diferente del inglés. Si desea información adicional, comuníquese con el Departamento de Atención al Cliente al número telefónico indicado arriba.

# Section II - Summary of Benefits

## IMPORTANT INFORMATION

| BENEFIT | ORIGINAL MEDICARE | Humana Gold Choice H8145-061 (PFFS) |
|---|---|---|
| ① **Premium and Other Important Information** | • In 2012 the monthly Part B Standard Premium is **$99.90** and the annual Part B deductible amount is **$140.**<br>• If a doctor or supplier does not accept assignment, their costs are often higher, which means you pay more.<br>• Most people will pay the standard monthly Part B premium. However, some people will pay a higher premium because of their yearly income (over **$85,000** for singles, **$170,000** for married couples). For more information about Part B premiums based on income, call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. You may also call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778. | **General**<br>• **$99** monthly plan premium in addition to your monthly Medicare Part B premium.<br>• Most people will pay the standard monthly Part B premium in addition to their MA plan premium. However, some people will pay higher Part B and Part D premiums because of their yearly income (over **$85,000** for singles, **$170,000** for married couples). For more information about Part B and Part D premiums based on income, call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. You may also call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778.<br>• This plan does not allow providers to balance bill (charging more than your cost share amount).<br>**In-Network**<br>• **$6,700** out-of-pocket limit for Medicare-covered services.<br>**In and Out-of-Network**<br>• **$6,700** out-of-pocket limit for Medicare-covered services.<br>**See page 33 for additional information about Premium and Other Important Information** |
| ② **Doctor and Hospital Choice** (For more information, see Emergency Care - #15 and Urgently Needed Care - #16.) | • You may go to any doctor, specialist or hospital that accepts Medicare. | **In and Out-of-Network**<br>• You may go to any doctor, specialist, or hospital that accepts the plan's terms and conditions of payment.<br>**See page 33 for additional information about Doctor and Hospital Choice** |

# INPATIENT CARE

| BENEFIT | ORIGINAL MEDICARE | Humana Gold Choice H8145-061 (PFFS) |
|---|---|---|
| ③ **Inpatient Hospital Care** (includes Substance Abuse and Rehabilitation Services) | • In 2012 the amounts for each benefit period are:<br>– Days 1 - 60: **$1,156** deductible<br>– Days 61 - 90: **$289** per day<br>– Days 91 - 150: **$578** per lifetime reserve day<br>• Call 1-800-MEDICARE (1-800-633-4227) for information about lifetime reserve days.<br>• Lifetime reserve days can only be used once.<br>• A "benefit period" starts the day you go into a hospital or skilled nursing facility. It ends when you go for 60 days in a row without hospital or skilled nursing care. If you go into the hospital after one benefit period has ended, a new benefit period begins. You must pay the inpatient hospital deductible for each benefit period. There is no limit to the number of benefit periods you can have. | **General**<br>• You may go to any doctor, specialist, or hospital that accepts the plan's terms and conditions of payment except in emergencies.<br>**In-Network**<br>• No limit to the number of days covered by the plan each hospital stay.<br>• For Medicare-covered hospital stays:<br>– Days 1 - 7: **$225** copayment per day<br>– Days 8 - 90: **$0** copayment per day<br>• **$0** copayment for each additional hospital day.<br>**Out-of-Network**<br>• For hospital stays:<br>– Days 1 - 7: **$225** copayment per day<br>– Days 8 - 90: **$0** copayment per day<br>**See page 33 for additional information about Inpatient Hospital Care** |
| ④ **Inpatient Mental Health Care** | • In 2012 the amounts for each benefit period are:<br>– Days 1 - 60: **$1,156** deductible<br>– Days 61 - 90: **$289** per day<br>– Days 91 - 150: **$578** per lifetime reserve day<br>• You get up to 190 days of inpatient psychiatric hospital care in a lifetime. Inpatient psychiatric hospital services count toward the 190-day lifetime limitation only if certain conditions are met. This limitation does not apply to inpatient psychiatric services furnished in a general hospital. | **In-Network**<br>• You get up to 190 days of inpatient psychiatric hospital care in a lifetime. Inpatient psychiatric hospital services count toward the 190-day lifetime limitation only if certain conditions are met. This limitation does not apply to inpatient psychiatric services furnished in a general hospital.<br>• For Medicare-covered hospital stays:<br>– Days 1 - 6: **$225** copayment per day<br>– Days 7 - 90: **$0** copayment per day<br>**Out-of-Network**<br>• For hospital stays:<br>– Days 1 - 6: **$225** copayment per day<br>– Days 7 - 90: **$0** copayment per day<br>**See page 33 for additional information about Inpatient Mental Health Care** |

(Inpatient Care - Continued on next page)

If you have any questions about this plan's benefits or costs, please contact Humana Insurance Company for details.

# INPATIENT CARE

| BENEFIT | ORIGINAL MEDICARE | Humana Gold Choice H8145-061 (PFFS) |
|---|---|---|
| (5) **Skilled Nursing Facility (SNF)** (in a Medicare-certified skilled nursing facility) | • In 2012 the amounts for each benefit period after at least a 3-day covered hospital stay are:<br>– Days 1 - 20: **$0** per day<br>– Days 21 - 100: **$144.50** per day<br>• 100 days for each benefit period.<br>• A "benefit period" starts the day you go into a hospital or SNF. It ends when you go for 60 days in a row without hospital or skilled nursing care. If you go into the hospital after one benefit period has ended, a new benefit period begins. You must pay the inpatient hospital deductible for each benefit period. There is no limit to the number of benefit periods you can have. | **In-Network**<br>• Plan covers up to 100 days each benefit period<br>• No prior hospital stay is required.<br>• For SNF stays:<br>– Days 1 - 7: **$0** copayment per day<br>– Days 8 - 100: **$50** copayment per day<br>**Out-of-Network**<br>• For each SNF stay:<br>– Days 1 - 7: **$0** copayment per SNF day<br>– Days 8 - 100: **$50** copayment per SNF day<br>**See page 33 for additional information about Skilled Nursing Facility (SNF)** |
| (6) **Home Health Care** (includes medically necessary intermittent skilled nursing care, home health aide services, and rehabilitation services, etc.) | • **$0** copayment. | **In-Network**<br>• **$0** copayment for Medicare-covered home health visits<br>**Out-of-Network**<br>• **$0** copayment for home health visits |
| (7) **Hospice** | • You pay part of the cost for outpatient drugs and inpatient respite care.<br>• You must get care from a Medicare-certified hospice. | **General**<br>• You must get care from a Medicare-certified hospice. Your plan will pay for a consultative visit before you select hospice. |

If you have any questions about this plan's benefits or costs, please contact Humana Insurance Company for details.

# OUTPATIENT CARE

| BENEFIT | ORIGINAL MEDICARE | Humana Gold Choice H8145-061 (PFFS) |
|---|---|---|
| (8) **Doctor Office Visits** | • **20%** coinsurance | **General**<br>• You may go to any doctor, specialist, or hospital that accepts the plan's terms and conditions of payment.<br>**In-Network**<br>• **$10** copayment for each primary care doctor visit for Medicare-covered benefits.<br>• **$30** copayment for each in-area, network urgent care Medicare-covered visit<br>• **$30** copayment for each specialist visit for Medicare-covered benefits.<br>**Out-of-Network**<br>• **$10** copayment for each primary care doctor visit<br>• **$30** copayment for each specialist visit<br>**See page 34 for additional information about Doctor Office Visits** |
| (9) **Chiropractic Services** | • Supplemental routine care not covered<br>• **20%** coinsurance for manual manipulation of the spine to correct subluxation (a displacement or misalignment of a joint or body part) if you get it from a chiropractor or other qualified providers. | **In-Network**<br>• **$20** copayment for each Medicare-covered visit<br>• Medicare-covered chiropractic visits are for manual manipulation of the spine to correct subluxation (a displacement or misalignment of a joint or body part) if you get it from a chiropractor or other qualified providers.<br>**Out-of-Network**<br>• **$20** copayment for chiropractic benefits. |
| (10) **Podiatry Services** | • Supplemental routine care not covered.<br>• **20%** coinsurance for medically necessary foot care, including care for medical conditions affecting the lower limbs. | **In-Network**<br>• **$30** copayment for each Medicare-covered visit<br>• Medicare-covered podiatry benefits are for medically-necessary foot care.<br>**Out-of-Network**<br>• **$30** copayment for podiatry benefits. |

(Outpatient Care - Continued on next page)

If you have any questions about this plan's benefits or costs, please contact Humana Insurance Company for details.

