2013

Summary of Benefits
Optional Supplemental Benefits
Extra Services and Programs

HumanaChoice®
H3619-001 (PPO)

Humana®

2013

Summary of Benefits

HumanaChoice®

H3619-001 (PPO)

Cincinnati/Dayton

Cincinnati and Dayton Areas

Humana®

Section I – Introduction to Summary of Benefits

Thank you for your interest in HumanaChoice H3619-001 (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 H3619-001 (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 H3619-001 (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 H3619-001 (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 H3619-001 (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 H3619-001 (PPO) Available?
The service area for this plan includes: Dearborn, Franklin, Ohio, Switzerland Counties, IN; Boone, Bracken, Campbell, Gallatin, Grant, Kenton, Mason, Pendleton Counties, KY; Adams, Brown, Butler, Champaign, Clark, Clermont, Clinton, Darke, Fayette, Greene, Hamilton, Highland, Miami, Montgomery, Pike, Preble, Ross, Shelby, Warren Counties, OH. You must live in one of these areas to join the plan.

Who Is Eligible To Join HumanaChoice H3619-001 (PPO)?
You can join HumanaChoice H3619-001 (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 are generally not eligible to enroll in HumanaChoice H3619-001 (PPO) unless they are members of our organization and have been since their dialysis began.

Can I Choose My Doctors?
HumanaChoice H3619-001 (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 **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.

Section I (continued)

Where Can I Get My Prescriptions If I Join This Plan?
HumanaChoice H3619-001 (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 H3619-001 (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.

Does My Plan Cover Medicare Part B Or Part D Drugs?
HumanaChoice H3619-001 (PPO) does cover both Medicare Part B prescription drugs and Medicare Part D prescription drugs.

What Is A Prescription Drug Formulary?
HumanaChoice H3619-001 (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/members/tools/prescription_tools/medicare_drug_list.asp.**

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

How Can I Get Extra Help With My Prescription Drug Plan Costs Or Get Extra Help With Other Medicare Costs?
You may be able to get extra help to pay for your prescription drug premiums and costs as well as get help with other Medicare costs. To see if you qualify for getting extra help, call:

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

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

As a member of HumanaChoice H3619-001 (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 H3619-001 (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 H3619-001 (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 H3619-001 (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 (Epoetin Alfa or Epogen®):** By injection if you have end-stage renal disease (permanent kidney failure requiring either dialysis or transplantation) and need this drug to treat anemia.
- **Hemophilia Clotting Factors:** Self-administered clotting factors if you have hemophilia.
- **Injectable Drugs:** Most injectable drugs administered incident to a physician's service.
- **Immunosuppressive Drugs:** Immunosuppressive drug therapy for transplant patients if the transplant 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 may use the web tools on www.medicare.gov and select "Health and Drug Plans" then "Compare Drug and Health Plans" to compare the plan ratings for Medicare plans in your area. You can also call us directly to obtain a copy of the plan ratings for this plan. Our customer service number is listed below.

Please call Humana Insurance Company for more information about HumanaChoice H3619-001 (PPO).

Visit us at **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. Eastern

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

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

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

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

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

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

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

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

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

For more information about Medicare, please call Medicare at 1-800-MEDICARE (1-800-633-4227).

TTY users should call 1-877-486-2048. You can call 24 hours a day, 7 days a week. Or, visit www.medicare.gov on the web. This document may be available in other formats such as Braille, large print or other alternate formats.

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

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

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

Section II – Summary of Benefits

IMPORTANT INFORMATION

BENEFIT	ORIGINAL MEDICARE	HumanaChoice H3619-001 (PPO)
① **Premium and Other Important Information**	• In 2012 the monthly Part B Premium was **$99.90** and may change for 2013 and the annual Part B deductible amount was **$140** and may change for 2013. • 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** • **$50** 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 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 www.medicare.gov/physician or www.medicare.gov/supplier. You can also call 1-800-MEDICARE, or ask your

(Important Information - Continued on next page)

Section II – Summary of Benefits

IMPORTANT INFORMATION

BENEFIT	ORIGINAL MEDICARE	HumanaChoice H3619-001 (PPO)
		physician, provider, or supplier if they accept assignment. **In-Network** • **$5,900** out-of-pocket limit for Medicare-covered services. **In and Out-of-Network** • **$1,000** annual deductible. Contact the plan for services that apply. • Any annual service category deductible may count towards the plan level deductible, if there is one. • **$10,000** 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 H3619-001 (PPO)
③ **Inpatient Hospital Care** (includes Substance Abuse and Rehabilitation Services)	• In 2012 the amounts for each benefit period were: – Days 1 - 60: **$1,156** deductible – Days 61 - 90: **$289** per day – Days 91 - 150: **$578** per lifetime reserve day • These amounts may change for 2013. • 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: **$250** copayment per day – Days 8 - 90: **$0** copayment per day • **$0** copayment for each additional 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 hospital stay. **See page 36 for additional information about Inpatient Hospital Care**
④ **Inpatient Mental Health Care**	• In 2012 the amounts for each benefit period were: – Days 1 - 60: **$1,156** deductible – Days 61 - 90: **$289** per day – Days 91 - 150: **$578** per lifetime reserve day • These amounts may change for 2013. • 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 - 5: **$250** copayment per day – Days 6 - 90: **$0** copayment per 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 hospital stay. **See page 36 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 H3619-001 (PPO)
(5) **Skilled Nursing Facility (SNF)** (in a Medicare-certified skilled nursing facility)	• In 2012 the amounts for each benefit period after at least a 3-day covered hospital stay were: – Days 1 - 20: **$0** per day – Days 21 - 100: **$144.50** per day • These amounts may change for 2013. • 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 - 7: **$0** copayment per day – Days 8 - 100: **$50** copayment per day **Out-of-Network** • **30%** of the cost for each SNF stay. **See page 36 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 Medicare-covered home health visits **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. Your plan will pay for a consultative visit before you select hospice.

