2014

Summary of Benefits
Extra Services and Programs

HumanaChoice®
R5826-005 (Regional PPO)

Region 9
State of Florida

Humana®

2014

Summary of Benefits

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R5826-005 (Regional PPO)

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Section I – Introduction to Summary of Benefits

Thank you for your interest in HumanaChoice R5826-005 (Regional PPO). Our plan is offered by HUMANA INSURANCE COMPANY, a Medicare Advantage Preferred Provider Organization (PPO) that contracts with the Federal government. 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 HumanaChoice R5826-005 (Regional PPO) 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 health plan, like HumanaChoice R5826-005 (Regional PPO). You may have other options too. You make the choice. No matter what you decide, you are still in the Medicare Program.

You may be able to join or leave a plan only at certain times. Please call HumanaChoice R5826-005 (Regional PPO) at the 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 HumanaChoice R5826-005 (Regional PPO) 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 HumanaChoice R5826-005 (Regional PPO) Available?
The service area for this plan includes: Florida. You must live in this area to join the plan.

Who Is Eligible To Join HumanaChoice R5826-005 (Regional PPO)?
You can join HumanaChoice R5826-005 (Regional PPO) 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 generally are not eligible to enroll in HumanaChoice R5826-005 (Regional PPO) unless they are members of our organization and have been since their dialysis began.

Can I Choose My Doctors?
HumanaChoice R5826-005 (Regional PPO) has formed a network of doctors, specialists, and hospitals. You can use any doctor who is part of our network. You may also go to doctors outside of our network. The health providers in our network can change at any time.

You can ask for a current provider directory. For an updated list, visit us at **http://www.humana.com/members/tools.** Our customer service number is listed at the end of this introduction.

What Happens If I Go To A Doctor Who's Not In Your Network?
You can go to doctors, specialists, or hospitals in or out of network. You may have to pay more for the services you receive outside the network, and you may have to follow special rules prior to getting services in and/or out of network. For more information, please call the customer service number at the end of this introduction.

Where Can I Get My Prescriptions If I Join This Plan?
HumanaChoice R5826-005 (Regional PPO) 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.

HumanaChoice R5826-005 (Regional PPO) 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.

What If My Doctor Prescribes Less Than A Month's Supply?
In consultation with your doctor or pharmacist, you may receive less than a month's supply of certain drugs. Also, if you live in a long-term care facility, you will receive less than a month's supply of certain brand and generic drugs. Dispensing fewer drugs at a time can help reduce cost and waste in the Medicare Part D program, when this is medically appropriate.

The amount you pay in these circumstances will depend on whether you are responsible for paying coinsurance (a percentage of the cost of the drug) or a copayment (a flat dollar amount for the drug). If you are responsible for coinsurance for the drug, you will continue to pay the applicable percentage of the drug cost. If you are responsible for a copayment for the drug, a "daily cost-sharing rate" will be applied. If your doctor decides to continue the drug after a trial period, you should not pay more for a month's supply than you otherwise would have paid. Contact your plan if you have questions about cost-sharing when less than a one-month supply is dispensed.

Does My Plan Cover Medicare Part B Or Part D Drugs?
HumanaChoice R5826-005 (Regional PPO) does cover both Medicare Part B prescription drugs and Medicare Part D prescription drugs.

What Is A Prescription Drug Formulary?
HumanaChoice R5826-005 (Regional PPO) 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 members 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/medicare/medicare_prescription_drugs/medicare_drug_tools/medicare_drug_list/.

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 http://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.

Section I (continued)

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 HumanaChoice R5826-005 (Regional PPO), 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 HumanaChoice R5826-005 (Regional PPO), 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 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 HumanaChoice R5826-005 (Regional PPO) 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 HumanaChoice R5826-005 (Regional PPO) 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 osteoporosis drugs for some women.
- **Erythropoietin:** 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 took place in a Medicare-certified facility and was paid for by Medicare or by a private insurance company that was the primary payer for Medicare Part A coverage.
- **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 Durable Medical Equipment.**

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 can find the Plan Ratings information by using the "Find health & drug plans" web tool on medicare.gov 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 HumanaChoice R5826-005 (Regional PPO).

Visit us at **http://www.humana-medicare.com** or, call us:
Customer Service Hours for October 1 - February 14: Sunday, Monday, Tuesday, Wednesday, Thursday, Friday, Saturday, 8:00 a.m. - 8:00 p.m. Local

Customer Service Hours for February 15 - September 30: Monday, Tuesday, Wednesday, Thursday, Friday, 8:00 a.m. - 8:00 p.m. Local

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 http://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	HumanaChoice R5826-005 (Regional PPO)
① **Premium and Other Important Information**	• In 2013 the monthly Part B Premium was **$104.90** and may change for 2014 and the annual Part B deductible amount was **$147** and may change for 2014. • If a doctor or supplier does not accept assignment, their costs are often higher, which means you pay more. • 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** • **$92** monthly plan premium in addition to your monthly Medicare Part B premium. • 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. • Some physicians, providers and suppliers that are out of a plan's network (i.e., out-of-network) accept "assignment" from Medicare and will only charge up to a Medicare-approved amount. If you choose to see an out-of-network physician who does NOT accept Medicare "assignment," your coinsurance can be based on the Medicare-approved amount plus an additional amount up to a higher Medicare "limiting charge." If you are a member of a plan that charges a copayment for out-of-network physician services, the higher Medicare "limiting charge" does not apply. See the publications Medicare & You or Your Medicare Benefits available on **http://www.medicare.gov** for a full listing of benefits under Original Medicare, as well as for explanations of the rules related to "assignment" and "limiting charges" that apply by benefit type. • To find out if physicians and DME suppliers accept assignment or participate in Medicare, visit **http://www.medicare.gov/physician** or **http://www.medicare.gov/supplier.** You can also call 1-800-MEDICARE, or ask your

(Important Information - Continued on next page)

IMPORTANT INFORMATION

BENEFIT	ORIGINAL MEDICARE	HumanaChoice R5826-005 (Regional PPO)
		physician, provider, or supplier if they accept assignment. **In-Network** • **$5,700** out-of-pocket limit for Medicare-covered services. **In and Out-of-Network** • **$8,900** out-of-pocket limit for Medicare-covered services. **See page 35 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-Network** • No referral required for network doctors, specialists, and hospitals. **In and Out-of-Network** • You can go to doctors, specialists, and hospitals in or out of the network. It will cost more to get out of network benefits. **Out of Service Area** • Plan covers you when you travel in the U.S. or its territories. **See page 35 for additional information about Doctor and Hospital Choice**

If you have any questions about this plan's benefits or costs, please contact HUMANA INSURANCE COMPANY for details.