# OUTPATIENT CARE

| BENEFIT | ORIGINAL MEDICARE | Humana Gold Choice H8145-061 (PFFS) |
|---|---|---|
| (11) **Outpatient Mental Health Care** | • **40%** coinsurance for most outpatient mental health services<br>• Specified copayment for outpatient partial hospitalization program services furnished by a hospital or community mental health center (CMHC). Copayment cannot exceed the Part A inpatient hospital deductible.<br>• "Partial hospitalization program" is a structured program of active outpatient psychiatric treatment that is more intense than the care received in your doctor's or therapist's office and is an alternative to inpatient hospitalization. | **In-Network**<br>• **$30** copayment for each Medicare-covered individual therapy visit<br>• **$30** copayment for each Medicare-covered group therapy visit<br>• **$30** copayment for each Medicare-covered individual therapy visit with a psychiatrist<br>• **$30** copayment for each Medicare-covered group therapy visit with a psychiatrist<br>• **20%** of the cost for Medicare-covered partial hospitalization program services<br>**Out-of-Network**<br>• **20%** of the cost for partial hospitalization program services<br>• **$30** copayment for Mental Health benefits with a psychiatrist<br>• **$30** copayment for Mental Health benefits<br>**See page 34 for additional information about Outpatient Mental Health Care** |
| (12) **Outpatient Substance Abuse Care** | • **20%** coinsurance | **In-Network**<br>• **25%** of the cost for Medicare-covered individual visits<br>• **25%** of the cost for Medicare-covered group visits<br>**Out-of-Network**<br>• **25%** of the cost for outpatient substance abuse benefits.<br>**See page 34 for additional information about Outpatient Substance Abuse Care** |

(Outpatient Care - Continued on next page)

If you have any questions about this plan's benefits or costs, please contact Humana Insurance Company for details.

# OUTPATIENT CARE

| BENEFIT | ORIGINAL MEDICARE | Humana Gold Choice H8145-061 (PFFS) |
|---|---|---|
| (13) **Outpatient Services/Surgery** | • **20%** coinsurance for the doctor's services<br>• Specified copayment for outpatient hospital facility services. Copayment cannot exceed the Part A inpatient hospital deductible.<br>• **20%** coinsurance for ambulatory surgical center facility services | **In-Network**<br>• **20%** of the cost for each Medicare-covered ambulatory surgical center visit<br>• **20%** to **25%** of the cost for each Medicare-covered outpatient hospital facility visit<br>**Out-of-Network**<br>• **20%** of the cost for ambulatory surgical center benefits.<br>• **25%** of the cost for outpatient hospital facility benefits.<br>**See page 34 for additional information about Outpatient Services/Surgery** |
| (14) **Ambulance Services** (medically necessary ambulance services) | • **20%** coinsurance | **In-Network**<br>• **$150** copayment for Medicare-covered ambulance benefits.<br>**Out-of-Network**<br>• **$150** copayment for ambulance benefits. |
| (15) **Emergency Care** (You may go to any emergency room if you reasonably believe you need emergency care.) | • **20%** coinsurance for the doctor's services<br>• Specified copayment for outpatient hospital facility emergency services.<br>• Emergency services copayment cannot exceed Part A inpatient hospital deductible for each service provided by the hospital.<br>• You don't have to pay the emergency room copayment if you are admitted to the hospital as an inpatient for the same condition within 3 days of the emergency room visit.<br>• Not covered outside the U.S. except under limited circumstances. | **General**<br>• **$65** copayment for Medicare-covered emergency room visits<br>• **$25,000** plan coverage limit for emergency services outside the U.S. every year.<br>**See page 34 for additional information about Emergency Care** |
| (16) **Urgently Needed Care** (This is NOT emergency care, and in most cases, is out of the service area.) | • **20%** coinsurance, or a set copayment<br>• NOT covered outside the U.S. except under limited circumstances. | **General**<br>• **$10** to **$30** copayment for Medicare-covered urgently-needed-care visits |

(Outpatient Care - Continued on next page)

If you have any questions about this plan's benefits or costs, please contact Humana Insurance Company for details.

# OUTPATIENT CARE

| BENEFIT | ORIGINAL MEDICARE | Humana Gold Choice H8145-061 (PFFS) |
|---|---|---|
| (17) **Outpatient Rehabilitation Services** (Occupational Therapy, Physical Therapy, Speech and Language Therapy) | • **20%** coinsurance | **In-Network**<br>• There may be limits on physical therapy, occupational therapy, and speech and language pathology services If so, there may be exceptions to these limits.<br>• **$30** copayment [or **25%** of the cost] for Medicare-covered Occupational Therapy visits<br>• **$30** copayment [or **25%** of the cost] for Medicare-covered Physical and/or Speech and Language Therapy visits<br>**Out-of-Network**<br>• **$30** copayment [or **20%** to **25%** of the cost] for Physical and/or Speech and Language Therapy visits<br>• **$30** copayment [or **20%** to **25%** of the cost] for Occupational Therapy benefits.<br>**See page 34 for additional information about Outpatient Rehabilitation Services** |

If you have any questions about this plan's benefits or costs, please contact Humana Insurance Company for details.

# OUTPATIENT MEDICAL SERVICES AND SUPPLIES

| BENEFIT | ORIGINAL MEDICARE | Humana Gold Choice H8145-061 (PFFS) |
|---|---|---|
| (18) **Durable Medical Equipment** (includes wheelchairs, oxygen, etc.) | • **20%** coinsurance | **In-Network**<br>• **20%** of the cost for Medicare-covered items<br>**Out-of-Network**<br>• **20%** of the cost for durable medical equipment |
| (19) **Prosthetic Devices** (includes braces, artificial limbs and eyes, etc.) | • **20%** coinsurance | **In-Network**<br>• **20%** of the cost for Medicare-covered items<br>**Out-of-Network**<br>• **20%** of the cost for prosthetic devices. |
| (20) **Diabetes Programs and Supplies** | • **20%** coinsurance for diabetes self-management training<br>• **20%** coinsurance for diabetes supplies<br>• **20%** coinsurance for diabetic therapeutic shoes or inserts | **In-Network**<br>• **$0** copayment for Diabetes self-management training<br>• **0%** to **20%** of the cost for Diabetes monitoring supplies<br>• **$10** copayment for Therapeutic shoes or inserts<br>**Out-of-Network**<br>• **20%** of the cost for Diabetes monitoring supplies<br>• **20%** of the cost for Therapeutic shoes or inserts<br>• **$0** copayment for Diabetes self-management training<br>**See page 35 for additional information about Diabetes Programs and Supplies** |

(Outpatient Medical Services and Supplies - Continued on next page)

# OUTPATIENT MEDICAL SERVICES AND SUPPLIES

| BENEFIT | ORIGINAL MEDICARE | Humana Gold Choice H8145-061 (PFFS) |
|---|---|---|
| (21) **Diagnostic Tests, X-Rays, Lab Services, and Radiology Services** | • **20%** coinsurance for diagnostic tests and x-rays<br>• **$0** copayment for Medicare-covered lab services<br>• Lab Services: Medicare covers medically necessary diagnostic lab services that are ordered by your treating doctor when they are provided by a Clinical Laboratory Improvement Amendments (CLIA) certified laboratory that participates in Medicare. Diagnostic lab services are done to help your doctor diagnose or rule out a suspected illness or condition. Medicare does not cover most supplemental routine screening tests, like checking your cholesterol. | **In-Network**<br>• **$0** to **$30** copayment [or **0%** to **25%** of the cost] for Medicare-covered lab services<br>• **$0** to **$30** copayment [or **0%** to **25%** of the cost] for Medicare-covered diagnostic procedures and tests<br>• **$10** to **$30** copayment [or **20%** to **25%** of the cost] for Medicare-covered X-rays<br>• **$10** to **$75** copayment [or **20%** to **25%** of the cost] for Medicare-covered diagnostic radiology services (not including X-rays)<br>• **$30** copayment [or **20%** of the cost] for Medicare-covered therapeutic radiology services<br>• If the doctor provides you services in addition to Outpatient Diagnostic and Therapeutic Radiology Services, separate cost sharing of **$10** to **$30** may apply<br>**Out-of-Network**<br>• **$0** to **$30** copayment [or **20%** to **25%** of the cost] for diagnostic procedures, tests, and lab services<br>• **$10** to **$30** copayment [or **20%** to **25%** of the cost] for outpatient X-rays<br>• **$30** to **$75** copayment [or **20%** to **25%** of the cost] for diagnostic radiology services<br>• **$30** copayment [or **20%** of the cost] for therapeutic radiology services<br>**See page 35 for additional information about Diagnostic Tests, X-rays, Lab Services and Radiology Services** |