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

OUTPATIENT CARE

BENEFIT	ORIGINAL MEDICARE	HumanaChoice H3619-001 (PPO)
⑧ **Doctor Office Visits**	• **20%** coinsurance	**In-Network** • **$15** copayment for each Medicare-covered primary care doctor visit. • **$45** copayment for each Medicare-covered specialist visit. **Out-of-Network** • **30%** of the cost for each Medicare-covered primary care doctor visit • **30%** of the cost 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) if you get it from a chiropractor or other qualified providers.	**General** • Authorization rules may apply. **In-Network** • **$15** 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) if you get it from a chiropractor. **Out-of-Network** • **30%** of the cost 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** • **$45** copayment for each Medicare-covered podiatry visit • Medicare-covered podiatry visits are for medically-necessary foot care. **Out-of-Network** • **30%** of the cost for Medicare-covered podiatry visits

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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 H3619-001 (PPO)
(11) **Outpatient Mental Health Care**	• **35%** 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** • **$40** copayment for each Medicare-covered individual therapy visit • **$40** copayment for each Medicare-covered group therapy visit • **$40** copayment for each Medicare-covered individual therapy visit with a psychiatrist • **$40** copayment for each Medicare-covered group therapy visit with a psychiatrist • **$40** copayment for Medicare-covered partial hospitalization program services **Out-of-Network** • **30%** of the cost for Medicare-covered Mental Health visits with a psychiatrist • **30%** of the cost 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** • **$50** copayment for Medicare-covered individual substance abuse outpatient treatment visits • **$50** 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 H3619-001 (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** • **$200** copayment for each Medicare-covered ambulatory surgical center visit • **$45** to **$250** copayment [or **20%** of the cost] for each Medicare-covered outpatient hospital facility visit **Out-of-Network** • **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** • **$200** copayment for Medicare-covered ambulance benefits. **Out-of-Network** • **$200** 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)

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 H3619-001 (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 • NOT covered outside the U.S. except under limited circumstances.	**General** • **$15** to **$45** copayment for Medicare-covered urgently-needed-care visits • **30%** of the cost for Medicare-covered urgently-needed-care visits **See page 37 for additional information about Urgently Needed Care**
(17) **Outpatient Rehabilitation Services** (Occupational Therapy, Physical Therapy, Speech and Language Therapy)	• **20%** coinsurance	**General** • Authorization rules may apply. **In-Network** • **$50** copayment for Medicare-covered Occupational Therapy visits • **$50** copayment for Medicare-covered Physical Therapy and/or Speech and Language Pathology visits **Out-of-Network** • **30%** of the cost for Medicare-covered Physical Therapy and/or Speech and Language Pathology visits • **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 H3619-001 (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** • **30%** of the cost for Medicare-covered durable medical equipment
(19) **Prosthetic Devices** (includes braces, artificial limbs and eyes, etc.)	• **20%** coinsurance	**General** • Authorization rules may apply. **In-Network** • **20%** of the cost for Medicare-covered prosthetic devices **Out-of-Network** • **30%** of the cost for Medicare-covered prosthetic devices.
(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 • **0%** of the cost for Medicare-covered Therapeutic shoes or inserts **Out-of-Network** • **30%** of the cost for Medicare-covered Diabetes self-management training • **30%** of the cost for Medicare-covered Diabetes monitoring supplies • **30%** of the cost for Medicare-covered Therapeutic shoes or inserts **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 H3619-001 (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 **$45** copayment for Medicare-covered lab services • **$0** to **$100** copayment for Medicare-covered diagnostic procedures and tests • **$15** to **$50** copayment for Medicare-covered X-rays • **$150** to **$175** copayment for Medicare-covered diagnostic radiology services (not including X-rays) • **$45** 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 **$15** to **$45** may apply **Out-of-Network** • **30%** of the cost for Medicare-covered therapeutic radiology services • **30%** of the cost for Medicare-covered outpatient X-rays • **30%** of the cost for Medicare-covered diagnostic radiology services • **30%** of the cost for Medicare-covered diagnostic procedures, tests, and 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 H3619-001 (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 • This applies to program services provided in a doctor's office. Specified cost sharing for program services provided by hospital outpatient departments.	**General** • Authorization rules may apply. **In-Network** • **$15** copayment for Medicare-covered Cardiac Rehabilitation Services • **$15** copayment for Medicare-covered Intensive Cardiac Rehabilitation Services • **$15** copayment for Medicare-covered Pulmonary Rehabilitation Services **Out-of-Network** • **30%** of the cost for Medicare-covered Cardiac Rehabilitation Services • **30%** of the cost for Medicare-covered Intensive Cardiac Rehabilitation Services • **30%** of the cost for Medicare-covered 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 H3619-001 (PPO)
(23) **Preventive Services, Wellness/Education and other Supplemental Benefit Programs**	• 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 counseling to help you manage your diabetes or kidney disease – Personalized Prevention Plan Services (Annual Wellness Visits)	**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 an annual physical exam • The plan covers the following supplemental education/wellness programs: – Health Education – Health Club Membership/Fitness Classes – Nursing Hotline **Out-of-Network** • **30%** of the cost for an annual physical exam • **50%** of the cost for supplemental education/wellness programs • **0%** to **30%** of the cost for Medicare-covered preventive services **See page 38 for additional information about Preventive Services, Wellness/Education, and other Supplemental Benefit Programs**

(Preventive Services - Continued on next page)

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 H3619-001 (PPO)
	– 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.	

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

OTHER SERVICES

BENEFIT	ORIGINAL MEDICARE	HumanaChoice H3619-001 (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** • **30%** of the cost 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**
(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/members/tools/prescription_tools/medicare_drug_list.asp** 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.

(Other Services - Continued on next page)

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

OTHER SERVICES

BENEFIT	ORIGINAL MEDICARE	HumanaChoice H3619-001 (PPO)
Outpatient Prescription Drugs (continued)		
		• The plan may require you to first try one drug to treat your condition before it will cover another drug for that condition. • Some drugs have quantity limits. • Your provider must get prior authorization from HumanaChoice H3619-001 (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. • 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 H3619-001 (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 **$2,970**: **Retail Pharmacy** • Tier 1: Preferred Generic – **$6** copayment for a one-month (30-day) supply of drugs in this tier – **$18** 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 – **$15** copayment for a one-month (30-day) supply of drugs in this tier

(Other Services - Continued on next page)

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

OTHER SERVICES

BENEFIT	ORIGINAL MEDICARE	HumanaChoice H3619-001 (PPO)
Outpatient Prescription Drugs (continued)		
		– **$45** 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 – **$45** copayment for a one-month (30-day) supply of drugs in this tier – **$135** 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 – **$95** copayment for a one-month (30-day) supply of drugs in this tier – **$285** 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** • Tier 1: Preferred Generic – **$6** copayment for a one-month (31-day) supply of drugs in this tier • Tier 2: Non-Preferred Generic – **$15** copayment for a one-month (31-day) supply of drugs in this tier • Tier 3: Preferred Brand – **$45** copayment for a one-month (31-day) supply of drugs in this tier • Tier 4: Non-Preferred Brand – **$95** 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 • Please note that brand drugs must be dispensed incrementally in long-term care facilities. Generic drugs may be dispensed incrementally. Contact your plan about