INPATIENT CARE

BENEFIT	ORIGINAL MEDICARE	HumanaChoice R5826-005 (Regional PPO)
③ **Inpatient Hospital Care** (includes Substance Abuse and Rehabilitation Services)	• In 2013 the amounts for each benefit period were: – Days 1 - 60: **$1,184** deductible – Days 61 - 90: **$296** per day – Days 91 - 150: **$592** per lifetime reserve day • These amounts may change for 2014. • Call 1-800-MEDICARE (1-800-633-4227) for information about lifetime reserve days. • Lifetime reserve days can only be used once. • 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.	**In-Network** • No limit to the number of days covered by the plan each hospital stay. • For Medicare-covered hospital stays: – Days 1 - 7: **$225** copayment per day – Days 8 - 90: **$0** copayment per day • **$0** copayment for each additional non-Medicare-covered hospital day. • Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital. **Out-of-Network** • **30%** of the cost for each Medicare-covered hospital stay. **See page 35 for additional information about Inpatient Hospital Care**
④ **Inpatient Mental Health Care**	• In 2013 the amounts for each benefit period were: – Days 1 - 60: **$1,184** deductible – Days 61 - 90: **$296** per day – Days 91 - 150: **$592** per lifetime reserve day • These amounts may change for 2014. • 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** • 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. • For Medicare-covered hospital stays: – Days 1 - 7: **$205** copayment per day – Days 8 - 90: **$0** copayment per day • Plan covers 60 lifetime reserve days. **$0** copayment per lifetime reserve day. • Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital. **Out-of-Network** • **30%** of the cost for each Medicare-covered hospital stay. **See page 35 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	HumanaChoice R5826-005 (Regional PPO)
(5) **Skilled Nursing Facility (SNF)** (in a Medicare-certified skilled nursing facility)	• In 2013 the amounts for each benefit period after at least a 3-day Medicare-covered hospital stay were: – Days 1 - 20: **$0** per day – Days 21 - 100: **$148** per day • These amounts may change for 2014. • 100 days for each benefit period. • 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.	**General** • Authorization rules may apply. **In-Network** • Plan covers up to 100 days each benefit period • No prior hospital stay is required. • For SNF stays: – Days 1 - 20: **$25** copayment per day – Days 21 - 58: **$50** copayment per day – Days 59 - 100: **$0** copayment per day **Out-of-Network** • **30%** of the cost for each Medicare-covered SNF stay. **See page 35 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.	**General** • Authorization rules may apply. **In-Network** • **$0** copayment for each Medicare-covered home health visit **Out-of-Network** • **30%** of the cost for Medicare-covered home health visits
(7) **Hospice**	• You pay part of the cost for outpatient drugs and inpatient respite care. • You must get care from a Medicare-certified hospice.	**General** • You must get care from a Medicare-certified hospice. You must consult with your plan 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	HumanaChoice R5826-005 (Regional PPO)
(8) **Doctor Office Visits**	• **20%** coinsurance	**In-Network** • **$5** copayment for each Medicare-covered primary care doctor visit. • **$35** copayment for each Medicare-covered specialist visit. **Out-of-Network** • **$40** copayment for each Medicare-covered primary care doctor visit • **$40** copayment for each Medicare-covered specialist visit **See page 36 for additional information about Doctor Office Visits**
(9) **Chiropractic Services**	• Supplemental routine care not covered • **20%** coinsurance for manual manipulation of the spine to correct subluxation (a displacement or misalignment of a joint or body part).	**General** • Authorization rules may apply. **In-Network** • **$20** copayment for each Medicare-covered chiropractic visit • Medicare-covered chiropractic visits are for manual manipulation of the spine to correct subluxation (a displacement or misalignment of a joint or body part). **Out-of-Network** • **$40** copayment for Medicare-covered chiropractic visits.
(10) **Podiatry Services**	• Supplemental routine care not covered. • **20%** coinsurance for medically necessary foot care, including care for medical conditions affecting the lower limbs.	**General** • Authorization rules may apply. **In-Network** • **$35** copayment for each Medicare-covered podiatry visit • Medicare-covered podiatry visits are for medically necessary foot care. **Out-of-Network** • **$40** copayment for Medicare-covered podiatry 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	HumanaChoice R5826-005 (Regional PPO)
(11) **Outpatient Mental Health Care**	• **20%** coinsurance for most outpatient mental health services • 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. • "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.	**General** • Authorization rules may apply. **In-Network** • **$35** copayment for each Medicare-covered individual therapy visit • **$35** copayment for each Medicare-covered group therapy visit • **$35** copayment for each Medicare-covered individual therapy visit with a psychiatrist • **$35** copayment for each Medicare-covered group therapy visit with a psychiatrist • **$35** copayment for Medicare-covered partial hospitalization program services **Out-of-Network** • **$40** copayment for Medicare-covered Mental Health visits with a psychiatrist • **$40** copayment for Medicare-covered Mental Health visits • **30%** of the cost for Medicare-covered partial hospitalization program services **See page 36 for additional information about Outpatient Mental Health Care**
(12) **Outpatient Substance Abuse Care**	• **20%** coinsurance	**General** • Authorization rules may apply. **In-Network** • **$150** copayment for Medicare-covered individual substance abuse outpatient treatment visits • **$150** copayment for Medicare-covered group substance abuse outpatient treatment visits **Out-of-Network** • **30%** of the cost for Medicare-covered substance abuse outpatient treatment visits **See page 36 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	HumanaChoice R5826-005 (Regional PPO)
(13) **Outpatient Services**	• **20%** coinsurance for the doctor's services • Specified copayment for outpatient hospital facility services. Copayment cannot exceed the Part A inpatient hospital deductible. • **20%** coinsurance for ambulatory surgical center facility services	**General** • Authorization rules may apply. **In-Network** • **$150** copayment for each Medicare-covered ambulatory surgical center visit • **$60** to **$195** copayment [or **20%** of the cost] for each Medicare-covered outpatient hospital facility visit **Out-of-Network** • **20%** to **30%** of the cost for Medicare-covered outpatient hospital facility visits • **30%** of the cost for Medicare-covered ambulatory surgical center visits **See page 36 for additional information about Outpatient Services**
(14) **Ambulance Services** (medically necessary ambulance services)	• **20%** coinsurance	**General** • Authorization rules may apply. **In-Network** • **$250** copayment for Medicare-covered ambulance benefits. **Out-of-Network** • **$250** copayment for Medicare-covered 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 • Specified copayment for outpatient hospital facility emergency services. • Emergency services copayment cannot exceed Part A inpatient hospital deductible for each service provided by the hospital. • 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. • Not covered outside the U.S. except under limited circumstances.	**General** • **$65** copayment for Medicare-covered emergency room visits • Worldwide coverage. • If you are admitted to the hospital within 24-hour(s) for the same condition, you pay **$0** for the emergency room visit.

(Outpatient Care - Continued on next page)

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OUTPATIENT CARE

BENEFIT	ORIGINAL MEDICARE	HumanaChoice R5826-005 (Regional PPO)
(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 • If you are admitted to the hospital within 3 days for the same condition, you pay **$0** for the urgently-needed-care visit. • NOT covered outside the U.S. except under limited circumstances.	**General** • **$40** copayment for Medicare-covered urgently-needed-care visits • **30%** of the cost for Medicare-covered urgently-needed-care visits **See page 36 for additional information about Urgently Needed Care**
(17) **Outpatient Rehabilitation Services** (Occupational Therapy, Physical Therapy, Speech and Language Therapy)	• **20%** coinsurance • Medically necessary physical therapy, occupational therapy, and speech and language pathology services are covered.	**General** • Authorization rules may apply. • Medically necessary physical therapy, occupational therapy, and speech and language pathology services are covered. **In-Network** • **$60** copayment for Medicare-covered Occupational Therapy visits • **$60** copayment for Medicare-covered Physical Therapy and/or Speech and Language Pathology visits **Out-of-Network** • **$40** copayment [or **30%** of the cost] for Medicare-covered Physical Therapy and/or Speech and Language Pathology visits • **$40** copayment [or **30%** of the cost] for Medicare-covered Occupational Therapy visits. **See page 37 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	HumanaChoice R5826-005 (Regional PPO)
(18) **Durable Medical Equipment** (includes wheelchairs, oxygen, etc.)	• **20%** coinsurance	**General** • Authorization rules may apply. **In-Network** • **20%** of the cost for Medicare-covered durable medical equipment • You may pay less if you purchase these items from the plan's preferred manufacturers/vendors. Contact the plan for a list of non-preferred and preferred manufacturers/vendors. **Out-of-Network** • **28%** of the cost for Medicare-covered durable medical equipment
(19) **Prosthetic Devices** (includes braces, artificial limbs and eyes, etc.)	• **20%** coinsurance • **20%** coinsurance for Medicare-covered medical supplies related to prosthetics, splints, and other devices.	**General** • Authorization rules may apply. **In-Network** • **20%** of the cost for Medicare-covered prosthetic devices • **20%** of the cost for Medicare-covered medical supplies related to prosthetics, splints, and other devices **Out-of-Network** • **35%** of the cost for Medicare-covered prosthetic devices.

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

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	HumanaChoice R5826-005 (Regional PPO)
(20) **Diabetes Programs and Supplies**	• **20%** coinsurance for diabetes self-management training • **20%** coinsurance for diabetes supplies • **20%** coinsurance for diabetic therapeutic shoes or inserts	**General** • Authorization rules may apply. **In-Network** • **$0** copayment for Medicare-covered Diabetes self-management training • **0%** to **20%** of the cost for Medicare-covered Diabetes monitoring supplies • **$10** copayment for Medicare-covered Therapeutic shoes or inserts **Out-of-Network** • **28%** of the cost for Medicare-covered Diabetes monitoring supplies • **28%** of the cost for Medicare-covered Therapeutic shoes or inserts • **$40** copayment [or **30%** of the cost] for Medicare-covered Diabetes self-management training **See page 37 for additional information about Diabetes Programs and Supplies**

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

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	HumanaChoice R5826-005 (Regional PPO)
(21) **Diagnostic Tests, X-Rays, Lab Services, and Radiology Services**	• **20%** coinsurance for diagnostic tests and x-rays • **$0** copayment for Medicare-covered lab services • 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.	**General** • Authorization rules may apply. **In-Network** • **$0** to **$150** copayment for Medicare-covered lab services • **$0** to **$150** copayment for Medicare-covered diagnostic procedures and tests • **$5** to **$150** copayment for Medicare-covered X-rays • **$100** to **$150** copayment for Medicare-covered diagnostic radiology services (not including X-rays) • **$35** copayment [or **20%** of the cost] for Medicare-covered therapeutic radiology services • If the doctor provides you services in addition to Outpatient Diagnostic and Therapeutic Radiology Services, separate cost sharing of **$5** to **$35** may apply **Out-of-Network** • **$150** copayment [or **30%** of the cost] for Medicare-covered diagnostic radiology services • If the doctor provides you services in addition to (Diagnostic Radiological Services), separate cost sharing of **$40** may apply • **$40** copayment [or **30%** of the cost] for Medicare-covered therapeutic radiology services • **$40** copayment [or **30%** of the cost] for Medicare-covered outpatient X-rays • **$40** copayment [or **30%** of the cost] for Medicare-covered diagnostic procedures and tests • **$40** copayment [or **30%** of the cost] for Medicare-covered lab services **See page 37 for additional information about Diagnostic Tests, X-rays, Lab Services, and Radiology Services**