(Outpatient Medical Services and Supplies - Continued on next page)

# OUTPATIENT MEDICAL SERVICES AND SUPPLIES

| BENEFIT | ORIGINAL MEDICARE | Humana Gold Choice H8145-061 (PFFS) |
|---|---|---|
| (22) **Cardiac and Pulmonary Rehabilitation Services** | • **20%** coinsurance for Cardiac Rehabilitation services<br>• **20%** coinsurance for Pulmonary Rehabilitation services<br>• **20%** coinsurance for Intensive Cardiac Rehabilitation services<br>• This applies to program services provided in a doctor's office. Specified cost sharing for program services provided by hospital outpatient departments. | **In-Network**<br>• **$30** copayment [or **25%** of the cost] for Medicare-covered Cardiac Rehabilitation Services<br>• **$30** copayment [or **25%** of the cost] for Medicare-covered Intensive Cardiac Rehabilitation Services<br>• **$30** copayment [or **20%** to **25%** of the cost] for Medicare-covered Pulmonary Rehabilitation Services<br>**Out-of-Network**<br>• **$30** copayment [or **20%** to **25%** of the cost] for Cardiac Rehabilitation Services<br>• **$30** copayment [or **20%** to **25%** of the cost] for Intensive Cardiac Rehabilitation Services<br>• **$30** copayment [or **20%** to **25%** of the cost] for Pulmonary Rehabilitation Services<br>**See page 36 for additional information about Cardiac and Pulmonary Rehabilitation Services** |

# PREVENTIVE SERVICES

| BENEFIT | ORIGINAL MEDICARE | Humana Gold Choice H8145-061 (PFFS) |
|---|---|---|
| (23) **Preventive Services and Wellness/Education Programs** | • No coinsurance, copayment or deductible for the following:<br>– Abdominal Aortic Aneurysm Screening<br>– Bone Mass Measurement. Covered once every 24 months (more often if medically necessary) if you meet certain medical conditions.<br>– Cardiovascular Screening<br>– Cervical and Vaginal Cancer Screening. Covered once every 2 years. Covered once a year for women with Medicare at high risk.<br>– Colorectal Cancer Screening<br>– Diabetes Screening<br>– Influenza Vaccine<br>– Hepatitis B Vaccine for people with Medicare who are at risk<br>– HIV Screening. **$0** copayment for the HIV screening, but you generally pay **20%** of the Medicare-approved amount for the doctor's visit. HIV screening is covered for people with Medicare who are pregnant and people at increased risk for the infection, including anyone who asks for the test. Medicare covers this test once every 12 months or up to three times during a pregnancy.<br>– Breast Cancer Screening (Mammogram). Medicare covers screening mammograms once every 12 months for all women with Medicare age 40 and older. Medicare covers one baseline mammogram for women between ages 35-39.<br>– Medical Nutrition Therapy Services. Nutrition therapy is for people who have diabetes or kidney disease (but aren't on dialysis or haven't had a kidney transplant) when referred by a doctor. These services can be given by a registered dietitian and may include a nutritional assessment and counseling to help you manage your diabetes or kidney disease<br>– Personalized Prevention Plan Services (Annual Wellness Visits) | **General**<br>• **$0** copayment for all preventive services covered under Original Medicare at zero cost sharing:<br>– Abdominal Aortic Aneurysm screening<br>– Bone Mass Measurement<br>– Cardiovascular Screening<br>– Cervical and Vaginal Cancer Screening (Pap Test and Pelvic Exam)<br>– Colorectal Cancer Screening<br>– Diabetes Screening<br>– Influenza Vaccine<br>– Hepatitis B Vaccine<br>– HIV Screening<br>– Breast Cancer Screening (Mammogram)<br>– Medical Nutrition Therapy Services<br>– Personalized Prevention Plan Services (Annual Wellness Visits)<br>– Pneumococcal Vaccine<br>– Prostate Cancer Screening (Prostate Specific Antigen (PSA) test only)<br>– Smoking Cessation (Counseling to stop smoking)<br>– Welcome to Medicare Physical Exam (Initial Preventive Physical Exam)<br>• HIV screening is covered for people with Medicare who are pregnant and people at increased risk for the infection, including anyone who asks for the test. Medicare covers this test once every 12 months or up to three times during a pregnancy. Please contact plan for details.<br>**In-Network**<br>• The plan covers the following supplemental education/wellness programs:<br>– Written health education materials, including Newsletters<br>– Additional Smoking Cessation<br>– Health Club Membership/Fitness Classes<br>– Nursing Hotline<br>**Out-of-Network**<br>• **$0** copayment for Medicare-covered preventive services<br>• **$0** copayment for supplemental education/wellness programs |

(Preventive Services - Continued on next page)

# PREVENTIVE SERVICES

| BENEFIT | ORIGINAL MEDICARE | Humana Gold Choice H8145-061 (PFFS) |
|---|---|---|
| | – Pneumococcal Vaccine. You may only need the Pneumonia vaccine once in your lifetime. Call your doctor for more information.<br>– Prostate Cancer Screening. Prostate Specific Antigen (PSA) test only. Covered once a year for all men with Medicare over age 50.<br>– Smoking Cessation (counseling to stop smoking). Covered if ordered by your doctor. Includes two counseling attempts within a 12-month period. Each counseling attempt includes up to four face-to-face visits.<br>– Welcome to Medicare Physical Exam (initial preventive physical exam). When you join Medicare Part B, then you are eligible as follows. During the first 12 months of your new Part B coverage, you can get either a Welcome to Medicare Physical Exam or an Annual Wellness Visit. After your first 12 months, you can get one Annual Wellness Visit every 12 months. | **See page 36 for additional information about Preventive Services and Wellness/Education Programs** |

# OTHER SERVICES

| BENEFIT | ORIGINAL MEDICARE | Humana Gold Choice H8145-061 (PFFS) |
|---|---|---|
| (24) **Kidney Disease and Conditions** | • **20%** coinsurance for renal dialysis<br>• **20%** coinsurance for kidney disease education services | **In-Network**<br>• **20%** of the cost for renal dialysis<br>• **$0** copayment for kidney disease education services<br>**Out-of-Network**<br>• **20%** of the cost for renal dialysis<br>• **$0** copayment for kidney disease education services<br>**See page 37 for additional information about Kidney Disease and Conditions** |
| (25) **Outpatient Prescription Drugs** | • Most drugs are not covered under Original Medicare. You can add prescription drug coverage to Original Medicare by joining a Medicare Prescription Drug Plan, or you can get all your Medicare coverage, including prescription drug coverage, by joining a Medicare Advantage Plan or a Medicare Cost Plan that offers prescription drug coverage. | **Drugs covered under Medicare Part B General**<br>• **0%** to **20%** of the cost for Part B-covered drugs (not including Part B-covered chemotherapy drugs).<br>• **20%** of the cost for Part B-covered chemotherapy drugs.<br>• **0%** to **25%** of the cost for Part B drugs out-of-network.<br>**Drugs covered under Medicare Part D General**<br>• This plan uses a formulary. The plan will send you the formulary. You can also see the formulary at **http://www.humana.com/members/tools/prescription_tools/medicare_drug_list.asp** on the web.<br>• Different out-of-pocket costs may apply for people who<br>– have limited incomes,<br>– live in long term care facilities, or<br>– have access to Indian/Tribal/Urban (Indian Health Service) providers.<br>• The plan offers national in-network prescription coverage (i.e., this would include 50 states and the District of Columbia). This means that you will pay the same cost-sharing amount for your prescription drugs if you get them at an in-network pharmacy outside of the plan's service area (for instance when you travel).<br>• Total yearly drug costs are the total drug costs paid by both you and a Part D plan. |