(Other Services - Continued on next page)

OTHER SERVICES

BENEFIT	ORIGINAL MEDICARE	HumanaChoice H3619-001 (PPO)
Outpatient Prescription Drugs (continued)		
		cost-sharing billing/collection when less than a one-month supply is dispensed. **Mail Order** • Tier 1: Preferred Generic – **$0** 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. – **$6** copayment for a one-month (30-day) supply of drugs in this tier from a non-preferred mail order pharmacy. – **$18** 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 – **$0** 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. – **$15** copayment for a one-month (30-day) supply of drugs in this tier from a non-preferred mail order pharmacy. – **$45** 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 – **$45** copayment for a one-month (30-day) supply of drugs in this tier from a preferred mail order pharmacy. – **$125** copayment for a three-month (90-day) supply of drugs in this tier from a preferred mail order pharmacy. – **$45** copayment for a one-month (30-day) supply of drugs in this tier from a non-preferred mail order pharmacy.

(Other Services - Continued on next page)

OTHER SERVICES

BENEFIT	ORIGINAL MEDICARE	HumanaChoice H3619-001 (PPO)
Outpatient Prescription Drugs (continued)		
		– **$135** 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 – **$95** copayment for a one-month (30-day) supply of drugs in this tier from a preferred mail order pharmacy. – **$275** copayment for a three-month (90-day) supply of drugs in this tier from a preferred mail order pharmacy. – **$95** copayment for a one-month (30-day) supply of drugs in this tier from a non-preferred mail order pharmacy. – **$285** 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 **$2,970,** 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 **79%** of the plan's costs for generic drugs until your yearly out-of-pocket drug costs reach **$4,750.** **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.

(Other Services - Continued on next page)

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

OTHER SERVICES

BENEFIT	ORIGINAL MEDICARE	HumanaChoice H3619-001 (PPO)
Outpatient Prescription Drugs (continued)		
		• The plan offers additional coverage in the gap for the following tiers. • You pay the following: **Retail Pharmacy** • Tier 1: Preferred Generic – **$6** copayment for a one-month (30-day) supply of select drugs covered in this tier – **$18** copayment for a three-month (90-day) supply of select drugs covered 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 – **$15** copayment for a one-month (30-day) supply of select drugs covered in this tier – **$45** copayment for a three-month (90-day) supply of select drugs covered 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 – **$45** copayment for a one-month (30-day) supply of select drugs covered in this tier – **$135** copayment for a three-month (90-day) supply of select drugs covered 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 – **$95** copayment for a one-month (30-day) supply of select drugs covered in this tier – **$285** copayment for a three-month (90-day) supply of select drugs covered 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

(Other Services - Continued on next page)

OTHER SERVICES

BENEFIT	ORIGINAL MEDICARE	HumanaChoice H3619-001 (PPO)
Outpatient Prescription Drugs (continued)		
		– **33%** coinsurance for a one-month (30-day) supply of select drugs covered in this tier **Long Term Care Pharmacy** • Tier 1: Preferred Generic – **$6** copayment for a one-month (31-day) supply of select drugs in this tier • Tier 2: Non-Preferred Generic – **$15** copayment for a one-month (31-day) supply of select drugs in this tier • Tier 3: Preferred Brand – **$45** copayment for a one-month (31-day) supply of select drugs in this tier • Tier 4: Non-Preferred Brand – **$95** copayment for a one-month (31-day) supply of select drugs in this tier • Tier 5: Specialty Tier – **33%** coinsurance for a one-month (31-day) supply of select drugs in this tier • Please note that brand drugs must be dispensed incrementally in long-term care facilities. Generic drugs may be dispensed incrementally. Contact your plan about cost-sharing billing/collection when less than a one-month supply is dispensed. **Mail Order** • Tier 1: Preferred Generic – **$0** copayment for a one-month (30-day) supply of select drugs covered in this tier from a preferred mail order pharmacy – **$0** copayment for a three-month (90-day) supply of select drugs covered in this tier from a preferred mail order pharmacy – **$6** copayment for a one-month (30-day) supply of select drugs covered in this tier from a non-preferred mail order pharmacy

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

OTHER SERVICES

BENEFIT	ORIGINAL MEDICARE	HumanaChoice H3619-001 (PPO)
Outpatient Prescription Drugs (continued)		
		– **$18** copayment for a three-month (90-day) supply of select drugs covered 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 – **$0** copayment for a one-month (30-day) supply of select drugs covered in this tier from a preferred mail order pharmacy – **$0** copayment for a three-month (90-day) supply of select drugs covered in this tier from a preferred mail order pharmacy – **$15** copayment for a one-month (30-day) supply of select drugs covered in this tier from a non-preferred mail order pharmacy – **$45** copayment for a three-month (90-day) supply of select drugs covered 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 – **$45** copayment for a one-month (30-day) supply of select drugs covered in this tier from a preferred mail order pharmacy – **$125** copayment for a three-month (90-day) supply of select drugs covered in this tier from a preferred mail order pharmacy – **$45** copayment for a one-month (30-day) supply of select drugs covered in this tier from a non-preferred mail order pharmacy – **$135** copayment for a three-month (90-day) supply of select drugs covered in this tier from a non-preferred mail order pharmacy

(Other Services - Continued on next page)

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

OTHER SERVICES

BENEFIT	ORIGINAL MEDICARE	HumanaChoice H3619-001 (PPO)
Outpatient Prescription Drugs (continued)		
		• 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 – **$95** copayment for a one-month (30-day) supply of select drugs covered in this tier from a preferred mail order pharmacy – **$275** copayment for a three-month (90-day) supply of select drugs covered in this tier from a preferred mail order pharmacy – **$95** copayment for a one-month (30-day) supply of select drugs covered in this tier from a non-preferred mail order pharmacy – **$285** copayment for a three-month (90-day) supply of select drugs covered 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 select drugs covered in this tier from a preferred mail order pharmacy – **33%** coinsurance for a one-month (30-day) supply of select drugs covered in 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 **$4,750,** you pay the greater of: – **5%** coinsurance, or – **$2.65** copayment for generic (including brand drugs treated as generic) and a **$6.60** 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

(Other Services - Continued on next page)