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

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	HumanaChoice R5826-005 (Regional PPO)
(22) **Cardiac and Pulmonary Rehabilitation Services**	• **20%** coinsurance for Cardiac Rehabilitation services • **20%** coinsurance for Pulmonary Rehabilitation services • **20%** coinsurance for Intensive Cardiac Rehabilitation services	**General** • Authorization rules may apply. **In-Network** • **$35** to **$100** copayment for Medicare-covered Cardiac Rehabilitation Services • **$35** to **$100** copayment for Medicare-covered Intensive Cardiac Rehabilitation Services • **$35** to **$100** copayment for Medicare-covered Pulmonary Rehabilitation Services **Out-of-Network** • **$40** copayment [or **30%** of the cost] for Medicare-covered Cardiac Rehabilitation Services • **$40** copayment [or **30%** of the cost] for Medicare-covered Intensive Cardiac Rehabilitation Services • **$40** copayment [or **30%** of the cost] for Medicare-covered Pulmonary Rehabilitation Services **See page 38 for additional information about Cardiac and Pulmonary Rehabilitation Services**

If you have any questions about this plan's benefits or costs, please contact HUMANA INSURANCE COMPANY for details.

PREVENTIVE SERVICES

BENEFIT	ORIGINAL MEDICARE	HumanaChoice R5826-005 (Regional PPO)
(23) **Preventive Services**	• No coinsurance, copayment or deductible for the following: – Abdominal Aortic Aneurysm Screening – Bone Mass Measurement. Covered once every 24 months (more often if medically necessary) if you meet certain medical conditions. – Cardiovascular Screening – Cervical and Vaginal Cancer Screening. Covered once every 2 years. Covered once a year for women with Medicare at high risk. – Colorectal Cancer Screening – Diabetes Screening – Influenza Vaccine – Hepatitis B Vaccine for people with Medicare who are at risk – 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. – 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. – 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	**General** • **$0** copayment for all preventive services covered under Original Medicare at zero cost sharing. • Any additional preventive services approved by Medicare mid-year will be covered by the plan or by Original Medicare. **In-Network** • **$0** copayment for a supplemental annual physical exam **Out-of-Network** • **$40** copayment for a supplemental annual physical exam • **$0** to **$40** copayment [or **30%** of the cost] for Medicare-covered preventive services **See page 38 for additional information about Preventive Services**

(Preventive Services - Continued on next page)

PREVENTIVE SERVICES

BENEFIT	ORIGINAL MEDICARE	HumanaChoice R5826-005 (Regional PPO)
	counseling to help you manage your diabetes or kidney disease – Personalized Prevention Plan Services (Annual Wellness Visits) – Pneumococcal Vaccine. You may only need the Pneumonia vaccine once in your lifetime. Call your doctor for more information. – Prostate Cancer Screening – Prostate Specific Antigen (PSA) test only. Covered once a year for all men with Medicare over age 50. – Smoking and Tobacco Use Cessation (counseling to stop smoking and tobacco use). 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. – Screening and behavioral counseling interventions in primary care to reduce alcohol misuse – Screening for depression in adults – Screening for sexually transmitted infections (STI) and high-intensity behavioral counseling to prevent STIs – Intensive behavioral counseling for Cardiovascular Disease (bi-annual) – Intensive behavioral therapy for obesity – Welcome to Medicare Preventive Visits (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 Preventive Visits or an Annual Wellness Visit. After your first 12 months, you can get one Annual Wellness Visit every 12 months.	

(Preventive Services - Continued on next page)

PREVENTIVE SERVICES

BENEFIT	ORIGINAL MEDICARE	HumanaChoice R5826-005 (Regional PPO)
(24) **Kidney Disease and Conditions**	• **20%** coinsurance for renal dialysis • **20%** coinsurance for kidney disease education services	**General** • Authorization rules may apply. **In-Network** • **0%** to **20%** of the cost for Medicare-covered renal dialysis • **$0** copayment for Medicare-covered kidney disease education services **Out-of-Network** • **$40** copayment for Medicare-covered kidney disease education services • **0%** to **20%** of the cost for Medicare-covered renal dialysis **See page 39 for additional information about Kidney Disease and Conditions**

If you have any questions about this plan's benefits or costs, please contact HUMANA INSURANCE COMPANY for details.

PRESCRIPTION DRUG BENEFITS

BENEFIT	ORIGINAL MEDICARE	HumanaChoice R5826-005 (Regional PPO)
(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** • **20%** of the cost for Medicare Part B chemotherapy drugs and other Part B drugs. • **20%** to **30%** of the cost for Medicare Part B drugs out-of-network. **Drugs covered under Medicare Part D** **General** • This plan uses a formulary. The plan will send you the formulary. You can also see the formulary at **http://www.humana.com/medicare/medicare_prescription_drugs/medicare_drug_tools/medicare_drug_list/** on the web. • Different out-of-pocket costs may apply for people who – have limited incomes, – live in long term care facilities, or – have access to Indian/Tribal/Urban (Indian Health Service) providers. • 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). • Total yearly drug costs are the total drug costs paid by both you and a Part D plan. • The plan may require you to first try one drug to treat your condition before it will cover another drug for that condition. • Some drugs have quantity limits. • Your provider must get prior authorization from HumanaChoice R5826-005 (Regional PPO) for certain drugs. • 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.

(Prescription Drug Benefits - Continued on next page)

PRESCRIPTION DRUG BENEFITS

BENEFIT	ORIGINAL MEDICARE	HumanaChoice R5826-005 (Regional PPO)
		• 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. • The plan charges a minimum cost sharing amount for certain low-cost drugs. • If you request a formulary exception for a drug and HumanaChoice R5826-005 (Regional PPO) approves the exception, you will pay Tier 4: Non-Preferred Brand cost sharing for that drug. **In-Network** • **$0** deductible. **Initial Coverage** • You pay the following until total yearly drug costs reach **$2,850**: **Retail Pharmacy** • Contact your plan if you have questions about cost-sharing or billing when less than a one-month supply is dispensed. • You can get drugs the following way(s): • Tier 1: Preferred Generic – **$3** copayment for a one-month (30-day) supply of drugs in this tier – **$9** copayment for a three-month (90-day) supply of drugs in this tier • Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information. • Tier 2: Non-Preferred Generic – **$8** copayment for a one-month (30-day) supply of drugs in this tier – **$24** copayment for a three-month (90-day) supply of drugs in this tier • Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information. • Tier 3: Preferred Brand – **$40** copayment for a one-month (30-day) supply of drugs in this tier – **$120** copayment for a three-month (90-day) supply of drugs in this tier • Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information. • Tier 4: Non-Preferred Brand – **$85** copayment for a one-month (30-day) supply of drugs in this tier

(Prescription Drug Benefits - Continued on next page)

PRESCRIPTION DRUG BENEFITS

BENEFIT	ORIGINAL MEDICARE	HumanaChoice R5826-005 (Regional PPO)
		– **$255** copayment for a three-month (90-day) supply of drugs in this tier • Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information. • Tier 5: Specialty Tier – **33%** coinsurance for a one-month (30-day) supply of drugs in this tier **Long Term Care Pharmacy** • Long term care pharmacies must dispense brand name drugs in amounts less than a 14 days supply at a time. They may also dispense less than a month's supply of generic drugs at a time. Contact your plan if you have questions about cost-sharing or billing when less than a one-month supply is dispensed. • You can get drugs the following way(s): • Tier 1: Preferred Generic – **$3** copayment for a one-month (31-day) supply of drugs in this tier • Tier 2: Non-Preferred Generic – **$8** copayment for a one-month (31-day) supply of drugs in this tier • Tier 3: Preferred Brand – **$40** copayment for a one-month (31-day) supply of drugs in this tier • Tier 4: Non-Preferred Brand – **$85** copayment for a one-month (31-day) supply of drugs in this tier • Tier 5: Specialty Tier – **33%** coinsurance for a one-month (31-day) supply of drugs in this tier **Mail Order** • Contact your plan if you have questions about cost-sharing or billing when less than a one-month supply is dispensed. • You can get drugs from a preferred and non-preferred mail order pharmacy the following way(s): • Tier 1: Preferred Generic – **$3** copayment for a one-month (30-day) supply of drugs in this tier from a preferred mail order pharmacy. – **$0** copayment for a three-month (90-day) supply of drugs in this tier from a preferred mail order pharmacy.