(Other Services - Continued on next page)

# OTHER SERVICES

| BENEFIT | ORIGINAL MEDICARE | Humana Gold Choice H8145-061 (PFFS) |
|---|---|---|
| **Outpatient Prescription Drugs (continued)** | | |
| | | • The plan may require you to first try one drug to treat your condition before it will cover another drug for that condition.<br>• Some drugs have quantity limits.<br>• Your provider must get prior authorization from Humana Gold Choice H8145-061 (PFFS) for certain drugs.<br>• You must go to certain pharmacies for a very limited number of drugs, due to special handling, provider coordination, or patient education requirements that cannot be met by most pharmacies in your network. These drugs are listed on the plan's website, formulary, printed materials, as well as on the Medicare Prescription Drug Plan Finder on Medicare.gov.<br>• If the actual cost of a drug is less than the normal cost-sharing amount for that drug, you will pay the actual cost, not the higher cost-sharing amount.<br>• If you request a formulary exception for a drug and Humana Gold Choice H8145-061 (PFFS) approves the exception, you will pay Tier 3: Non-Preferred Brand Drugs cost sharing for that drug.<br>**In-Network**<br>• **$0** deductible.<br>**Initial Coverage**<br>• You pay the following until total yearly drug costs reach **$2,930**:<br>**Retail Pharmacy**<br>• Tier 1: Preferred Generic Drugs<br>– **$8** copayment for a one-month (30-day) supply of drugs in this tier<br>– **$24** copayment for a three-month (90-day) supply of drugs in this tier<br>• Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information.<br>• Tier 2: Preferred Brand Drugs<br>– **$42** copayment for a one-month (30-day) supply of drugs in this tier |

(Other Services - Continued on next page)

# OTHER SERVICES

| BENEFIT | ORIGINAL MEDICARE | Humana Gold Choice H8145-061 (PFFS) |
|---|---|---|
| **Outpatient Prescription Drugs (continued)** | | |
| | | – **$126** copayment for a three-month (90-day) supply of drugs in this tier<br>• Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information.<br><br>• Tier 3: Non-Preferred Brand Drugs<br>– **$81** copayment for a one-month (30-day) supply of drugs in this tier<br>– **$243** copayment for a three-month (90-day) supply of drugs in this tier<br>• Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information.<br><br>• Tier 4: Specialty Tier Drugs<br>– **33%** coinsurance for a one-month (30-day) supply of drugs in this tier<br>**Long Term Care Pharmacy**<br>• Tier 1: Preferred Generic Drugs<br>– **$8** copayment for a one-month (34-day) supply of drugs in this tier<br><br>• Tier 2: Preferred Brand Drugs<br>– **$42** copayment for a one-month (34-day) supply of drugs in this tier<br><br>• Tier 3: Non-Preferred Brand Drugs<br>– **$81** copayment for a one-month (34-day) supply of drugs in this tier<br><br>• Tier 4: Specialty Tier Drugs<br>– **33%** coinsurance for a one-month (34-day) supply of drugs in this tier<br>**Mail Order**<br>• Tier 1: Preferred Generic Drugs<br>– **$0** copayment for a one-month (30-day) supply of drugs in this tier from a preferred mail order pharmacy.<br>– **$0** copayment for a three-month (90-day) supply of drugs in this tier from a preferred mail order pharmacy. |

(Other Services - Continued on next page)

# OTHER SERVICES

| BENEFIT | ORIGINAL MEDICARE | Humana Gold Choice H8145-061 (PFFS) |
|---|---|---|
| **Outpatient Prescription Drugs (continued)** | | |
| | | – **$8** copayment for a one-month (30-day) supply of drugs in this tier from a non-preferred mail order pharmacy.<br>– **$24** copayment for a three-month (90-day) supply of drugs in this tier from a non-preferred mail order pharmacy.<br>• Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information.<br><br>• Tier 2: Preferred Brand Drugs<br>– **$42** copayment for a one-month (30-day) supply of drugs in this tier from a preferred mail order pharmacy.<br>– **$116** copayment for a three-month (90-day) supply of drugs in this tier from a preferred mail order pharmacy.<br>– **$42** copayment for a one-month (30-day) supply of drugs in this tier from a non-preferred mail order pharmacy.<br>– **$126** copayment for a three-month (90-day) supply of drugs in this tier from a non-preferred mail order pharmacy.<br>• Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information.<br><br>• Tier 3: Non-Preferred Brand Drugs<br>– **$81** copayment for a one-month (30-day) supply of drugs in this tier from a preferred mail order pharmacy.<br>– **$233** copayment for a three-month (90-day) supply of drugs in this tier from a preferred mail order pharmacy.<br>– **$81** copayment for a one-month (30-day) supply of drugs in this tier from a non-preferred mail order pharmacy.<br>– **$243** copayment for a three-month (90-day) supply of drugs in this tier from a non-preferred mail order pharmacy.<br>• Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information. |

(Other Services - Continued on next page)

# OTHER SERVICES

| BENEFIT | ORIGINAL MEDICARE | Humana Gold Choice H8145-061 (PFFS) |
|---|---|---|
| **Outpatient Prescription Drugs (continued)** | | |
| | | • Tier 4: Specialty Tier Drugs<br>– **33%** coinsurance for a one-month (30-day) supply of drugs in this tier from a preferred mail order pharmacy.<br>– **33%** coinsurance for a one-month (30-day) supply of drugs in this tier from a non-preferred mail order pharmacy.<br>**Additional Coverage Gap**<br>• The plan covers few formulary generics (less than **10%** of formulary generic drugs), few formulary brands (less than **10%** of formulary brand drugs) through the coverage gap.<br>• You pay the following:<br>**Retail Pharmacy**<br>• Tier 1: Preferred Generic Drugs<br>– **$8** copayment for a one-month (30-day) supply of select drugs covered in this tier<br>– **$24** copayment for a three-month (90-day) supply of select drugs covered in this tier<br>• Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information.<br><br>• Tier 2: Preferred Brand Drugs<br>– **$42** copayment for a one-month (30-day) supply of select drugs covered in this tier<br>– **$126** copayment for a three-month (90-day) supply of select drugs covered in this tier<br>• Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information.<br><br>• Tier 3: Non-Preferred Brand Drugs<br>– **$81** copayment for a one-month (30-day) supply of select drugs covered in this tier<br>– **$243** copayment for a three-month (90-day) supply of select drugs covered in this tier<br>• Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information. |

(Other Services - Continued on next page)

# OTHER SERVICES

| BENEFIT | ORIGINAL MEDICARE | Humana Gold Choice H8145-061 (PFFS) |
|---|---|---|
| **Outpatient Prescription Drugs (continued)** | | |
| | | • Tier 4: Specialty Tier Drugs<br>– **33%** coinsurance for a one-month (30-day) supply of select drugs covered in this tier<br>**Long Term Care Pharmacy**<br>• Tier 1: Preferred Generic Drugs<br>– **$8** copayment for a one-month (34-day) supply of select drugs covered in this tier<br>• Tier 2: Preferred Brand Drugs<br>– **$42** copayment for a one-month (34-day) supply of select drugs covered in this tier<br>• Tier 3: Non-Preferred Brand Drugs<br>– **$81** copayment for a one-month (34-day) supply of select drugs covered in this tier<br>• Tier 4: Specialty Tier Drugs<br>– **33%** coinsurance for a one-month (34-day) supply of select drugs covered in this tier<br>**Mail Order**<br>• Tier 1: Preferred Generic Drugs<br>– **$0** copayment for a one-month (30-day) supply of select drugs covered in this tier from a preferred mail order pharmacy<br>– **$0** copayment for a three-month (90-day) supply of select drugs covered in this tier from a preferred mail order pharmacy<br>– **$8** copayment for a one-month (30-day) supply of select drugs covered in this tier from a non-preferred mail order pharmacy<br>– **$24** copayment for a three-month (90-day) supply of select drugs covered in this tier from a non-preferred mail order pharmacy<br>• Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information.<br>• Tier 2: Preferred Brand Drugs<br>– **$42** copayment for a one-month (30-day) supply of select drugs covered in this tier from a preferred mail order pharmacy<br>– **$116** copayment for a three-month (90-day) supply of select drugs covered in |