OTHER SERVICES

BENEFIT	ORIGINAL MEDICARE	HumanaChoice H3619-001 (PPO)
Outpatient Prescription Drugs (continued)		
		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 H3619-001 (PPO). **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 **$2,970**: • Tier 1: Preferred Generic – **$6** copayment for a one-month (30-day) supply of drugs in this tier • Tier 2: Non-Preferred Generic – **$15** copayment for a one-month (30-day) supply of drugs in this tier • Tier 3: Preferred Brand – **$45** copayment for a one-month (30-day) supply of drugs in this tier • Tier 4: Non-Preferred Brand – **$95** 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 **21%** of the plan allowable cost for generic drugs purchased out-of-network until total yearly out-of-pocket drug costs reach **$4,750.** 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

(Other Services - Continued on next page)

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

OTHER SERVICES

BENEFIT	ORIGINAL MEDICARE	HumanaChoice H3619-001 (PPO)
Outpatient Prescription Drugs (continued)		
		$4,750. 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** • 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. • 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 – **$6** copayment for a one-month (30-day) supply of select drugs covered in this tier • Tier 2: Non-Preferred Generic – **$15** copayment for a one-month (30-day) supply of select drugs covered in this tier • Tier 3: Preferred Brand – **$45** copayment for a one-month (30-day) supply of select drugs covered in this tier • Tier 4: Non-Preferred Brand – **$95** copayment for a one-month (30-day) supply of select drugs covered in this tier • Tier 5: Specialty Tier – **33%** coinsurance for a one-month (30-day) supply of select drugs covered 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 Catastrophic Coverage** • After your yearly out-of-pocket drug costs reach **$4,750,** 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

(Other Services - Continued on next page)

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

OTHER SERVICES

BENEFIT	ORIGINAL MEDICARE	HumanaChoice H3619-001 (PPO)
Outpatient Prescription Drugs (continued)		
		– **$2.65** copayment for generic (including brand drugs treated as generic) and a **$6.60** 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**

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

ADDITIONAL SERVICES

BENEFIT	ORIGINAL MEDICARE	HumanaChoice H3619-001 (PPO)
(26) **Dental Services**	• Preventive dental services (such as cleaning) not covered.	**In-Network** • **$0** copayment for the following preventive dental benefits: – up to 1 oral exam(s) every year – up to 1 cleaning(s) every year – up to 1 dental x-ray(s) every year • **$45** copayment for Medicare-covered dental benefits **Out-of-Network** • **30%** of the cost 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 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. • **$45** copayment for Medicare-covered diagnostic hearing exams **Out-of-Network** • **30%** of the cost for Medicare-covered diagnostic hearing exams.
(28) **Vision Services**	• **20%** coinsurance for diagnosis and treatment of diseases and conditions of the eye. • Supplemental routine eye exams and glasses not covered. • Medicare pays for one pair of eyeglasses or contact lenses after cataract surgery. • Annual glaucoma screenings covered for people at risk.	**General** • Authorization rules may apply. **In-Network** • **$0** copayment for – one pair of Medicare-covered eyeglasses or contact lenses after cataract surgery – **$0** to **$45** copayment for Medicare-covered exams to diagnose and treat diseases and conditions of the eye. – **$0** copayment for up to 1 supplemental routine eye exam(s) every year

(Additional Services - Continued on next page)

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

ADDITIONAL SERVICES

BENEFIT	ORIGINAL MEDICARE	HumanaChoice H3619-001 (PPO)
		Out-of-Network • **30%** of the cost for Medicare-covered eye exams • **$0** copayment for supplemental eye exams • **$0** copayment for Medicare-covered eye wear **In and Out-of-Network** • **$40** plan coverage limit for supplemental routine 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**
Over-the-Counter Items	• Not covered.	**General** • The plan does not cover Over-the-Counter items.
Transportation (Routine)	• Not covered.	**In-Network** • This plan does not cover supplemental routine transportation.
Acupuncture	• Not covered.	**In-Network** • This plan does not cover Acupuncture.

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

OPTIONAL SUPPLEMENTAL BENEFITS

BENEFIT	ORIGINAL MEDICARE	HumanaChoice H3619-001 (PPO)
OPTIONAL SUPPLEMENTAL PACKAGE #1		
Premium and Other Important Information		**General** • Package: 1 - MyOption Vision: • **$10** monthly premium, in addition to your **$50** monthly plan premium and the monthly Medicare Part B premium, for the following optional benefits: – Eye Exams – Eye Wear **See page 39 for additional information about Optional Supplemental Benefits**
Vision Services		**In-Network** – **$0** copayment for up to 1 pair(s) of contacts every year – **$0** copayment for up to 1 pair(s) of glasses every year – **$0** copayment for up to 1 supplemental routine eye exam(s) every year
OPTIONAL SUPPLEMENTAL PACKAGE #2		
Premium and Other Important Information		**General** • Package: 2 - MyOption Enhanced Dental PPO: • **$20** monthly premium, in addition to your **$50** monthly plan premium and the monthly Medicare Part B premium, for the following optional benefits: – Preventive Dental – Comprehensive Dental • **$1,500** plan coverage limit every year for these benefits. **See page 39 for additional information about Optional Supplemental Benefits**

(Optional Supplemental Benefits - Continued on next page)

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

OPTIONAL SUPPLEMENTAL BENEFITS

BENEFIT	ORIGINAL MEDICARE	HumanaChoice H3619-001 (PPO)
Dental Services		**In-Network** – up to 2 oral exam(s) every year – up to 2 cleaning(s) every year – up to 1 dental x-ray(s) every year **Out-of-Network** • **50%** of the cost for preventive dental services • **50%** to **75%** of the cost for comprehensive dental services **In and Out-of-Network** • Contact the plan for availability of additional in-network and out-of-network comprehensive dental benefits. • **$1,500** plan coverage limit for dental benefits every year. This limit applies to both in-network and out-of-network benefits.

SECTION III – ABOUT YOUR PLAN

HumanaChoice H3619-001 (PPO)

This section further explains some of the benefits of your plan. To get a complete list of benefits, limitations, and exclusions, call HumanaChoice H3619-001 (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
- Your Optional Supplemental Benefit monthly premium(s) and services
- Outpatient Part D prescription drugs
- Routine vision services
- Routine dental services

Combined Deductible
All services received from in-network providers are excluded from the combined deductible.
The following services received from out-of-network providers are excluded from the combined deductible:
- Outpatient Part D prescription drugs
- Routine vision services
- Routine dental services
- Your Optional Supplemental Benefit monthly premium(s) and services

If you qualify for Medicaid coverage through your state, be sure to show your Medicaid ID card in addition to your HumanaChoice H3619-001 (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 H3619-001 (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; otherwise, **you may have to pay more** for their services. Any doctors who refuse to accept HumanaChoice H3619-001 (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 H3619-001 (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 H3619-001 (PPO) service areas and help you find an in-network provider.