(Prescription Drug Benefits - Continued on next page)

PRESCRIPTION DRUG BENEFITS

BENEFIT	ORIGINAL MEDICARE	HumanaChoice R5826-005 (Regional PPO)
		– **$3** copayment for a one-month (30-day) supply of drugs in this tier from a non-preferred mail order pharmacy. – **$9** copayment for a three-month (90-day) supply of drugs in this tier from a non-preferred mail order pharmacy. • Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information. • Tier 2: Non-Preferred Generic – **$8** copayment for a one-month (30-day) supply of drugs in this tier from a preferred mail order pharmacy. – **$0** copayment for a three-month (90-day) supply of drugs in this tier from a preferred mail order pharmacy. – **$8** copayment for a one-month (30-day) supply of drugs in this tier from a non-preferred mail order pharmacy. – **$24** copayment for a three-month (90-day) supply of drugs in this tier from a non-preferred mail order pharmacy. • Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information. • Tier 3: Preferred Brand – **$40** copayment for a one-month (30-day) supply of drugs in this tier from a preferred mail order pharmacy. – **$110** copayment for a three-month (90-day) supply of drugs in this tier from a preferred mail order pharmacy. – **$40** copayment for a one-month (30-day) supply of drugs in this tier from a non-preferred mail order pharmacy. – **$120** copayment for a three-month (90-day) supply of drugs in this tier from a non-preferred mail order pharmacy. • Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information. • Tier 4: Non-Preferred Brand – **$85** copayment for a one-month (30-day) supply of drugs in this tier from a preferred mail order pharmacy. – **$245** copayment for a three-month (90-day) supply of drugs in this tier from a preferred mail order pharmacy.

(Prescription Drug Benefits - Continued on next page)

PRESCRIPTION DRUG BENEFITS

BENEFIT	ORIGINAL MEDICARE	HumanaChoice R5826-005 (Regional PPO)
		– **$85** copayment for a one-month (30-day) supply of drugs in this tier from a non-preferred mail order pharmacy. – **$255** copayment for a three-month (90-day) supply of drugs in this tier from a non-preferred mail order pharmacy. • Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information. • Tier 5: Specialty Tier – **33%** coinsurance for a one-month (30-day) supply of drugs in this tier from a preferred mail order pharmacy. – **33%** coinsurance for a one-month (30-day) supply of drugs in this tier from a non-preferred mail order pharmacy. **Coverage Gap** • After your total yearly drug costs reach **$2,850,** you receive limited coverage by the plan on certain drugs. You will also receive a discount on brand name drugs and generally pay no more than **47.5%** for the plan's costs for brand drugs and **72%** of the plan's costs for generic drugs until your yearly out-of-pocket drug costs reach **$4,550.** **Additional Coverage Gap** • 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. • The plan offers additional coverage in the gap for the following tiers. • You pay the following: **Retail Pharmacy** • Contact your plan if you have questions about cost-sharing or billing when less than a one-month supply is dispensed. • Tier 1: Preferred Generic – **$3** copayment for a one-month (30-day) supply of certain drugs covered within this tier – **$9** copayment for a three-month (90-day) supply of certain drugs covered within this tier

(Prescription Drug Benefits - Continued on next page)

PRESCRIPTION DRUG BENEFITS

BENEFIT	ORIGINAL MEDICARE	HumanaChoice R5826-005 (Regional PPO)
		• Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information. • Tier 2: Non-Preferred Generic – **$8** copayment for a one-month (30-day) supply of certain drugs covered within this tier – **$24** copayment for a three-month (90-day) supply of certain drugs covered within this tier • Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information. • Tier 3: Preferred Brand – **$40** copayment for a one-month (30-day) supply of certain drugs covered within this tier – **$120** copayment for a three-month (90-day) supply of certain drugs covered within this tier • Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information. • Tier 4: Non-Preferred Brand – **$85** copayment for a one-month (30-day) supply of certain drugs covered within this tier – **$255** copayment for a three-month (90-day) supply of certain drugs covered within this tier • Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information. • Tier 5: Specialty Tier – **33%** coinsurance for a one-month (30-day) supply of certain drugs covered within this tier **Long Term Care Pharmacy** • Long term care pharmacies must dispense brand name drugs in amounts less than a 14 days supply at a time. They may also dispense less than a month's supply of generic drugs at a time. Contact your plan if you have questions about cost-sharing or billing when less than a one-month supply is dispensed. • Tier 1: Preferred Generic

(Prescription Drug Benefits - Continued on next page)

PRESCRIPTION DRUG BENEFITS

BENEFIT	ORIGINAL MEDICARE	HumanaChoice R5826-005 (Regional PPO)
		– **$3** copayment for a one-month (31-day) supply of certain drugs covered within this tier • Tier 2: Non-Preferred Generic – **$8** copayment for a one-month (31-day) supply of certain drugs covered within this tier • Tier 3: Preferred Brand – **$40** copayment for a one-month (31-day) supply of certain drugs covered within this tier • Tier 4: Non-Preferred Brand – **$85** copayment for a one-month (31-day) supply of certain drugs covered within this tier • Tier 5: Specialty Tier – **33%** coinsurance for a one-month (31-day) supply of certain drugs covered within this tier **Mail Order** • Contact your plan if you have questions about cost-sharing or billing when less than a one-month supply is dispensed. • Tier 1: Preferred Generic – **$3** copayment for a one-month (30-day) supply of certain drugs covered within this tier from a preferred mail order pharmacy – **$0** copayment for a three-month (90-day) supply of certain drugs covered within this tier from a preferred mail order pharmacy – **$3** copayment for a one-month (30-day) supply of certain drugs covered within this tier from a non-preferred mail order pharmacy – **$9** copayment for a three-month (90-day) supply of certain drugs covered within this tier from a non-preferred mail order pharmacy • Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information. • Tier 2: Non-Preferred Generic – **$8** copayment for a one-month (30-day) supply of certain drugs covered within this tier from a preferred mail order pharmacy

(Prescription Drug Benefits - Continued on next page)

PRESCRIPTION DRUG BENEFITS

BENEFIT	ORIGINAL MEDICARE	HumanaChoice R5826-005 (Regional PPO)
		– **$0** copayment for a three-month (90-day) supply of certain drugs covered within this tier from a preferred mail order pharmacy – **$8** copayment for a one-month (30-day) supply of certain drugs covered within this tier from a non-preferred mail order pharmacy – **$24** copayment for a three-month (90-day) supply of certain drugs covered within this tier from a non-preferred mail order pharmacy • Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information. • Tier 3: Preferred Brand – **$40** copayment for a one-month (30-day) supply of certain drugs covered within this tier from a preferred mail order pharmacy – **$110** copayment for a three-month (90-day) supply of certain drugs covered within this tier from a preferred mail order pharmacy – **$40** copayment for a one-month (30-day) supply of certain drugs covered within this tier from a non-preferred mail order pharmacy – **$120** copayment for a three-month (90-day) supply of certain drugs covered within this tier from a non-preferred mail order pharmacy • Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information. • Tier 4: Non-Preferred Brand – **$85** copayment for a one-month (30-day) supply of certain drugs covered within this tier from a preferred mail order pharmacy – **$245** copayment for a three-month (90-day) supply of certain drugs covered within this tier from a preferred mail order pharmacy – **$85** copayment for a one-month (30-day) supply of certain drugs covered within this tier from a non-preferred mail order pharmacy

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PRESCRIPTION DRUG BENEFITS

BENEFIT	ORIGINAL MEDICARE	HumanaChoice R5826-005 (Regional PPO)
		– **$255** copayment for a three-month (90-day) supply of certain drugs covered within this tier from a non-preferred mail order pharmacy • Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information. • Tier 5: Specialty Tier – **33%** coinsurance for a one-month (30-day) supply of certain drugs covered within this tier from a preferred mail order pharmacy – **33%** coinsurance for a one-month (30-day) supply of certain drugs covered within this tier from a non-preferred mail order pharmacy • Please contact the plan for a complete list of drugs covered through the gap. **Catastrophic Coverage** • After your yearly out-of-pocket drug costs reach **$4,550,** you pay the greater of: – **5%** coinsurance, or – **$2.55** copayment for generic (including brand drugs treated as generic) and a **$6.35** copayment for all other drugs. **Out-of-Network** • 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 HumanaChoice R5826-005 (Regional PPO). • You can get out-of-network drugs the following way: **Out-of-Network Initial Coverage** • 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 **$2,850**: • Tier 1: Preferred Generic – **$3** copayment for a one-month (30-day) supply of drugs in this tier