(Other Services - Continued on next page)

# OTHER SERVICES

| BENEFIT | ORIGINAL MEDICARE | Humana Gold Choice H8145-061 (PFFS) |
|---|---|---|
| **Outpatient Prescription Drugs (continued)** | | |
| | | this tier from a preferred mail order pharmacy<br>– **$42** copayment for a one-month (30-day) supply of select drugs covered in this tier from a non-preferred mail order pharmacy<br>– **$126** copayment for a three-month (90-day) supply of select drugs covered in this tier from a non-preferred mail order pharmacy<br>• Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information.<br><br>• Tier 3: Non-Preferred Brand Drugs<br>– **$81** copayment for a one-month (30-day) supply of select drugs covered in this tier from a preferred mail order pharmacy<br>– **$233** copayment for a three-month (90-day) supply of select drugs covered in this tier from a preferred mail order pharmacy<br>– **$81** copayment for a one-month (30-day) supply of select drugs covered in this tier from a non-preferred mail order pharmacy<br>– **$243** copayment for a three-month (90-day) supply of select drugs covered in this tier from a non-preferred mail order pharmacy<br>• Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information.<br><br>• Tier 4: Specialty Tier Drugs<br>– **33%** coinsurance for a one-month (30-day) supply of select drugs covered in this tier from a preferred mail order pharmacy<br>– **33%** coinsurance for a one-month (30-day) supply of select drugs covered in this tier from a non-preferred mail order pharmacy<br>• Please contact the plan for a complete list of drugs covered through the gap.<br>• After your total yearly drug costs reach **$2,930,** you receive limited coverage by the |

(Other Services - Continued on next page)

# OTHER SERVICES

| BENEFIT | ORIGINAL MEDICARE | Humana Gold Choice H8145-061 (PFFS) |
|---|---|---|
| **Outpatient Prescription Drugs (continued)** | | |
| | | plan on certain drugs. You will also receive a discount on brand name drugs and generally pay no more than **86%** of the plan's costs for generic drugs until your yearly out-of-pocket drug costs reach **$4,700.**<br>**Catastrophic Coverage**<br>• After your yearly out-of-pocket drug costs reach **$4,700,** you pay the greater of:<br>– **5%** coinsurance, or<br>– **$2.60** copayment for generic (including brand drugs treated as generic) and a **$6.50** copayment for all other drugs.<br>**Out-of-Network**<br>• Plan drugs may be covered in special circumstances, for instance, illness while traveling outside of the plan's service area where there is no network pharmacy. You may have to pay more than your normal cost-sharing amount if you get your drugs at an out-of-network pharmacy. In addition, you will likely have to pay the pharmacy's full charge for the drug and submit documentation to receive reimbursement from Humana Gold Choice H8145-061 (PFFS).<br>**Out-of-Network Initial Coverage**<br>• You will be reimbursed up to the plan's cost of the drug minus the following for drugs purchased out-of-network until total yearly drug costs reach **$2,930**:<br>• Tier 1: Preferred Generic Drugs<br>– **$8** copayment for a one-month (30-day) supply of drugs in this tier<br>• Tier 2: Preferred Brand Drugs<br>– **$42** copayment for a one-month (30-day) supply of drugs in this tier<br>• Tier 3: Non-Preferred Brand Drugs<br>– **$81** copayment for a one-month (30-day) supply of drugs in this tier<br>• Tier 4: Specialty Tier Drugs |

(Other Services - Continued on next page)

# OTHER SERVICES

| BENEFIT | ORIGINAL MEDICARE | Humana Gold Choice H8145-061 (PFFS) |
|---|---|---|
| **Outpatient Prescription Drugs (continued)** | | |
| | | – **33%** coinsurance for a one-month (30-day) supply of drugs in this tier<br>• You will not be reimbursed for the difference between the Out-of-Network Pharmacy charge and the plan's In-Network allowable amount.<br>**Additional Out-of-Network Coverage Gap**<br>• You will be reimbursed for these drugs purchased out-of-network up to the plan's cost of the drug minus the following:<br>• Tier 1: Preferred Generic Drugs<br>– **$8** copayment for a one-month (30-day) supply of select drugs covered in this tier<br>• Tier 2: Preferred Brand Drugs<br>– **$42** copayment for a one-month (30-day) supply of select drugs covered in this tier<br>• Tier 3: Non-Preferred Brand Drugs<br>– **$81** copayment for a one-month (30-day) supply of select drugs covered in this tier<br>• Tier 4: Specialty Tier Drugs<br>– **33%** coinsurance for a one-month (30-day) supply of select drugs covered in this tier<br>• You will not be reimbursed for the difference between the Out-of-Network Pharmacy charge and the plan's In-Network allowable amount.<br>**Out-of-Network Catastrophic Coverage**<br>• After your yearly out-of-pocket drug costs reach **$4,700,** you will be reimbursed for drugs purchased out-of-network up to the plan's cost of the drug minus your cost share, which is the greater of:<br>– **5%** coinsurance, or<br>– **$2.60** copayment for generic (including brand drugs treated as generic) and a **$6.50** copayment for all other drugs.<br>• You will not be reimbursed for the difference between the Out-of-Network Pharmacy charge and the plan's In-Network allowable amount. |

(Other Services - Continued on next page)

If you have any questions about this plan's benefits or costs, please contact Humana Insurance Company for details.

# OTHER SERVICES

| BENEFIT | ORIGINAL MEDICARE | Humana Gold Choice H8145-061 (PFFS) |
|---|---|---|
| **Outpatient Prescription Drugs (continued)** | | |
| | | **See page 37 for additional information about Outpatient Prescription Drugs** |

If you have any questions about this plan's benefits or costs, please contact Humana Insurance Company for details.

# ADDITIONAL BENEFITS

| BENEFIT | ORIGINAL MEDICARE | Humana Gold Choice H8145-061 (PFFS) |
|---|---|---|
| (26) **Dental Services** | • Preventive dental services (such as cleaning) not covered. | **In-Network**<br>• In general, preventive dental benefits (such as cleaning) not covered.<br>• **$30** copayment for Medicare-covered dental benefits<br>**Out-of-Network**<br>• **$30** copayment for comprehensive dental benefits |
| (27) **Hearing Services** | • Supplemental routine hearing exams and hearing aids not covered.<br>• **20%** coinsurance for diagnostic hearing exams. | **In-Network**<br>• In general, supplemental routine hearing exams and hearing aids not covered.<br>– **$30** copayment for Medicare-covered diagnostic hearing exams<br>**Out-of-Network**<br>• **$30** copayment for hearing exams. |
| (28) **Vision Services** | • **20%** coinsurance for diagnosis and treatment of diseases and conditions of the eye.<br>• Supplemental routine eye exams and glasses not covered.<br>• Medicare pays for one pair of eyeglasses or contact lenses after cataract surgery.<br>• Annual glaucoma screenings covered for people at risk. | **In-Network**<br>– **$25** copayment for one pair of eyeglasses or contact lenses after cataract surgery.<br>– **$0** to **$30** copayment for exams to diagnose and treat diseases and conditions of the eye.<br>– **$0** copayment for up to 1 supplemental routine eye exam(s) every year<br>**Out-of-Network**<br>• **$0** copayment for eye wear.<br>• **$0** to **$30** copayment for eye exams.<br>**See page 37 for additional information about Vision Services** |
| **Over-the-Counter Items** | • Not covered. | **General**<br>• Please visit our plan website to see our list of covered Over-the-Counter items.<br>• OTC items may be purchased only for the enrollee.<br>• Please contact the plan for specific instructions for using this benefit.<br>**See page 37 for additional information about Over-the-Counter items** |

(Additional Benefits - Continued on next page)

If you have any questions about this plan's benefits or costs, please contact Humana Insurance Company for details.