Authorization Requirements
Your provider will need an authorization from HumanaChoice H3619-001 (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 H3619-001 (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	**$15** copayment	**30%** of the cost
Specialist's office	**$45** copayment	**30%** of the cost

(11) Outpatient Mental Health Care

(12) Outpatient Substance Abuse Care

	In-Network	**Out-of-Network**
Specialist's office	**$40** copayment	**30%** of the cost
Hospital facility as an outpatient	**$50** copayment	**30%** of the cost
Partial hospitalization at a hospital facility	**$40** copayment	**30%** of the cost

(13) Outpatient Services

Outpatient services included in this category are lab services, radiation therapy, chemotherapy drugs, occupational therapy, physical therapy, speech therapy, advanced imaging services (MRI, MRA, PET, CT Scan), nuclear medicine, basic radiology, diagnostic mammography, surgery services, and renal dialysis 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	**$175** copayment	**30%** of the cost
Chemotherapy drugs	**20%** of the cost	**30%** of the cost
Lab services	**$45** copayment	**30%** of the cost
Nuclear medicine	**$175** copayment	**30%** of the cost
Surgical services	**$250** copayment	**30%** of the cost
Renal dialysis services	**20%** of the cost	**20%** of the cost

All other services for this benefit category received at a hospital facility as an outpatient	**$50** 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	**$15** copayment	**30%** of the cost
Specialist's office	**$45** copayment	**30%** of the cost
Concentra immediate care facility	**$35** copayment	Not available
Any other immediate care facility	**$45** 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	**$15** copayment	**30%** of the cost
Comprehensive outpatient rehabilitation facility for occupational, physical and speech therapy services	**$15** copayment	**30%** of the cost
Hospital facility as an outpatient for occupational, physical and speech therapy services	**$50** 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	**30%** of the cost
Durable medical equipment provider	**20%** of the cost	**30%** 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	**30%** of the cost
Durable medical equipment provider	**20%** of the cost	**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	**$15** copayment	**30%** of the cost
Specialist's office	**$45** copayment	**30%** of the cost
Concentra immediate care facility	**$35** copayment	Not available
Any other immediate care facility	**$45** copayment	**30%** of the cost
Freestanding lab	**$0** copayment	**30%** of the cost
Hospital facility as an outpatient	**$45** copayment	**30%** of the cost

Diagnostic procedures and tests	**In-Network**	**Out-of-Network**
Primary care doctor's office	**$15** copayment	**30%** of the cost
Specialist's office	**$45** copayment	**30%** of the cost
Concentra immediate care facility	**$35** copayment	Not available
Any other immediate care facility	**$45** copayment	**30%** of the cost
Hospital facility as an outpatient	**$100** copayment	**30%** of the cost

X-rays and diagnostic radiology services	**In-Network**	**Out-of-Network**
Primary care doctor's office	**$15** copayment	**30%** of the cost
Specialist's office	**$45** copayment	**30%** of the cost

Freestanding radiological facility	**$45** copayment	**30%** of the cost
Hospital facility as an outpatient	**$50** copayment	**30%** of the cost
Concentra immediate care facility	**$35** copayment	Not available
Any other immediate care facility	**$45** 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	**30%** of the cost
Specialist's office		
- in addition to office visit copayment	**$150** copayment	**30%** of the cost
Freestanding radiological facility	**$150** copayment	**30%** of the cost
Hospital facility as an outpatient	**$175** 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	**$175** copayment	**30%** of the cost

Therapeutic radiology services (Radiation Therapy)	**In-Network**	**Out-of-Network**
Specialist's office	**$45** copayment	**30%** of the cost
Freestanding radiological facility	**20%** of the cost	**30%** of the cost
Hospital facility as an outpatient	**20%** of the cost	**30%** of the cost

You pay:	**In-Network**	**Out-of-Network**
EKG screening at all places of treatment.	**$0** copayment	**30%** of the cost

PREVENTIVE SERVICES

(23) Preventive Services, Wellness/Education, and other Supplemental Benefit Programs

Routine immunizations are **$0** copayment out-of-network and all other preventive services are **30%** of the cost out-of-network.

Humana Active Outlook®

Humana Active Outlook is a lifestyle enrichment program with great features like HAO Magazine, HAO Digest, HAO Website, Individual Health Coaching, and other health and wellness education 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.

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.

OTHER SERVICES

(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	**30%** of the cost
Specialist's office	**$0** copayment	**30%** of the cost

(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 H3619-001 (PPO) to see if a certain drug is covered or visit **Humana-Medicare.com**.

ADDITIONAL SERVICES

(26) Dental Services

You pay:	**In-Network**	**Out-of-Network**
Specialist's office - Medicare-covered benefits only	**$45** copayment	**30%** of the cost
Amalgam filling, bitewing X-rays, oral evaluation, prophylaxis (cleaning), up to one per year	**$0** copayment	**50%** coinsurance

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

(28) Vision Services

Medicare-covered vision services include:

	In-Network	**Out-of-Network**
Medicare-covered vision services	**$45** copayment	**30%** of the cost
Glaucoma screening, one per year	**$0** copayment	**30%** of the cost

Mandatory Supplemental Benefit includes:

- **$40** 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 **$40** maximum coverage amount. If you choose to use an out-of-network provider, you will be responsible for costs above the plan-approved amount.

OPTIONAL SUPPLEMENTAL BENEFITS

For more information on customizing your Humana Medicare Advantage coverage, for an additional monthly premium, please see the 2013 Optional Supplemental Benefits book. Ask your agent or call us if you need help finding this information.

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

Humana®

2013

Optional Supplemental Benefits

HumanaChoice®

H3619-001 (PPO)

Cincinnati/Dayton

Cincinnati and Dayton Areas

Humana®

My Options, My Choice

Adding Benefits to Your Plan

You're unique and have unique needs for staying healthy. That's why Humana offers optional supplemental benefits. For an extra premium, each of these extra benefit choices lets you customize your Humana Medicare Advantage plan.

These benefits make it easier for you to get more coverage when you need it. They can also help you control your costs.

You can add these extra benefits when you sign up for your Medicare Advantage plan or any time during the year.

You have many choices. The information in this booklet will tell you about the benefits you can add to your plan. If you have questions, you can call **1-888-866-3154** (TTY: **711**), seven days a week, 8 a.m. to 8 p.m.

