HUMANA®

2012

Summary of Benefits

Optional Supplemental Benefits
Extra Services and Programs

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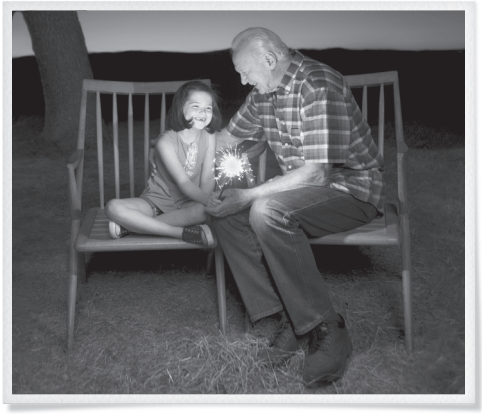

HumanaChoice℠

H4408-007 (PPO)

2012
Summary of Benefits

HumanaChoice℠
H4408-007 (PPO)

Knoxville
Knoxville Metro Area

HUMANA®

Section I - Introduction to Summary of Benefits

Thank you for your interest in HumanaChoice H4408-007 (PPO). Our plan is offered by HUMANA INSURANCE COMPANY, a Medicare Advantage Preferred Provider Organization (PPO). 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 H4408-007 (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 H4408-007 (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 H4408-007 (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 H4408-007 (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 H4408-007 (PPO) Available?

The service area for this plan includes: Anderson, Blount, Campbell, Cocke, Fentress, Hamblen, Jefferson, Knox, Loudon, Roane, Scott, Sevier, Union Counties, TN. You must live in one of these areas to join the plan.

Who Is Eligible To Join HumanaChoice H4408-007 (PPO)?

You can join HumanaChoice H4408-007 (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 H4408-007 (PPO) unless they are members of our organization and have been since their dialysis began.

Can I Choose My Doctors?

HumanaChoice H4408-007 (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 H4408-007 (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 H4408-007 (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 H4408-007 (PPO) does cover both Medicare Part B prescription drugs and Medicare Part D prescription drugs.

What Is A Prescription Drug Formulary?

HumanaChoice H4408-007 (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 enrollees before the change is made. We will send a formulary to you and you can see our complete formulary on our Web site at **http://www.humana.com/members/tools/prescription_tools/medicare_drug_list.asp.**

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

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

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

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

What Are My Protections In This Plan?

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

As a member of HumanaChoice H4408-007 (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 H4408-007 (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 H4408-007 (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 H4408-007 (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 drugs for osteoporosis for certain women with Medicare.
- **Erythropoietin (Epoetin Alfa or Epogen®):** By injection if you have end-stage renal disease (permanent kidney failure requiring either dialysis or transplantation) and need this drug to treat anemia.
- **Hemophilia Clotting Factors:** Self-administered clotting factors if you have hemophilia.
- **Injectable Drugs:** Most injectable drugs administered incident to a physician's service.
- **Immunosuppressive Drugs:** Immunosuppressive drug therapy for transplant patients if the transplant was paid for by Medicare, or paid by a private insurance that paid as a primary payer to your Medicare Part A coverage, in a Medicare-certified facility.
- **Some Oral Cancer Drugs:** If the same drug is available in injectable form.
- **Oral Anti-Nausea Drugs:** If you are part of an anti-cancer chemotherapeutic regimen.
- **Inhalation and Infusion Drugs administered through DME.**

Where Can I Find Information On Plan Ratings?

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

Please call Humana Insurance Company for more information about HumanaChoice H4408-007 (PPO).

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

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

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

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

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

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

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

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

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

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

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

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

Section II - Summary of Benefits

IMPORTANT INFORMATION

BENEFIT	ORIGINAL MEDICARE	HumanaChoice H4408-007 (PPO)
① **Premium and Other Important Information**	• In 2012 the monthly Part B Standard Premium is **$99.90** and the annual Part B deductible amount is **$140.** • 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** • **$47** 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 physician, provider, or supplier if they accept assignment. **In-Network**

(Important Information - Continued on next page)

Section II - Summary of Benefits

IMPORTANT INFORMATION

BENEFIT	ORIGINAL MEDICARE	HumanaChoice H4408-007 (PPO)
		• **$5,300** out-of-pocket limit for Medicare-covered services. **Out-of-Network** • **$500** annual deductible. Contact the plan for services that apply. **In and Out-of-Network** • **$7,300** out-of-pocket limit for Medicare-covered services. **See page 36 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. **See page 36 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 H4408-007 (PPO)
③ **Inpatient Hospital Care** (includes Substance Abuse and Rehabilitation Services)	• In 2012 the amounts for each benefit period are: – Days 1 - 60: **$1,156** deductible – Days 61 - 90: **$289** per day – Days 91 - 150: **$578** per lifetime reserve day • Call 1-800-MEDICARE (1-800-633-4227) for information about lifetime reserve days. • Lifetime reserve days can only be used once. • A "benefit period" starts the day you go into a hospital or skilled nursing facility. It ends when you go for 60 days in a row without hospital or skilled nursing care. If you go into the hospital after one benefit period has ended, a new benefit period begins. You must pay the inpatient hospital deductible for each benefit period. There is no limit to the number of benefit periods you can have.	**In-Network** • No limit to the number of days covered by the plan each hospital stay. • For Medicare-covered hospital stays: – Days 1 - 7: **$225** copayment per day – Days 8 - 90: **$0** copayment per day • **$0** copayment for each additional 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 37 for additional information about Inpatient Hospital Care**
④ **Inpatient Mental Health Care**	• In 2012 the amounts for each benefit period are: – Days 1 - 60: **$1,156** deductible – Days 61 - 90: **$289** per day – Days 91 - 150: **$578** per lifetime reserve day • 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: **$225** 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 37 for additional information about Inpatient Mental Health Care**