# ADDITIONAL BENEFITS

| BENEFIT | ORIGINAL MEDICARE | Humana Gold Choice H8145-061 (PFFS) |
|---|---|---|
| **Transportation** (Routine) | • Not covered. | **In-Network**<br>• This plan does not cover supplemental routine transportation. |
| **Acupuncture** | • Not covered. | **In-Network**<br>• This plan does not cover Acupuncture. |

# SECTION III - ABOUT YOUR PLAN
## Humana Gold Choice H8145-061 (PFFS)

This section further explains some of the benefits of your plan. To get a complete list of benefits, limitations, and exclusions, call Humana Gold Choice H8145-061 (PFFS) and ask for the **"Evidence of Coverage."**

Most services are covered at the same cost share in and out-of-network.

**Access to services**

**Present your Humana Gold Choice (PFFS) ID card to providers before you receive services**. As a PFFS member, you may use providers who don't accept assignment from Original Medicare. These providers may charge you more for Medicare-covered services, up to the Medicare Limiting Charge, and you would be responsible for those excess charges.

# HOW TO USE YOUR PLAN

### ① Premium and Other Important Information

Maximum out-of-pocket limit

While most expenses apply to the maximum[s], the following don't:

- Your monthly plan premium
- Outpatient Part D prescription drugs
- Routine vision services
- Over-the-counter drugs and supplies
- Health expenses you incur during foreign travel

### ② Doctor and Hospital Choice

Choosing a doctor

As a Humana Gold Choice H8145-061 (PFFS) member, it's a good idea to select a doctor to act as your primary care physician (PCP). Although you don't have to have a PCP, it's important to have someone focus on your total healthcare. A PCP can provide much of your care. He or she can help ensure you get preventive care, provide timely access to services and coordinate with other doctors if needed. This helps you improve and manage your health.

Primary care doctor or specialist copayment applies for office and clinic visits.

# INPATIENT CARE

### ③ Inpatient Hospital Care

### ④ Inpatient Mental Health Care

### ⑤ Skilled Nursing Facility (SNF)

Prior authorization is not required. However, notification of hospital admissions is requested. This is one way we can let your doctor know about Humana programs that may be of assistance to you during this time.

Benefit periods don't apply to inpatient hospital care and inpatient mental health care. You pay the amounts shown in Section II each time you're admitted to a hospital, no matter how many days have passed since your last admission. If transferred to another inpatient facility - for example, to a long-term acute care center from an inpatient acute hospital - the day range will begin at one.

When admitted to a skilled nursing facility, you're covered for skilled care as defined by Original Medicare guidelines. No prior hospital stay is required. Your plan doesn't cover custodial care.

# OUTPATIENT CARE

You can receive outpatient services at different types of facilities. Usually, you pay only one copayment or coinsurance for each visit to an office or facility, no matter how many services you receive during the visit or the actual cost of those services. But if, for example, you receive care in your doctor's office and are then sent to another facility for additional services, you may have to pay an additional copayment or coinsurance.

## (8) Doctor Office Visits

| For Doctor Office Visits: | In-Network | Out-of-Network |
|---|---|---|
| Primary care doctor's office | **$10** copayment | **$10** copayment |
| Specialist's office | **$30** copayment | **$30** copayment |
| Immediate care facility | **$30** copayment | **$30** copayment |

## (11) Outpatient Mental Health Care

## (12) Outpatient Substance Abuse Care

| | In-Network | Out-of-Network |
|---|---|---|
| Specialist's office | **$30** copayment | **$30** copayment |
| Hospital facility as an outpatient | **25%** of the cost | **25%** of the cost |
| Partial hospitalization at a hospital facility | **20%** of the cost | **20%** of the cost |

## (13) Outpatient Services/Surgery

For services received at a hospital facility as an outpatient, you pay:

| | In-Network | Out-of-Network |
|---|---|---|
| Radiation therapy | **20%** of the cost | **20%** of the cost |
| Chemotherapy | **20%** of the cost | **20%** of the cost |
| Renal dialysis services | **20%** of the cost | **20%** of the cost |
| All other hospital facility services | **25%** of the cost | **25%** of the cost |

## (15) Emergency Care

Remember to carry your Humana Gold Choice (PFFS) plan ID card with you and to show it to each provider before receiving services. This will give the provider the opportunity to contact us for our payment terms and conditions. If your ID card is not available because of an emergency situation, you're still covered.

NOTE: If you're traveling outside the United States and Puerto Rico, your coverage is subject to a **$250** annual deductible and **20%** coinsurance. Coverage is limited to **$25,000** each calendar year and up to 60 consecutive days of foreign travel.

## (17) Outpatient Rehabilitation Services

| For outpatient rehabilitation services, you pay: | In-Network | Out-of-Network |
|---|---|---|
| Specialist's office for all therapy and rehabilitation services | **$30** copayment | **$30** copayment |
| Comprehensive outpatient rehabilitation facility for audiology, occupational, physical and speech therapy services | **20%** of the cost | **20%** of the cost |
| Hospital facility as an outpatient for audiology, occupational, physical and speech therapy services | **25%** of the cost | **25%** of the cost |

# OUTPATIENT MEDICAL SERVICES AND SUPPLIES

## (20) Diabetes Programs and Supplies

| For preferred diabetic monitoring supplies, you pay: | **In-Network** | **Out-of-Network** |
|---|---|---|
| Humana's mail order service | **0%** of the cost | not available |
| Pharmacy | **10%** of the cost | **20%** of the cost |
| Durable medical equipment provider | **20%** of the cost | **20%** of the cost |

| For non-preferred diabetic monitoring supplies, you pay: | **In-Network** | **Out-of-Network** |
|---|---|---|
| Humana's mail order service | **0%** of the cost | not available |
| Pharmacy | **20%** of the cost | **20%** of the cost |
| Durable medical equipment provider | **20%** of the cost | **20%** of the cost |

## (21) Diagnostic Tests, X-Rays, Lab Services, and Radiology Services

| Lab services | **In-Network** | **Out-of-Network** |
|---|---|---|
| Primary care doctor's office | **$10** copayment | **$10** copayment |
| Specialist's office | **$30** copayment | **$30** copayment |
| Immediate care facility | **$30** copayment | **$30** copayment |
| Freestanding lab | **$0** copayment | **$0** copayment |
| Hospital facility as an outpatient | **25%** of the cost | **25%** of the cost |

| Diagnostic procedures and tests | **In-Network** | **Out-of-Network** |
|---|---|---|
| Primary care doctor's office | **$10** copayment | **$10** copayment |
| Specialist's office | **$30** copayment | **$30** copayment |
| Immediate care facility | **$30** copayment | **$30** copayment |
| Hospital facility as an outpatient | **25%** of the cost | **25%** of the cost |
| Other Freestanding Facilities | **20%** of the cost | **20%** of the cost |

| X-rays and diagnostic radiology services | **In-Network** | **Out-of-Network** |
|---|---|---|
| Primary care doctor's office | **$10** copayment | **$10** copayment |
| Specialist's office | **$30** copayment | **$30** copayment |
| Freestanding radiological center | **20%** of the cost | **20%** of the cost |
| Hospital facility as an outpatient | **25%** of the cost | **25%** of the cost |
| Immediate care facility | **$30** copayment | **$30** copayment |

Advanced imaging services - MRI, MRA, PET, or CT Scan:

| | **In-Network** | **Out-of-Network** |
|---|---|---|
| Primary care doctor's office - in addition to office visit copayment | **$75** copayment | **$75** copayment |
| Specialist's office - in addition to office visit copayment | **$75** copayment | **$75** copayment |
| Freestanding radiology center | **20%** of the cost | **20%** of the cost |
| Hospital facility as an outpatient | **25%** of the cost | **25%** of the cost |

| Nuclear medicine services | **In-Network** | **Out-of-Network** |
|---|---|---|
| Freestanding radiology center | **20%** of the cost | **20%** of the cost |
| Hospital facility as an outpatient | **25%** of the cost | **25%** of the cost |

| Therapeutic radiology services (Radiation Therapy) | **In-Network** | **Out-of-Network** |
|---|---|---|
| Specialist's office | **$30** copayment | **$30** copayment |
| Freestanding radiology facility | **20%** of the cost | **20%** of the cost |
| Hospital facility as an outpatient | **20%** of the cost | **20%** of the cost |

| You pay: | **In-Network** | **Out-of-Network** |
|---|---|---|
| EKG screening at all places of treatment. | **$0** copayment | **$0** copayment |