MyOption Enhanced Dental PPO

The MyOption Enhanced Dental PPO benefit makes it easy for you to plan for your dental care. This benefit has no deductible and **100 percent** coverage for two routine exams every year with an in-network provider. That's on top of the dental benefits included in your Medicare Advantage plan.

The benefit also provides full coverage for basic procedures like fillings and routine cleanings. The benefit covers some of the cost for major services like crowns and dentures. There's a maximum annual benefit of **$1,500**, and there's no waiting period before your coverage begins. The premium for this OSB is **$20.00**. Here's how the benefit works:

COVERED DENTAL SERVICES	You Pay	You Pay	Total Annual Benefit (Medicare Advantage Plan plus OSB)
Preventative and Diagnostic Dental Services	**In Network***	**Out of Network****	**All benefit limitations run on a calendar year**
Oral Examinations	**0%**	**50%**	Three per year
Dental Prophylaxis (Cleanings)	**0%**	**50%**	Three per year
Bitewing X-ray	**0%**	**50%**	Two per year
Basic Dental Services (Minor Restorative)			
Amalgam Restorations (Fillings) and Composite Resin Restorations (Fillings)	**0%**	**50%**	Three per year
Extractions, nonsurgical	**50%**	**55%**	Two per year
Crown or Bridge Re-cement	**50%**	**55%**	One per year
Emergency Treatment for Pain	**50%**	**55%**	Two per year

OPTIONAL SUPPLEMENTAL BENEFITS (continued)

COVERED DENTAL SERVICES	You Pay	You Pay	Total Annual Benefit (Medicare Advantage Plan plus OSB)
Major Dental Services (Endodontics, Periodontics, and Oral Surgery)			
Root Canal Treatment	**70%**	**75%**	One per year
Crowns	**70%**	**75%**	One per year
Periodontal Scaling and Root Planing (Deep Cleaning)	**70%**	**75%**	One procedure per quadrant every three years
Denture Adjustments (not covered within 6 months of initial placement)	**70%**	**75%**	One per year
Denture Reline (not allowed on spare dentures)	**70%**	**75%**	One per year

Covered dental services are subject to conditions, limitations, exclusions, and maximums. Please see your Evidence of Coverage for details.

*Network dentists have agreed to provide services at an in-network rate. If you see a network dentist, you can't be billed more than the in-network rate.

**Non-network dentists haven't agreed to provide services at an in-network rate. Humana negotiates rates for dental services. When you see a non-network dentist, you'll pay your part of the negotiated rate (your coinsurance). If your dentist charges more than that rate, you may have to pay more.

MyOption Vision

The MyOption Vision benefit makes it easy to plan for your vision care. There's no deductible. You also get **$290** each year to use for either:

- One set of frames and one pair of lenses
- **Or** contact lenses (includes conventional or disposable)

There's no waiting period before your coverage begins. The premium for this OSB is **$10.00**. Here's how the benefit works:

COVERED VISION BENEFITS	EyeMed Network Vision Provider*	Non-EyeMed Network Vision Provider**
Routine exam with refraction/dilation as necessary	**$40 allowance*** **	**$40 allowance**
One set of frames and one pair of lenses	**$290** benefit (combined in and out of network)	**$290** reimbursement (combined in and out of network)

OPTIONAL SUPPLEMENTAL BENEFITS (continued)

COVERED VISION BENEFITS	EyeMed Network Vision Provider*	Non-EyeMed Network Vision Provider**
Contact lenses (in lieu of frames; includes conventional or disposable)	**$290** benefit (combined in and out of network)	**$290** reimbursement (combined in and out of network)
Frequency:		
Examination	Once every 12 months	
Either: • One set of frames and one pair of lenses • **Or** contact lenses	Once every 12 months	

Covered vision services are subject to conditions, limitations, exclusions, and maximums. Please see your Evidence of Coverage for details.

*Network providers have agreed to provide services at an in-network rate. If you see a network provider, you can't be billed more than the in-network rate.

**Non-network providers haven't agreed to provide services at an in-network rate. Humana negotiates rates for vision services. When you see a non-network provider, you'll pay your part of the negotiated rate (your coinsurance). If your provider charges more than that rate, you may have to pay more.

***Visit any in-network EyeMed Select vision provider, and your routine exam charge will not exceed the $40 allowance.

Humana MyOption Optional Supplemental Benefits (OSB) are only available to members of certain Humana Medicare Advantage (MA) plans, health plans with a Medicare contract. Members of Humana plans that offer OSBs may enroll in OSBs throughout the year. Not all OSBs are available with all plans. Benefits may change on January 1, 2013. This information is available for free in other languages. For more information, please call Humana customer service at 1-888-866-3154; TTY, call 711. Our hours are 8 a.m. to 8 p.m., seven days a week.

Este documento está disponible en otros formatos o idiomas. Llame al Servicio al Cliente al 1-888-866-3154, TTY, llame al 711. Nuestro horario es de 8 a.m. a 8 p.m. los siete dias de la semana.

Humana®

Humana.com

2013

Value-Added Services

HumanaChoice®

H3619-001 (PPO)

Cincinnati/Dayton

Cincinnati and Dayton Areas

Humana®

H3619001VAS13 0910

Value Added Services for Humana

Humana has 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 ID card or the discount card from this booklet.

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

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

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

Health and Wellness Products

Members of some Humana plans may be able to get discounts on over-the-counter (OTC) health and wellness products from RightSourceRx.

The discounts are for a wide range of non-prescription products like:

- Vitamins and minerals
- Pain relievers
- Cold and allergy medicines
- Antacids
- Laxatives and anti-diarrhea products
- First-aid and medical supplies
- Women's health products
- And many more OTC health and wellness products

How the discount works
Simply call our Customer Care team at **1-855-211-8370**. Ask for an OTC health and wellness order form. Then fill it out and mail it to:

RightSourceRx
P.O. Box 1197
Cincinnati, OH 45201-1197

Contact information
To find out if you can get the discounts or to ask for an order form, call our Customer Care team at **1-855-211-8370**. If you use a TTY, call **711**, seven days a week, 8 a.m. to 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 are calling. We'll call back by the end of the next business day. Please have your Humana ID card with you when you call.

HumanaDental Discount

You can save on dental care with HumanaDental. Just see a HumanaDental dentist or specialist. The discount will be taken off your bill.

How it works
Simply choose a HumanaDental dentist. Call to make an appointment. Cut out the HumanaDental discount card on the last page of this booklet. Show the dentist your Humana ID card and the dental discount card when you go in. The dentist will give you the discount. He or she will tell you if you pay then or should wait for a bill. You don't need to send a claim form to HumanaDental.