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PRESCRIPTION DRUG BENEFITS

BENEFIT	ORIGINAL MEDICARE	HumanaChoice R5826-005 (Regional PPO)
		• Tier 2: Non-Preferred Generic – **$8** copayment for a one-month (30-day) supply of drugs in this tier • Tier 3: Preferred Brand – **$40** copayment for a one-month (30-day) supply of drugs in this tier • Tier 4: Non-Preferred Brand – **$85** copayment for a one-month (30-day) supply of drugs in this tier • Tier 5: Specialty Tier – **33%** coinsurance for a one-month (30-day) supply of drugs in this tier • You will not be reimbursed for the difference between the Out-of-Network Pharmacy charge and the plan's In-Network allowable amount. **Out-of-Network Coverage Gap** • You will be reimbursed up to **28%** of the plan allowable cost for generic drugs purchased out-of-network until total yearly out-of-pocket drug costs reach **$4,550.** Please note that the plan allowable cost may be less than the out-of-network pharmacy price paid for your drug(s). • You will be reimbursed up to **52.5%** of the plan allowable cost for brand name drugs purchased out-of-network until your total yearly out-of-pocket drug costs reach **$4,550.** Please note that the plan allowable cost may be less than the out-of-network pharmacy price paid for your drug(s). **Additional Out-of-Network Coverage Gap** • You will be reimbursed for these drugs purchased out-of-network up to the plan's cost of the drug minus the following: • Tier 1: Preferred Generic – **$3** copayment for a one-month (30-day) supply of certain drugs covered within this tier • Tier 2: Non-Preferred Generic – **$8** copayment for a one-month (30-day) supply of certain drugs covered within this tier • Tier 3: Preferred Brand – **$40** copayment for a one-month (30-day) supply of certain drugs covered within this tier • Tier 4: Non-Preferred Brand

(Prescription Drug Benefits - Continued on next page)

PRESCRIPTION DRUG BENEFITS

BENEFIT	ORIGINAL MEDICARE	HumanaChoice R5826-005 (Regional PPO)
		– **$85** copayment for a one-month (30-day) supply of certain drugs covered within this tier • Tier 5: Specialty Tier – **33%** coinsurance for a one-month (30-day) supply of certain drugs covered within this tier **Out-of-Network Catastrophic Coverage** • After your yearly out-of-pocket drug costs reach **$4,550,** 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: – **5%** coinsurance, or – **$2.55** copayment for generic (including brand drugs treated as generic) and a **$6.35** copayment for all other drugs. • You will not be reimbursed for the difference between the Out-of-Network Pharmacy charge and the plan's In-Network allowable amount. **See page 39 for additional information about Outpatient Prescription Drugs**

OUTPATIENT MEDICAL SERVICES AND SUPPLIES

BENEFIT	ORIGINAL MEDICARE	HumanaChoice R5826-005 (Regional PPO)
(26) **Dental Services**	• Preventive dental services (such as cleaning) not covered.	**In-Network** • **$35** copayment for Medicare-covered dental benefits • **$0** copayment for up to 2 supplemental oral exam(s) every year • **$0** copayment for up to 2 supplemental cleaning(s) every year • **$0** copayment for up to 1 supplemental dental x-ray(s) every year **Out-of-Network** • **$40** copayment for Medicare-covered comprehensive dental benefits • **50%** of the cost for supplemental comprehensive dental benefits • **50%** of the cost for supplemental preventive dental benefits **In and Out-of-Network** • Contact the plan for availability of additional supplemental in-network and out-of-network comprehensive dental benefits. **See page 39 for additional information about Dental Services**
(27) **Hearing Services**	• Supplemental routine hearing exams and hearing aids not covered. • **20%** coinsurance for diagnostic hearing exams.	**General** • Authorization rules may apply. **In-Network** • In general, supplemental routine hearing exams and hearing aids not covered. • **$35** copayment for Medicare-covered diagnostic hearing exams **Out-of-Network** • **$40** copayment for Medicare-covered diagnostic hearing exams.
(28) **Vision Services**	• **20%** coinsurance for diagnosis and treatment of diseases and conditions of the eye, including an annual glaucoma screening for people at risk • Supplemental routine eye exams and eyeglasses (lenses and frames) not covered. • Medicare pays for one pair of eyeglasses or contact lenses after cataract surgery.	**In-Network** • **$0** to **$35** copayment for Medicare-covered exams to diagnose and treat diseases and conditions of the eye, including an annual glaucoma screening for people at risk • **$0** copayment for up to 1 supplemental routine eye exam(s) every year • **$0** copayment for one pair of Medicare-covered eyeglasses (lenses and frames) or contact lenses after cataract surgery.

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

OUTPATIENT MEDICAL SERVICES AND SUPPLIES

BENEFIT	ORIGINAL MEDICARE	HumanaChoice R5826-005 (Regional PPO)
		Out-of-Network • **$0** copayment for supplemental routine eye exams • **$0** copayment for Medicare-covered eyewear • **$40** copayment for Medicare-covered eye exams **In and Out-of-Network** • **$130** plan coverage limit for supplemental eye exams every year. This limit applies to both in-network and out-of-network benefits. **See page 39 for additional information about Vision Services**
Wellness/Education and Other Supplemental Benefits & Services	• Not covered.	**In-Network** • The plan covers the following supplemental education/wellness programs: – Health Education – Health Club Membership/Fitness Classes – Nursing Hotline **Out-of-Network** • **50%** of the cost for supplemental education/wellness programs **See page 40 for additional information about Wellness/Education and Other Supplemental Benefits & Services**
Over-the-Counter Items	• Not covered.	**General** • Please visit our plan website to see our list of covered Over-the-Counter items. • OTC items may be purchased only for the enrollee. • Please contact the plan for specific instructions for using this benefit. **See page 40 for additional information about Over-the-Counter Items**
Transportation (Routine)	• Not covered.	**In-Network** • This plan does not cover supplemental routine transportation.
Acupuncture and Other Alternative Therapies	• Not covered.	**In-Network** • This plan does not cover Acupuncture and other alternative therapies.

SECTION III – ABOUT YOUR PLAN
HumanaChoice R5826-005 (Regional PPO)

This section further explains some of the benefits of your plan. To get a complete list of benefits, limitations, and exclusions, call HumanaChoice R5826-005 (Regional PPO) and ask for the **"Evidence of Coverage."**

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
- Routine dental services
- Over-the-counter drugs and supplies

If you qualify for Medicaid coverage through your state, be sure to show your Medicaid ID card in addition to your HumanaChoice R5826-005 (Regional PPO) membership card to make your provider aware that you may have additional coverage.

② Doctor and Hospital Choice

Choosing a doctor
As a HumanaChoice R5826-005 (Regional PPO) member, it's a good idea to select a doctor to act as your primary care physician (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.

If you see any **out-of-network** doctors, please make sure they accept Medicare patients. Even if they do, **you may have to pay more** when using out-of-network doctors. Any doctors who refuse to accept HumanaChoice R5826-005 (Regional PPO) because they're not familiar with the plan can call our provider line, 1-800-457-4708, or visit **Humana-Medicare.com** for more information.

U.S. Travel Benefit
You have access to providers in the HumanaChoice R5826-005 (Regional PPO) network in all of our service areas. If you need non-emergency care while traveling outside the plan's service area, call Customer Service. We'll tell you whether you're in one of our other HumanaChoice R5826-005 (Regional PPO) service areas and help you find an in-network provider.

Authorization Requirements
Your provider will need an authorization from HumanaChoice R5826-005 (Regional PPO) before you receive certain services, except in an emergency or when care is urgently needed. The authorization process helps members receive appropriate and necessary Medicare-covered care and treatment. Providers in our network are aware of this process and will request the authorization. Without the authorization, your plan might not cover the services and you may have to pay the full cost.

INPATIENT CARE

③ Inpatient Hospital Care

④ Inpatient Mental Health Care

⑤ Skilled Nursing Facility (SNF)

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. HumanaChoice R5826-005 (Regional PPO) follows Original Medicare guidelines in determining authorization for skilled nursing facility services.