### (22) Cardiac and Pulmonary Rehabilitation Services

| For cardiac rehabilitation services, you pay: | **In-Network** | **Out-of-Network** |
|---|---|---|
| Specialist's office | **$30** copayment | **$30** copayment |
| Hospital facility as an outpatient | **25%** of the cost | **25%** of the cost |

| For pulmonary rehabilitation services, you pay: | **In-Network** | **Out-of-Network** |
|---|---|---|
| Specialist's office | **$30** copayment | **$30** copayment |
| Hospital facility as an outpatient | **25%** of the cost | **25%** of the cost |
| Comprehensive outpatient rehabilitation facility | **20%** of the cost | **20%** of the cost |

# PREVENTIVE SERVICES

### (23) Preventive Services and Wellness/Education Programs

**Stop-Smoking Program**

The QuitNet® smoking cessation program combines Web-based and telephone support, printed materials, and the option of nicotine replacement therapy, such as nicotine patches and nicotine gum. Enroll online at **www.quitnet.com/humana** or by phone at 1-888-572-4074, Monday - Friday, 8 a.m. - midnight, and Saturday, 8 a.m. - 9 p.m., Eastern time (TTY 711).

**Humana Active Outlook®**

Humana Active Outlook is a lifestyle enrichment program with great features like HAO Magazine, *Live It Up!* Digest insert for members with chronic conditions, the **HumanaActiveOutlook.com** Website, community outreach through seminars and classes, and many other programs. For more information, call 1-800-781-4233, Monday-Friday, 8 a.m. - 8 p.m., Eastern time (TTY 711).

**HumanaFirst® 24 Hour Nurse Advice Line**

As a Humana member, you have access to health information, guidance, and support. Whether you have an immediate health concern or questions about a particular medical condition, call HumanaFirst for expert advice and guidance - at no additional cost to you. Just call 1-800-622-9529 to talk with a nurse.

**SilverSneakers® Fitness Program**

The SilverSneakers Fitness Program is a health and physical activity program. In addition to a basic membership at participating locations, you can participate in low-impact SilverSneakers classes, have access to a specially trained Senior Advisor, and use any participating SilverSneakers fitness center in the country at no additional cost. If you're an eligible member who lives 15 miles or more from a participating SilverSneakers fitness center, you can participate in SilverSneakers Steps, a pedometer-measured walking program.

**Well Dine Inpatient Meal Program**

After your overnight stay in the hospital or nursing facility, you're eligible for 10 nutritious, precooked frozen meals delivered to your door at no cost to you. To arrange for this service, simply call 1-866-96MEALS (1-866-966-3257) after your discharge and provide your Humana member ID number, and other basic information. A Humana representative will assist you in scheduling your delivery.

# OTHER SERVICES

## (24) Kidney Disease and Conditions

You pay the following for kidney disease education services:

| | In-Network | Out-of-Network |
|---|---|---|
| Primary care doctor's office | **$0** copayment | **$0** copayment |
| Specialist's office | **$0** copayment | **$0** copayment |

## (25) Outpatient Prescription Drugs

Drugs covered under Medicare Part B

You pay **20%** of the cost for Medicare-covered Part B drugs you receive at a doctor's office. You pay **0%** of the cost for allergy serum.

For Medicare-covered Part B drugs purchased at a pharmacy, you pay **20%** of the cost .

Drugs covered under Medicare Part D

Drugs covered in the gap are limited to select home infusion drugs used as an alternative to inpatient treatment. Your cost for the medication is the same before and during the coverage gap. Contact Humana Gold Choice H8145-061 (PFFS) to see if a certain drug is covered or visit **Humana-Medicare.com**.

# ADDITIONAL BENEFITS

## (28) Vision Services

Benefit includes :

-**$0** copayment for routine comprehensive eye examination by an in-network provider. If you choose to use an out-of-network provider, you will be responsible for costs above the plan-approved amount.

| | In-Network | Out-of-Network |
|---|---|---|
| Medicare-covered vision services | **$30** copayment | **$30** copayment |
| Glaucoma screening, one per year | **$0** copayment | **$0** copayment |

### Over-the-Counter Items

**Health and Wellness Products**

You are eligible to receive a **$10** monthly benefit toward the purchase of selected over-the-counter items such as vitamins, pain relievers, cough and cold medicines, allergy medications, and first aid/medical supplies when you use Humana's mail order service. For more information or to request an order form, please call Customer Service.

HUMANA.

– Medicare
– Group health benefits
– Individual health
– Specialty Benefits
– Pharmacy Solutions

If you are a member of a qualified State Pharmaceutical Assistance Program, please contact the program, to verify that the mail order pharmacy will coordinate with the program.

Humana.com

# 2012
## Value-Added Services

## Humana Gold Choice®
H8145-061 (PFFS)

Florida

Select Counties in Florida

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# Value-Added Services

Humana has deals that let you get items and services for less. In this part, we'll let you know how you can save. To get some of the discounts, you may need to show your Humana ID card or a discount card.

For information, call Humana Customer Care at **1-800-457-4708**, seven days a week, 8 a.m. to 8 p.m. If you use a TTY, please call **711**. Our voice mail system takes your call on Saturdays, Sundays, and some holidays. Just leave a message and tell us why you're calling. A Humana representative will return your call.

- The products and services described on the following pages are neither offered nor guaranteed under our contract with the Medicare program. In addition, they are not subject to the Medicare appeals process. Any disputes regarding these products and services may be subject to the Humana grievance process. If you do not wish to receive information concerning value-added items and services available with the plan, please contact Humana.

- If you're unhappy with any of these items or services, we'd like to know about it. Please call **1-800-457-4708**, seven days a week, 8 a.m. to 8 p.m. If you use a TTY, call **711**.

# Prescription Medicine Discount

As a Humana member, you can get discounts on some medicines you get from the drug store. Use this discount for prescriptions Medicare won't pay for.

### How the discount works

Show your Humana ID card at a participating pharmacy when you buy non-covered prescriptions/medicines. Dependent upon your purchase, you may be limited to a certain amount.

### Contact Information

All major pharmacy chains participate. To find out if an independent pharmacy participates, call Customer Service at **1-800-457-4708**. If you use a TTY, call **711**, seven days a week, 8 a.m. to 8 p.m. Eastern time. Our voice mail system takes your call on Saturdays, Sundays, and some holidays. Just leave a message and tell us why you are calling. We'll call back by the end of the next business day. Please have your Humana ID card when you call.

# Careington Dental Discount

You may save **20 to 60 percent** when you receive dental services from a general dentist in the Careington network. Services include:

- Regular oral exams
- Cleanings
- Dentures
- Root canals
- Crowns

### How the discount works

Choose a participating CAREINGTON general dentist by calling **1-866-636-9248** or by visiting CAREINGTON online at www.careington.com. You will get the discount right away and let you know whether to pay at the time of service or wait for a bill. If you need to see a specialist, participating CAREINGTON specialists will give a **20 percent** discount off of their normal fees. At the time of service, present your Humana ID card.

### Contact information

Visit www.careington.com. You can also call **1-866-636-9248**, Monday through Friday, 7 a.m. to 7 p.m. Central time. If you use a TTY, call **711**, seven days a week, 8 a.m. to 8 p.m. Eastern time. Our voice mail system takes your call on Saturdays, Sundays, and some holidays. Just leave a message and tell us why you are calling. We'll call back by the end of the next business day. Please have your Humana ID card when you call.

- The Careington program is not intended to replace any other dental coverage.
- If your dentist leaves the Careington network, you'll need to find another one. Not all types of dentists may be in your area.
- In-network dentists are licensed in the state where they practice and are credentialed by Careington.
- If you have questions or concerns about the dentist, call Customer Care at the number on your Humana ID card.
- Discounts do not apply to dental work that was in progress before you joined this plan.