Contact information
To find a dentist or specialist near you, visit **HumanaDental.com** . Call HumanaDental at **1-800-898-0371** , Monday through Friday, 8 a.m. to 6 p.m. Eastern time. If you use a TTY, call **1-800-325-2025** , Monday through Friday, 8 a.m. to 6 p.m. Eastern time.

- The HumanaDental program does not take the place of any other dental coverage.
- If your dentist leaves the network, you'll need to find another dentist in the HumanaDental network. Not all types of dentists may be in your area.
- If you have questions or concerns about the care you got from a Humana dentist, call Customer Care at the number on your Humana ID card.
- If you already started dental work before joining Humana, you can't get the discount.
- Procedures not contracted with the dentist or contracted at the dentist's normal fee are not subject to a discount.

TruHearing's Discount Hearing Program

As a Humana member, you can get discounts and services from TruHearing, a national hearing aid provider. You can use the discounts and services when you buy your hearing aid. You must call TruHearing and make an appointment to get the discount. Please check with TruHearing for locations and available discounts in your area.

How the discount works
Save hundreds to thousands of dollars on hearing aids with TruHearing MemberPlus compared to national average retail. When you combine TruHearing MemberPlus with Humana hearing benefits, you save even more! Get the best savings – and find the lowest prices – on hearing aids through TruHearing MemberPlus.

TruHearing's members usually pay $108 for these discounts. All Humana members pay nothing extra for these discounts.

Examples of savings per hearing aid (visit www.TruHearingMemberPlus.com/products for a full listing):

	National Avg. Retail	TruHearing MemberPlus	YOU SAVE:
ReSound Live 9 Wireless	$2,800	$1,395	$1,405
Unitron Quantum Pro	$3,500	$2,195	$1,305
Medallion Bridge 12+	$1,999	$995	$1,004

Similar savings on more than 90 models in more than 420 styles.

TruHearing MemberPlus discount program features include:
- No enrollment fee for Humana members
- Save between $600 to $1,400 per hearing aid compared to national retail average
- Choose from five leading manufacturers; over 90 models and over 420 styles
- Access to more than 2,200 hearing providers nationwide, financing available OAC
- Only $75 each year for a comprehensive hearing exam

Purchases through TruHearing MemberPlus include:
- Forty-five-day money back guarantee and supply of 48 batteries per aid
- Three visits to a hearing professional for fitting and adjustments
- Three-year manufacturers repair warranty
- Three-year manufacturers coverage for one-time loss and damage (replacement fee paid to the manufacturer)

Signing up for TruHearing MemberPlus is simple:
1. Visit www.TruHearingMemberPlus.com/enroll.
2. Enter group number MPHU-MANA to get your free membership.
3. Enter your information.
4. Call **1-877-379-4530** (TTY: **1-800-975-2674**) to make your appointment. All appointments must be made through TruHearing.

THIS IS NOT INSURANCE

TruHearing provides discounts through contracted health plans and enrolled employer groups for hearing aid sales and professional services at selected hearing care providers. Professional services for fitting, programming, and three adjustment visits are included in the price of the aids. The customer is obligated to pay for testing, and all other post-fitting hearing care services, but will receive a discount from those health care providers who have contracted with TruHearing. For Florida and Oklahoma residents: The Member may cancel membership within 30 days, and receive a full refund of fees. The Member must return hearing aids within 30 days of purchase to receive a full refund of the purchase price. In Florida, the DMPO does not make payments directly to providers. As with all Members nationwide, fitting fees, programming fees and first three adjustment visits are included in the price of the aids.

This discount cannot be used in addition to any Humana hearing benefit plan.

HearUSA's Discount Hearing Program

As a Humana member, you can get discounts and services from HearUSA, a national hearing aid provider. You can use the discounts and services when you buy your hearing aid. You must call HearUSA and make an appointment to get the discount. Please check with HearUSA for locations and available discounts in your area.

How the discount works
Call HearUSA toll-free at **1-800-442-8231** (TTY: **1-888-300-3277**), to make an appointment with the nearest provider. Your appointment must be made by HearUSA to make sure you get the discount.

- HearUSA has the only accredited hearing care network with more than 2,500 providers nationwide.
- Humana members get these benefits:
  - All-digital hearing aids from several manufacturers
  - Prices range from $995 – $2,500 per hearing aid (up to a **40 percent** savings)
  - Free two-year supply of batteries (up to 96 cells)
  - Comprehensive three-year warranty, including loss and damage*
  - In-office service at no charge for the life of the hearing aids
  - 60-day money-back guarantee
  - No interest financing may be available
- A **20 percent** discount on accessories and assisted listening devices is also available. Just call **1-800-432-7872** or visit www.hearingshop.com. Please be sure to use checkout code "EARHUMANA."

Contact information
To find out more about HearUSA, America's Most Trusted Name in Hearing Care, call HearUSA toll-free at **1-800-442-8231** (TTY: **1-888-300-3277**) Monday through Friday, 8:30 a.m. to 8:30 p.m. Eastern time.

*Loss and damage claims limited to one per hearing aid and a deductible applies.

This discount cannot be used in addition to any Humana hearing benefit plan.

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 Networks** (HWHN) of 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 that they be added to the network.

To get your discount, simply show the provider the discount card, which can be printed from **Humana.com**, or show your Humana ID card.

Contact information
For details about the program, access the CAM website from **Humana.com**. Once you log in to MyHumana, go to:
- Health & Wellness
- Savings Center, then select "Alternative Medicine"
- Scroll down to the middle part of the screen and there is a link - select "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 through Friday, 8:30 a.m. to 8 p.m. Eastern time. If you use a TTY, call **1-877-440-5580,** Monday through Friday, 8:30 a.m. to 8 p.m. Eastern time.

Prescription Medicine Discount

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

How the discount works
Show your Humana ID card at a participating pharmacy when you buy non-covered medicines. Dependent upon the medicine purchased, quantity limits may apply.

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

Vision Discount Program

You can get this program through EyeMed Vision Care. Vision wellness is important to your overall health and well-being. With the vision discount program, it's easy to care for your eyes. You can also save on your eyewear needs. You have access to the extensive EyeMed network of 40,000 providers across the country. They are at about 20,000 locations. Some of them are companies that you know and trust. These include LensCrafters®, Pearle Vision®, Sears Optical, Target Optical, and JCPenney™ Optical. The program includes the following services:

- Exam with dilation (if necessary) – **$5 off** routine exam; **$10 off** contact lens exam.
- Frames – **40 percent off** retail price on most frames.
- Lenses – fixed prices for lenses and lens options.
- Contact Lens – **15 percent off** retail price for non-disposable contact lenses.
- Laser Vision Correction (Lasik or PRK)* – **15 percent off** retail price or **5 percent off** promotional price.