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	**$5** copayment	**$40** copayment
Specialist's office	**$35** copayment	**$40** copayment

(11) Outpatient Mental Health Care

(12) Outpatient Substance Abuse Care

	In-Network	**Out-of-Network**
Specialist's office	**$35** copayment	**$40** copayment
Hospital facility as an outpatient	**$150** copayment	**30%** of the cost
Partial hospitalization at a hospital facility	**$35** copayment	**30%** of the cost

(13) Outpatient Services

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

	In-Network	**Out-of-Network**
Radiation therapy	**20%** of the cost	**30%** of the cost
Advanced imaging		
- MRI, MRA, CT Scan, and PET services	**$150** copayment	**30%** of the cost
Chemotherapy drugs	**20%** of the cost	**30%** of the cost
Lab services	**$150** copayment	**30%** of the cost
Nuclear medicine	**$150** copayment	**30%** of the cost
Physical, occupational, or speech-language therapy	**$60** copayment	**30%** of the cost
Surgical services	**$195** copayment	**30%** of the cost
Renal dialysis services	**20%** of the cost	**20%** of the cost
Diagnostic Mammography	**$150** copayment	**30%** of the cost
Outpatient basic radiology	**$150** copayment	**30%** of the cost
Diagnostic procedures and tests	**$150** copayment	**30%** of the cost

(16) Urgently Needed Care

For Urgently Needed Care, you pay:	**In-Network**	**Out-of-Network**
Primary care doctor's office	**$5** copayment	**$40** copayment
Specialist's office	**$35** copayment	**$40** copayment
Immediate care facility	**$35** copayment	**30%** of the cost

(17) Outpatient Rehabilitation Services

For outpatient rehabilitation services, you pay:	In-Network	Out-of-Network
Specialist's office for all therapy and rehabilitation services	**$35** copayment	**$40** copayment
Comprehensive outpatient rehabilitation facility for occupational, physical and speech therapy services	**$35** copayment	**30%** of the cost
Hospital facility as an outpatient for occupational, physical and speech therapy services	**$60** copayment	**30%** 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	**28%** of the cost
Durable medical equipment provider	**20%** of the cost	**28%** 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	**28%** of the cost
Durable medical equipment provider	**20%** of the cost	**28%** of the cost

For Medicare-covered diabetes self-monitoring training, you pay:	In-Network	Out-of-Network
Primary care doctor's office	**$0** copayment	**$40** copayment
Specialist's office	**$0** copayment	**$40** copayment
Hospital facility as an outpatient	**$0** copayment	**30%** 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	**$5** copayment	**$40** copayment
Specialist's office	**$35** copayment	**$40** copayment
Immediate care facility	**$35** copayment	**30%** of the cost
Freestanding lab	**$0** copayment	**30%** of the cost
Hospital facility as an outpatient	**$150** copayment	**30%** of the cost

Diagnostic procedures and tests	In-Network	Out-of-Network
Primary care doctor's office	**$5** copayment	**$40** copayment
Specialist's office	**$35** copayment	**$40** copayment
Immediate care facility	**$35** copayment	**30%** of the cost
Hospital facility as an outpatient	**$150** copayment	**30%** of the cost

Sleep Study	In-Network	Out-of-Network
Member's home	**$0** copayment	**30%** of the cost
Specialist's office	**$150** copayment	**30%** of the cost
Hospital facility as an outpatient	**$150** copayment	**30%** of the cost

X-rays and diagnostic radiology services	In-Network	Out-of-Network
Primary care doctor's office	**$5** copayment	**$40** copayment
Specialist's office	**$35** copayment	**$40** copayment
Freestanding radiological facility	**$50** copayment	**30%** of the cost
Hospital facility as an outpatient	**$150** copayment	**30%** of the cost
Immediate care facility	**$35** copayment	**30%** of the cost

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	**$150** copayment	**$150** copayment
Specialist's office		
- in addition to office visit copayment	**$150** copayment	**$150** copayment
Freestanding radiological facility	**$100** copayment	**30%** of the cost
Hospital facility as an outpatient	**$150** copayment	**30%** of the cost

Nuclear medicine services	**In-Network**	**Out-of-Network**
Freestanding radiological facility	**$150** copayment	**30%** of the cost
Hospital facility as an outpatient	**$150** copayment	**30%** of the cost

Therapeutic radiology services (Radiation Therapy)	**In-Network**	**Out-of-Network**
Specialist's office	**$35** copayment	**$40** copayment
Freestanding radiological facility	**20%** of the cost	**30%** of the cost
Hospital facility as an outpatient	**20%** of the cost	**30%** of the cost

For EKG screening, you pay:	**In-Network**	**Out-of-Network**
Primary care doctor's office	**$0** copayment	**$40** copayment
Specialist's office	**$0** copayment	**$40** copayment
Hospital facility as an outpatient	**$0** copayment	**30%** of the cost

(22) Cardiac and Pulmonary Rehabilitation Services

For cardiac rehabilitation services, you pay:	**In-Network**	**Out-of-Network**
Specialist's office	**$35** copayment	**$40** copayment
Hospital facility as an outpatient	**$100** copayment	**30%** of the cost

For pulmonary rehabilitation services, you pay:	**In-Network**	**Out-of-Network**
Specialist's office	**$35** copayment	**$40** copayment
Hospital facility as an outpatient	**$100** copayment	**30%** of the cost

PREVENTIVE SERVICES

(23) Preventive Services

For abdominal aortic aneurysm screening or bone mass measurement, you pay:	**In-Network**	**Out-of-Network**
Specialist's office	**$0** copayment	**$40** copayment
Freestanding radiological facility	**$0** copayment	**30%** of the cost
Hospital facility as an outpatient	**$0** copayment	**30%** of the cost

For a cardiovascular, diabetes, or HIV screening, you pay:	**In-Network**	**Out-of-Network**
Primary care doctor's office	**$0** copayment	**$40** copayment
Specialist's office	**$0** copayment	**$40** copayment
Freestanding lab	**$0** copayment	**30%** of the cost
Hospital facility as an outpatient	**$0** copayment	**30%** of the cost

For colorectal screening, you pay:	**In-Network**	**Out-of-Network**
Specialist's office	**$0** copayment	**$40** copayment
Ambulatory surgical center	**$0** copayment	**30%** of the cost
Hospital facility as an outpatient	**$0** copayment	**30%** of the cost

You pay the following for nutrition therapy for kidney disease or diabetes:	**In-Network**	**Out-of-Network**
Primary care doctor's office	**$0** copayment	**$40** copayment

Specialist's office	**$0** copayment	**$40** copayment
Hospital facility as an outpatient	**$0** copayment	**30%** of the cost

For screening mammography, you pay:	**In-Network**	**Out-of-Network**
Specialist's office	**$0** copayment	**$40** copayment
Freestanding radiology facility	**$0** copayment	**30%** of the cost
Hospital facility as an outpatient	**$0** copayment	**30%** of the cost

(24) Kidney Disease and Conditions

You pay the following for renal dialysis received at:	**In-Network**	**Out-of-Network**
Renal dialysis center	**0%** of the cost	**0%** of the cost
Hospital facility as an outpatient	**20%** of the cost	**20%** of the cost

You pay the following for kidney disease education services:	**In-Network**	**Out-of-Network**
Primary care doctor's office	**$0** copayment	**$40** copayment
Specialist's office	**$0** copayment	**$40** copayment

PRESCRIPTION DRUG BENEFITS

(25) Outpatient Prescription Drugs

Drugs covered under Medicare Part B
For Medicare-covered Part B drugs, including chemotherapy drugs, you receive at an in-network doctor's office, you pay **20%** of the cost.
If you use an out-of-network doctor, you pay **30%** of the cost for chemotherapy drugs and **20%** of the cost for all other Medicare-covered Part B drugs.
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 HumanaChoice R5826-005 (Regional PPO) to see if a certain drug is covered or visit **Humana-Medicare.com**.
RightSource, Humana's mail-order pharmacy, is your plan's preferred mail-order pharmacy for Part D maintenance and specialty drugs. To find out more about **RightSource**, call **1-855-255-9310**.
Other Pharmacies are available in our network.

OUTPATIENT MEDICAL SERVICES AND SUPPLIES

(26) Dental Services

You pay:	**In-Network**	**Out-of-Network**
Specialist's office - Medicare-covered benefits only	**$35** copayment	**$40** copayment

Mandatory Supplemental Benefit includes:	**In-Network**	**Out-of-Network**
Amalgam filling, up to one per year	**$0** copayment	**50%** coinsurance
Denture reline, up to one per year	**$0** copayment	**50%** coinsurance
Extractions, up to one per year	**$0** copayment	**50%** coinsurance
Bitewing X-rays, up to one set(s) per year	**$0** copayment	**50%** coinsurance
Composite filling, up to two per year	**$0** copayment	**50%** coinsurance
Oral evaluation, up to two per year	**$0** copayment	**50%** coinsurance
Prophylaxis (cleaning), up to two per year	**$0** copayment	**50%** coinsurance

These dental services are equivalent to a yearly value of **$2,000**

To receive the in-network benefit, you must visit a CAREINGTON provider.

(28) Vision Services

Medicare-covered vision services include:	**In-Network**	**Out-of-Network**

Glaucoma screening, one per year	**$0** copayment	**$40** copayment
Medicare-covered vision services	**$35** copayment	**$40** copayment

Mandatory Supplemental Benefit includes:

- **$130** maximum coverage amount for routine comprehensive eye examination by an EyeMed Vision Care Select network optical provider, one per year. Visit any EyeMed Vision Care Select network optical provider and your routine exam charge will not exceed the **$130** maximum coverage amount. If you choose to use an out-of-network provider, you will be responsible for costs above the plan-approved amount.

Wellness/Education and Other Supplemental Benefits & Services

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.