# Vision Discount Program

You can get this program through EyeMed Vision Care. Vision wellness is important to your overall health and well-being. With the vision discount program, it's easy to care for your eyes. You can also save on your eyewear needs. You have access to the extensive EyeMed network of 40,000 providers across the country. They are at about 20,000 locations. Some of them are

companies that you know and trust. These include LensCrafters®, Pearle Vision®, Sears Optical, Target Optical, and JCPenney™ Optical. The program includes the following services:

- Exam with dilation (if necessary) – **$5 off** routine exam; **$10 off** contact lens exam.
- Frames – **40 percent off** retail price on all frames except when not allowed by the manufacturer.
- Lenses – fixed prices for lenses and lens options.
- Contact Lens – **15 percent off** retail price for non-disposable contact lenses.
- Laser Vision Correction (Lasik or PRK)* – **15 percent off** retail price or **5 percent off** promotional price.

### How the discount works

The discount applies only to services you get from providers in the EyeMed Select network. Choose a participating EyeMed provider by visiting **Humana.com** > Find a doctor > click onto EyeMed Vision Care. You can also call EyeMed's provider locator service at **1-866-392-6056**. Your personal information or ID is not in the EyeMed system. Once you've chosen a provider, call and schedule your appointment. Make sure to tell them you have the EyeMed discount through Humana.

Clip out the EyeMed Vision discount card printed on the last page of this booklet. Show the card when you go to your appointment. The EyeMed provider will take care of the rest. He or she will automatically give you the discount. You won't need to submit a claim. Since this is a discount offer, your ID, name, and address are not in EyeMed's files.

If you lose your discount card, just tell your provider you're a Humana member with the EyeMed discount.

### Contact information

To choose a participating EyeMed Select provider, visit **Humana.com**. You can also call EyeMed's provider locator service at **1-866-392-6056**, Monday through Saturday, 8 a.m. to 11 p.m., and Sunday, 11 a.m. to 8 p.m. Eastern time. If you use a TTY, call **1-866-308-5375**, Monday through Friday, 8 a.m. to 5 p.m. Eastern time.

* LASIK or PRK vision correction is a procedure you choose to have done. It is not needed for medical reasons. It is performed by specially trained providers. You may not always be able to get this discount from a provider near you. For a location near you and the discount authorization, please call **1-877-5LASER6 (1-877-552-7376)**, Monday through Friday, 8 a.m. to 8 p.m., and Saturday, 9 a.m. to 5 p.m. Eastern time. If you use a TTY, call **1-866-308-5375**, Monday through Friday, 8 a.m. to 5 p.m. Eastern time.

# Nutrisystem® Discount

The Nutrisystem® program helps you lose weight simply and easily. This lets you enjoy an active, healthy life. Nutrisystem is a low-calorie, nutritionally supercharged weight loss program. It is a good source of protein, fiber, and "good" fats. It also is low in salt. It has lower cholesterol, and fewer saturated fats. It can help you shed pounds sensibly.

With Nutrisystem, you also get the Glycemic Advantage. It is a weight-loss breakthrough. It gives you the benefits of a low-carb diet. But it lets you eat carbs. Nutrisystem foods contain "good carbs." This lets you eat your favorite foods, including pizza, pasta, cookies, and chocolate.

### How the discount works

It's easy to get started. Simply select your foods online or on the phone. You can choose from a huge variety of great-tasting meals and snacks. They come to your doorstep, all ready to heat and eat. All of the prepared Nutrisystem foods are perfectly portioned. You never have to weigh portions. You don't have to count calories and points. You get to eat six times a day. This will help cut down on those cravings between meals. You don't have to go to any meetings. You can call or e-mail the program counselors, nutritionists, and dietitians any time for free.

As a Humana member, you also get a **12 percent** discount on all 28-day programs. This could mean up to $45 off on the most expensive Nutrisystem program, in addition to the best available offer on the Website. And that isn't all. You get free membership and free access to the online Nutrisystem community support boards.

### Contact information

Visit us today at www.Nutrisystem.com/humanafl to learn more about individual programs and more savings. You can also call Nutrisystem toll-free at **1-866-936-6874** for all Florida plan members. Hours are Monday through Friday, 8 a.m. to 12 a.m., and Saturday and Sunday, 8:30 a.m. to 5 p.m. Eastern time. All other Humana plan members, please visit www.nutrisystem.com/humana or call **1-866-942-6874** to order. If you use a TTY, call **711**, seven days a week, 8 a.m. to 8 p.m. Eastern time. Our automated phone system may answer your call on Saturdays, Sundays, and some public holidays. Just leave a message and select the reason for your call from the automated list. We'll call back by the end of the next business day. Please have your Humana ID card handy when you call.

# Lifeline® Medical Alert Systems

Every day, Lifeline® helps thousands of people live more independent, active lives at home. Lifeline offers a monthly rate of **$31.25** for its standard medical alert service to all Humana members.

### How the discount works

### Standard Lifeline Service

Installation and enrollment fee

- Regular rate for self installations: $75
- Humana members' self-installation rate: **$40**

For a Lifeline Home Service Representative to install the home communicator for you, the rate is $75.

Monthly fee

- Regular rate: $42
- Humana members: **$31.25**

### How this service works

The standard service includes the new Lifeline CarePartners Home Communicator model 6800. It also includes Lifeline monitoring services by a trained, dedicated professional staff. They are there to help 24 hours a day, every day of the year.

If you need medical help, a push of a button signals the Lifeline monitoring center. One of our professionals will speak to you over our Home Communicator phone. He or she will figure out what help is needed. They will dispatch the appropriate responders. Family members, friends, neighbors, or emergency service personnel who can quickly get to your home can all be responders.

The standard service includes your choice of a necklace-style Slimline or Classic transmitter, or a wristwatch-style Slimline. You can exchange the transmitter for a different style one time during the subscription period at no additional charge.

### Contact information

For details about the program, call **1-866-674-9900**, extension **4304**, Monday through Friday, 7:30 a.m. to 10 p.m., and Saturday, 8 a.m. to 7 p.m. Eastern time. If you use a TTY, call **1-800-855-2881**, Monday through Friday, 7:30 a.m. to 10 p.m., and Saturday, 8 a.m. to 7 p.m. Eastern time.

## Hearing Care Program – HEARx and HearUSA

As a Humana member, you can get discounts from HEARx and HearUSA.

### How the discount works

- Free hearing test for the purpose of selecting and fitting hearing aids
- $500 for each hearing aid
- Two years of free batteries with a purchase of hearing aids (up to 40 cells)
- Two-year warranty on the hearing aids

To get your discount, show your Humana ID card at the time of your visit.

### Healthy Hearing Program

Other bonuses just for Humana members:

- Humana Battery Club: free hearing enhancement product with enrollment, special pricing for Humana members
- **10 percent** discount on e-hearing health products
- Lifetime in-house service warranty for Humana members
- Two-week check-up: free hearing enhancement product
- Hearing-aid checks at 6 months, one year, two years and three years

### Contact information

Visit www.hearusa.com. Call HearUSA at **1-800-333-3389**, Monday through Friday, 8:30 a.m. to 8:30 p.m. Eastern time. If you use a TTY, call **1-888-300-3277**, Monday through Friday, 8:30 a.m. to 8:30 p.m. Eastern time.

**CUT OUT THIS CARD AND KEEP IT IN YOUR WALLET FOR HANDY REFERENCE.**

**HumanaVision**
Medicare ***Discount*** Card

MEMBER NAME: _____

PLAN ID: 9243247

HUMANA.

FOLD

**For more information, call EyeMed:**
**1-866-392-6056**

This discount program is **not** part of your Medicare Advantage plan coverage. Discounts are only available at participating providers.

EyeMed
VISION CARE®

# Notes

# Notes

# Notes

HUMANA.

– Medicare
– Group health benefits
– Individual health
– Specialty Benefits
– Pharmacy Solutions

A Health plan with a Medicare contract, available to anyone enrolled in both Part A and Part B of Medicare. Medicare beneficiaries may enroll in the plan only during specific times of the year. Contact Humana for more information.

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– Medicare
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– Individual health
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