How the discount works

You can get a discount on services you get from providers in the EyeMed Select network. Find an EyeMed provider by visiting **Humana.com** > Find a doctor > on the right side under Provider Search click onto EyeMed Vision Care. You can also call EyeMed at **1-866-392-6056** . Once you choose a provider, call and set up your appointment. Make sure to tell them you have the EyeMed discount through Humana.

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

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

Contact information
To choose a participating EyeMed Select provider, visit **Humana.com** . You can also call EyeMed's provider locator service at **1-866-392-6056** , Monday through Saturday, 7:30 a.m. to 11 p.m., and Sunday, 11 a.m. to 8 p.m. Eastern time. If you use a TTY, call **1-866-308-5375** , Monday through Friday, 8 a.m. to 5 p.m. Eastern time.

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

Nutrisystem® Discount

For over 40 years, Nutrisystem has been helping people lose weight in order to live healthier, happier lives. Featuring low calorie, low sodium foods that are high in fiber and protein to help keep you feeling full, Nutrisystem programs are the perfect choice for safe and effective weight loss.

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 130 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. And with no center visits or embarrassing weigh-ins, you'll have access to everything you need, including Nutrisystem phone counseling, right from the privacy of your own home.

How the discount works
As a Humana member, you also get a **12 percent** discount on all 28-day programs. This could mean up to $45 off on the most expensive Nutrisystem program, plus other offers on the website – and on top of that, you'll also get free support from the online Nutrisystem community.

Contact information
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** for all Florida plan members. Hours are Monday through Friday, 8 a.m. to midnight., and Saturday and Sunday, 8:30 a.m. to 5 p.m. Eastern time. All other Humana plan members, please visit www.nutrisystem.com/humana or call **1-866-942-6874** to order. If you use a TTY, call **711**, seven days a week, 8 a.m. to 8 p.m. Eastern time. Our 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 ID card handy when you call.

Lifeline® Medical Alert Systems

Every day, Lifeline® helps thousands of people live more independent, active lives at home. Lifeline offers a monthly rate of **$35** for its standard medical alert service to all Humana members. You can also get **free** activation – a $90.00 value.

How the discount works
Standard Lifeline Service
Set up fee

- Regular rate for set up: $90
- Humana members' set up: **Free**

Monthly fee

- Regular rate: $42.00
- Humana members: **$35**

How this service works
The standard service includes the new Lifeline CarePartners Home Communicator model and Lifeline monitoring services by a trained, dedicated professional staff 24 hours a day, every day of the year.

If you need medical help, a push of a button signals the Lifeline monitoring center. One of our professionals will speak to you over our Home Communicator phone. They will send any help that may be needed, including family members, friends, neighbors, or emergency service providers who can quickly get to your home.

The standard service includes your choice of a necklace-style Slimline or Classic transmitter or a wristwatch-style Slimline.

Contact information
For details about the program, visit the Lifeline website at www.lifelinesys.com or call **1-800-594-8192**, Monday through Friday, 7:30 a.m. to 10 p.m., and Saturday, 8 a.m. to 7 p.m. Eastern time. If you use a TTY, call **1-800-855-2881**. If you live in Massachusetts and use a TTY, call **1-800-439-0183**, Monday through Friday, 7:30 a.m. to 10 p.m., and Saturday, 8 a.m. to 7 p.m. Eastern time.

Vitality HealthyFood™

What is Vitality HealthyFood?
Vitality HealthyFood is a healthy food discount program brought to you by HumanaVitality®, that comes with some Humana Medicare plans. Humana is offering members a **5 percent** future discount on Great For You™ healthy food items only available at Walmart®. You'll get a discount on Great For You foods that are listed as healthy by the U.S. Food and Drug Administration (FDA), U.S. Department of Agriculture (USDA), Institute of Medicine (IOM) and Walmart. The Great For You logo on packages and in-store signs shows groceries that are eligible for the discount. The discount can be used on Great For You fruits, vegetables, lean meats, lean dairy, and oils.

How does it work?
Vitality HealthyFood gives you a discount card that works like a Walmart gift card. To ask for your card, call the Customer Care number on the back of your Humana ID card. You should get your rewards card in the mail within 10 business days.

After you get your Vitality HealthyFood card, go to your local Walmart and buy your groceries as usual. The first time you use your card, have the cashier scan it at checkout. Your future **5 percent** savings on Great For You items will be added to your card in about three business days.

The next time you go to Walmart, you can use your savings. Every time you shop, scan your Vitality HealthyFood card to use the savings that have been added to your card. Each time you buy Great For You healthy food items, more savings will be added to your card for you to use the next time you shop at Walmart. You can only earn the **5 percent** discount at Walmart locations, but you can use the savings on your card anywhere Walmart gift cards are accepted.

For more information, call the number on the back of your Humana ID card or visit **Humana.com**.

Cut out this card and keep it in your wallet for handy reference.

HumanaVision
Medicare Discount Card

Member Name: _____

Plan ID: 9243247

Humana.

Fold

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

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

EyeMed
VISION CARE

Cut out this card and keep it in your wallet for handy reference.

HumanaDental
Access Discount Card

Member Name: _____

Member ID: _____

Humana.

More information on other side of this card.

Fold

For more information, visit Humana-Medicare.com or call **1-800-898-0371.** This discount program is **not** part of your Medicare Advantage plan coverage. Discounts are only available at participating providers. In addition to the HumanaDental network, the following networks are available in the respective states: DenteMax in District of Columbia, Connecticut, Maryland, Michigan, Massachusetts, New Jersey, New York, Pennsylvania & Virginia, MN Premier in Minnesota, Diversified in Nevada, ADP in Wisconsin

Notes

Humana Insurance Company is a Medicare Advantage organization with a Medicare contract.

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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 notre 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 vụ thông dịch miễn phí để trả lời các câu hỏi về chương sức khỏe và chương trình thuốc men. Nếu quí vị cần thông dịch viên xin gọi 1-800-457-4708 sẽ 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 المترجم الفوري المجانية للإجابة عن أي أسئلة تتعلق بالصحة أو جدول الأدوية لدينا. للحصول على مترجم فوري، ليس عليك سوى الاتصال بنا على 1 800 457 4708 . سيقوم شخص ما يتحدث بمساعدتك. هذه خدمة مجانية العربية.

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.

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.

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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