Humana Active Outlook®

Humana Active Outlook is a lifestyle enrichment program with great features like HAO Publications, HAO Website, Classes, and other health and wellness educational materials.
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** (TTY: **711**) to talk with a nurse.

Over-the-Counter Items

Health and Wellness Products

You are eligible to receive a **$25** 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.

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2014

Value-Added Items and Services

HumanaChoice®
R5826-005 (Regional PPO)

Region 9
State of Florida

Humana®

R5826005VAS14

Value-Added Items and Services for Humana

Humana offers deals that let you get items and services for less. The following pages tell you how you can save. To get some of the discounts, you may need to show your Humana member ID card or the discount card from this booklet.

For information or if you have questions, please call us at **1-800-457-4708**. If you use a TTY, call **711**. You can call us 7 days a week, from 8 a.m. to 8 p.m. However, please note that our automated phone system may answer your call during weekends and holidays from Feb. 15 to Sept. 30. Please leave your name and telephone number, and we'll call you back by the end of the next business day. For 24-hour service you can visit us at **Humana.com**.

- 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.
- Humana is not responsible for the performance or non-performance of any vendor or any product warranties. Humana is not responsible for payment of nor rebilling for these transactions. The sale transaction is solely between yourself and the vendor.

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. - 8 p.m. If you use a TTY, call **711**.

Meal Delivery

As a Humana member, you can get healthy meals delivered to your home for less. This program is called Independent Living Systems® Meals Discount Services Program, or ILS. These meals are good if you have chronic health conditions such as diabetes, high blood pressure, or high cholesterol. They are low in carbs, fats and salt.

The meals are home-delivered and ready to serve in a few minutes. This is great if it is hard for you to cook meals or get to the market.

How it works
Go online or call the contact information listed below to order your meals. ILS offers five different packages. Each one has a different frozen entrée and side items. Each package of five meals costs $25. This includes delivery to your home. You have a choice of several diet options:

- Regular
- Hispanic or American
- Low salt
- For diabetes
- Soft food

Contact information
For information, visit the ILS website at www.ilsmeals.com. You can order your meals online or call **1-800-460-7176**, Monday - Friday, 8:30 a.m. - 5 p.m. Eastern time. If you use a TTY, call **711**, seven days a week, 8 a.m. - 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're calling. We'll call back by the end of the next business day. Please have your Humana member ID card when you call.

Note: this discount is in addition to any meal delivery benefit you may have under your plan. Please consult your plan benefits to determine if you can receive meal delivery to your home in some situations at no additional cost to you.

Complementary and Alternative Medicine

Complementary and alternative medicine (CAM) services include chiropractic, acupuncture, and massage. As a Humana member, you can get these services at a discount through the **Healthways WholeHealth Network** (HWHN). This network has more than 35,000 practitioners.

Services include:

- **Acupuncture** - A trained professional uses very thin needles on different parts of the body. Needles are put just deep enough into the skin to keep them from falling out and are usually left in place for a few minutes. Acupuncture can be used to treat conditions such as pain, stomach problems, headaches, and more.
- **Massage** - A massage therapist uses hands and fingers to rub, press, and move your skin and muscles. A massage can relax and energize you and help heal muscles after an injury.
- **Chiropractic** - A chiropractor checks for problems in your spine and fixes them by using hands to adjust the spine, joints, and muscles.

How the discount works
You don't need a referral to visit a practitioner in the HWHN network. You may see HWHN providers as often as you like – but you should talk with your primary care doctor about any treatment you're thinking about getting. If you're already seeing CAM professionals who are not on the HWHN list, you can ask to have them added to the network.

To get your discount, simply show the provider the discount card, which you can print from **Humana.com**, or show the provider your Humana member ID card.

Contact information
For details about the program, go to the CAM website from **Humana.com**. Once you log in to MyHumana, go to:

- Health & Wellness
- SavingsCenter, then select "Alternative Medicine"
- Scroll down to the middle part of the screen and click the link "Find an alternative medicine provider"

To find a provider in your area, visit the HWHN website at **http://humana.wholehealthmd.com** or call **1-866-430-8647**, Monday - Friday, 8:30 a.m. - 8 p.m. Eastern time. If you use a TTY, call **711**, Monday - Friday, 8:30 a.m. to 8 p.m. Eastern time.

Prescription medicine discount

Certain prescription medicines are not covered by Medicare prescription drug plans. As a Humana member, you can get discounts on some prescription medicines that you get from the drug store. Use this discount for prescriptions Medicare won't pay for.

How the discount works
Show your Humana member ID card at participating pharmacies when you buy non-covered prescription medicines. Depending on the medicine purchased, quantity limits may apply. Most pharmacy chains and many independent pharmacies will give you a discount. Discounts can vary greatly, please check with your pharmacy to ensure you are getting the best available discount.

Contact information
To find out if a pharmacy will give you a discount, call Customer Care using the number on the back of your Humana member ID card. If you use a TTY, call **711**. You can call us seven days a week, from 8 a.m. - 8 p.m. However, please note that our automated phone system may answer your call during weekends and holidays from Feb. 15 to Sept. 30. Please leave your name and telephone number, and we'll call back by the end of the next business day. Please have your Humana member ID card available when you call. For 24-hour service, you can visit us at **Humana.com**.

Nutrisystem® Discount

For over 40 years, Nutrisystem has been helping people lose weight in order to live healthier, happier lives. Nutrisystem programs are the perfect choice for safe and effective weight loss. They are low calorie, low sodium foods that are high in fiber and protein to help keep you feeling full. Nutrisystem is based on the proven science of the Glycemic Index, which encourages foods containing "good carbs" to help keep your blood sugar levels stable and your appetite in check. As a result, you can continue to enjoy all of your favorite foods, including pizza, pasta, cookies-even chocolate!

Getting started is easy! Simply choose from over 150 delicious foods, either online or by phone. All of your delicious breakfast, lunch, dinners and snacks will be delivered directly to your door, ready to heat and eat. Nutrisystem entrees are perfectly-portioned so you'll never have to count calories or points. And with six mealtimes throughout the day, you'll help cut down on those cravings between meals. You'll have access to everything you need, including Nutrisystem phone counseling, right from the privacy of your own home. No center visits or embarrassing weigh-ins!

How the discount works
As a Humana member, you get an extra **12 percent** discount on all 28-day programs in addition to our current promotional offer PLUS you'll also get free support from the online Nutrisystem community.

Contact information
Humana members in Florida: please visit us today at **www.nutrisystem.com/humanafl** to find out more about programs and more savings. You can also call Nutrisystem toll-free at **1-866-936-6874**. If you use a TTY, call **711**. Hours are Monday - Friday, 8 a.m. - midnight, and Saturday and Sunday, 8:30 a.m. - 5 p.m. Eastern time. Please have your Humana member ID card handy when you call.

All other Humana members: please visit us today at **www.nutrisystem.com/humana** or call Nutrisystem toll-free at **1-866-942-6874** to order. If you use a TTY, call **711**. You can contact us seven days a week, 8 a.m. - 8 p.m. Eastern time. Our phone system may answer your call on Saturdays, Sundays and some public holidays. Just leave a message and let us know why you called. We'll call back by the end of the next business day. Please have your Humana member ID card handy when you call.

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 when you buy hearing aids (up to 40 cells)
- Two-year warranty on the hearing aids
- Other hearing items given to you during check-ups

To get your discount, show your Humana member 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 and special pricing for Humana members
- **10 percent** discount on e-hearing health products
- Lifetime in-house service warranty
- Two-week check-up: free hearing enhancement product
- Hearing aid checks at six months, one year, two years and three years: free hearing enhancement product
- You must be a Humana member during the three-year period to fully participate in the Healthy Hearing Program. You must have bought your hearing aids from an authorized provider during the time period covered by the HearUSA agreement. To get Healthy Hearing products and services, visit the authorized provider that originally sold you the hearing aids you have now. This program doesn't apply to hearing aids bought before 2005.

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

LifeCard Plans - "Life Happens, Be Prepared"

LifeCard Plans provides members emergency access to medical and legal documents from anywhere in the world. LifeCard Plans provides a member's entire family with secure digital storage of key information and documents through an easy-to-use online portal that can be accessed via a secure login from anywhere, anytime.

A wallet card is also available for you that provides important immediate emergency information and the directions and means to access other important medical information in your LifeCard Plans Digital Vault.

Humana members will be able to purchase one of the four plan levels listed below: Basic, Standard, Premium, or Ultimate and save **16-33 percent off the normal retail price**. Humana members will also be waived the activation and document charges.

- **Basic DigitalVault** - With 2 gigabytes (GB) of storage space, a member can store their existing legal and medical documents, making them retrievable 24 hours a day, 7 days a week. They may also store emergency medical information to help save their life if a medical emergency arises. This account covers primary member, spouse or significant other, and all dependents.
  - Included documents: HIPAA Statement, Annual Credit Report Service Request Form
  - Free unlimited document revisions
  - Free smart-phone application
  - Retail pricing: $5.99 a month, $14.99 activation fee
  - **Humana members: $4.99 a month, activation fee waived**
- **Standard DigitalVault with Advance Medical Directives document set** - With 5 GB of storage space, a member receives all the great features of the Basic DigitalVault plus the Advance Medical Directives document set. These critical medical and legal documents are provided for the primary member and spouse or significant other.
  - Included documents: Living Will, Durable Power of Attorney for Health Care, Durable Agent Notices, HIPAA Statement, Annual Credit Report Service Request Form
  - Free unlimited document revisions
  - Free smart-phone application
  - Retail pricing: $9.99 a month, $14.99 activation fee, $9.99 document charge
  - **Humana members: $6.99 a month, activation fee and document charge waived**

- **Premium DigitalVault with Last Will & Testament document set** - With 10 GB of storage space, a member receives all the great features of the Standard DigitalVault plus the Last Will & Testament document set. These critical medical and legal documents are provided for the primary member and spouse or significant other.
  - Included documents: Stand-Alone Will, Durable Power of Attorney for Finances and Property, Revocation of Durable Power of Attorney for Finances and Property, Durable Power of Attorney for Health Care, Durable Agent Notices, HIPAA Statement, Annual Credit Report Service Request Form
  - Free unlimited document revisions
  - Free smart-phone application
  - Retail pricing: $14.99 a month, $14.99 activation fee, $15.99 document charge
  - **Humana members: $9.99 a month, activation fee and document charge waived**
- **Ultimate DigitalVault with Living Trust** - With 15 GB of storage space, a member receives all the great features of the Premium DigitalVault plus the Living Trust document set. These critical medical and legal documents are provided for the primary member and spouse or significant other.
  - Included documents: Simple Trust, Pour-Over Will, Durable Power of Attorney for Finances and Property, Revocation of Durable Power of Attorney for Finances and Property, Durable Power of Attorney for Health Care, Durable Agent Notices, HIPAA Statement, Annual Credit Report Service Request Form
  - Free unlimited document revisions
  - Free smart-phone application
  - Retail pricing: $19.99 a month, $14.99 activation fee, $19.99 document charge
  - **Humana members: $13.99 a month, activation fee and document charge waived**

How the discount works
Visit us today at www.lifecardplans.com/humanavalue and sign up for the basic, standard, premium, or ultimate product and automatically save **16-33 percent off the normal retail price** as shown above and pay $0 activation or document fees.

Contact information
Visit **www.lifecardplans.com/humanavalue** to find out more about the product and services. For assistance call **1-855-698-6600**. If you use a TTY, call **711**. You can reach us Monday - Friday 8 a.m. - 5 p.m. Central time.

Disclaimer: *LifeCard Plans provides access to the website and self-help services at your specific direction subject to LifeCard Plans Terms and Conditions of use. LifeCard Plans is not a law firm or a substitute for a Lawyer. LifeCard Plans does not provide advice, explanations, or recommendations concerning possible legal rights, remedies or selection of forms and communications are not considered attorney-client privilege or attorney work product.*

Notes

Humana is a Medicare Advantage organization with a Medicare contract. Enrollment in this Humana plan depends on contract renewal.

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Multi-language Interpreter Services

English: We have free interpreter services to answer any questions you may have about our health or drug plan. To get an interpreter, just call us at 1-800-457-4708. Someone who speaks English/Language can help you. This is a free service.

Spanish: Tenemos servicios de intérprete sin costo alguno para responder cualquier pregunta que pueda tener sobre nuestro plan de salud o medicamentos. Para hablar con un intérprete, por favor llame al 1-800-457-4708. Alguien que hable español le podrá ayudar. Este es un servicio gratuito.

Chinese Mandarin: 我们提供免费的翻译服务，帮助您解答关于健康或药物保险的任何疑问。如果您需要此翻译服务，请致电 1-800-457-4708。我们的中文工作人员很乐意帮助您。这是一项免费服务。

Chinese Cantonese: 您對我們的健康或藥物保險可能存有疑問，為此我們提供免費的翻譯服務。如需翻譯服務，請致電 1-800-457-4708。我們講中文的人員將樂意為您提供幫助。這是一項免費服務。

Tagalog: Mayroon kaming libreng serbisyo sa pagsasaling-wika upang masagot ang anumang mga katanungan ninyo hinggil sa aming planong pangkalusugan o panggamot. Upang makakuha ng tagasaling-wika, tawagan lamang kami sa 1-800-457-4708. Maaari kayong tulungan ng isang nakakapagsalita ng Tagalog. Ito ay libreng serbisyo.

French: Nous proposons des services gratuits d'interprétation pour répondre à toutes vos questions relatives à no tre régime de santé ou d'assurance-médicaments. Pour accéder au service d'interprétation, il vous suffit de nous appeler au 1-800-457-4708. Un interlocuteur parlant Français pourra vous aider. Ce service est gratuit.

Vietnamese: Chúng tôi có dịch v ụ thông dịch miễn phí để trả l ời các câu hỏi về chương sức khỏe và chương trình thuốc men. Nếu quí vị cần thông dịch viên xin gọi 1-800-281-6918 s ẽ có nhân viên nói tiếng Việt giúp đỡ quí vị. Đây là dịch vụ miễn phí .

German: Unser kostenloser Dolmetscherservice beantwortet Ihren Fragen zu unserem Gesundheits- und Arzneimittelplan. Unsere Dolmetscher erreichen Sie unter 1-800-457-4708. Man wird Ihnen dort auf Deutsch weiterhelfen. Dieser Service ist kostenlos.

Korean: 당사는 의료 보험 또는 약품 보험에 관한 질문에 답해 드리고자 무료 통역 서비스를 제공하고 있습니다. 통역 서비스를 이용하려면 전화 1-800-457-4708 번으로 문의해 주십시오. 한국어를 하는 담당자가 도와 드릴 것입니다. 이 서비스는 무료로 운영됩니다.

Russian: Если у вас возникнут вопросы относительно страхового или медикаментного плана, вы можете воспользоваться нашими бесплатными услугами переводчиков. Чтобы воспользоваться услугами переводчика, позвоните нам по телефону 1-800-457-4708. Вам окажет помощь сотрудник, который говорит по-русски. Данная услуга бесплатная.

Arabic:
إننا نقدم خدمات الترجمة الفورية المجانية للإجابة عن أي أسئلة تتعلق بالصحة أو جدول الأدوية لدينا. للحصول على مترجم فوري، ليس عليك سوى الإتصال بنا على 1-800-457-4708. سيقوم شخص ما يتحدث اللغة العربية بمساعدتك. هذه الخدمة مجانية.

Hindi: हमारे स्वास्थ्य या दवा की योजना के बारे में आपके किसी भी प्रश्न के जवाब देने के लिए हमारे पास मुफ्त दुभाषिया सेवाएँ उपलब्ध हैं. एक दुभाषिया प्राप्त करने के लिए, बस हमें 1-800-457-4708 पर फोन करें. कोई व्यक्ति जो हिन्दी बोलता है आपकी मदद कर सकता है. यह एक मुफ्त सेवा है.

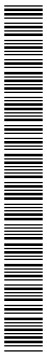
Italian: È disponibile un servizio di interpretariato gratuito per rispondere a eventuali domande sul nostro piano sanitario e farmaceutico. Per un interprete, contattare il numero 1-800-457-4708. Un nostro incaricato che parla Italianovi fornirà l'assistenza necessaria. È un servizio gratuito.

Portugués: Dispomos de serviços de interpretação gratuitos para responder a qualquer questão que tenha acerca do nosso plano de saúde ou de medicação. Para obter um intérprete, contacte-nos através do número 1-800-457-4708. Irá encontrar alguém que fale o idioma Português para o ajudar. Este serviço é gratuito.

French Creole: Nou genyen sèvis entèprèt gratis pou reponn tout kesyon ou ta genyen konsènan plan medikal oswa dwòg nou an. Pou jwenn yon entèprèt, jis rele nou nan 1-800-457-4708. Yon moun ki pale Kreyòl kapab ede w. Sa a se yon sèvis ki gratis.

Polish: Umożliwiamy bezpłatne skorzystanie z usług tłumacza ustnego, który pomoże w uzyskaniu odpowiedzi na temat planu zdrowotnego lub dawkowania leków. Aby skorzystać z pomocy tłumacza znającego język polski, należy zadzwonić pod numer 1-800-457-4708. Ta usługa jest bezpłatna.

Japanese:当社の健康 健康保険と薬品 処方薬プランに関するご質問にお答えするために、無料の通訳サービスがありますございます。通訳をご用命になるには、1-800-457-4708にお電話ください。日本語を話す人者が支援いたします。これは無料のサービスです。



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