(Inpatient Care - Continued on next page)

INPATIENT CARE

BENEFIT	ORIGINAL MEDICARE	HumanaChoice H4408-007 (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 are: – Days 1 - 20: **$0** per day – Days 21 - 100: **$144.50** per day • 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 37 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 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 H4408-007 (PPO)
⑧ **Doctor Office Visits**	• **20%** coinsurance	**In-Network** • **$20** copayment for each primary care doctor visit for Medicare-covered benefits. • **$40** copayment for each in-area, network urgent care Medicare-covered visit • **$20** to **$40** copayment for each specialist visit for Medicare-covered benefits. **Out-of-Network** • **30%** of the cost for each primary care doctor visit • **30%** of the cost for each specialist visit **See page 37 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** • **$20** copayment for each Medicare-covered 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 or other qualified providers. **Out-of-Network** • **30%** of the cost for chiropractic benefits.
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** • **$40** copayment for each Medicare-covered visit • Medicare-covered podiatry benefits are for medically-necessary foot care. **Out-of-Network** • **30%** of the cost for podiatry benefits.

(Outpatient Care - Continued on next page)

OUTPATIENT CARE

BENEFIT	ORIGINAL MEDICARE	HumanaChoice H4408-007 (PPO)
(11) **Outpatient Mental Health Care**	• **40%** 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 Mental Health benefits with a psychiatrist • **30%** of the cost for Mental Health benefits • **30%** of the cost for partial hospitalization program services **See page 37 for additional information about Outpatient Mental Health Care**
(12) **Outpatient Substance Abuse Care**	• **20%** coinsurance	**General** • Authorization rules may apply. **In-Network** • **$75** copayment for Medicare-covered individual visits • **$75** copayment for Medicare-covered group visits **Out-of-Network** • **30%** of the cost for outpatient substance abuse benefits. **See page 37 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 H4408-007 (PPO)
(13) **Outpatient Services/Surgery**	• **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** • **$225** copayment for each Medicare-covered ambulatory surgical center visit • **$20** to **$225** copayment [or **20%** of the cost] for each Medicare-covered outpatient hospital facility visit **Out-of-Network** • **30%** of the cost for ambulatory surgical center benefits. • **20%** to **30%** of the cost for outpatient hospital facility benefits. **See page 37 for additional information about Outpatient Services/Surgery**
(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 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.
(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** • **30%** of the cost for Medicare-covered urgently-needed-care visits

(Outpatient Care - Continued on next page)

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

OUTPATIENT CARE

BENEFIT	ORIGINAL MEDICARE	HumanaChoice H4408-007 (PPO)
(17) **Outpatient Rehabilitation Services** (Occupational Therapy, Physical Therapy, Speech and Language Therapy)	• **20%** coinsurance	**General** • Authorization rules may apply. **In-Network** • **$20** copayment for Medicare-covered Occupational Therapy visits • **$20** copayment for Medicare-covered Physical and/or Speech and Language Therapy visits **Out-of-Network** • **30%** of the cost for Physical and/or Speech and Language Therapy visits • **30%** of the cost for Occupational Therapy benefits.

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 H4408-007 (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 items **Out-of-Network** • **30%** of the cost for 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 items **Out-of-Network** • **30%** of the cost for 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 Diabetes self-management training • **0%** to **20%** of the cost for Diabetes monitoring supplies • **$10** copayment for Therapeutic shoes or inserts **Out-of-Network** • **30%** of the cost for Diabetes self-management training • **30%** of the cost for Diabetes monitoring supplies • **30%** of the cost for Therapeutic shoes or inserts **See page 38 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 H4408-007 (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 **$75** copayment for Medicare-covered lab services • **$0** to **$75** copayment for Medicare-covered diagnostic procedures and tests • **$20** to **$75** copayment for Medicare-covered X-rays • **$20** to **$150** copayment for Medicare-covered diagnostic radiology services (not including X-rays) • **$40** to **$50** 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 **$20** to **$40** may apply **Out-of-Network** • **30%** of the cost for therapeutic radiology services • **30%** of the cost for outpatient X-rays • **30%** of the cost for diagnostic radiology services • **30%** of the cost for diagnostic procedures, tests, and lab services **See page 38 for additional information about Diagnostic Tests, X-rays, Lab Services and Radiology Services**

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

OUTPATIENT MEDICAL SERVICES AND SUPPLIES

BENEFIT	ORIGINAL MEDICARE	HumanaChoice H4408-007 (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** • **$20** copayment for Medicare-covered Cardiac Rehabilitation Services • **$20** copayment for Medicare-covered Intensive Cardiac Rehabilitation Services • **$20** copayment for Medicare-covered Pulmonary Rehabilitation Services **Out-of-Network** • **30%** of the cost for Cardiac Rehabilitation Services • **30%** of the cost for Intensive Cardiac Rehabilitation Services • **30%** of the cost for Pulmonary Rehabilitation Services

PREVENTIVE SERVICES

BENEFIT	ORIGINAL MEDICARE	HumanaChoice H4408-007 (PPO)
(23) **Preventive Services and Wellness/Education 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) – Pneumococcal Vaccine. You may only need the Pneumonia vaccine once in your	**General** • **$0** copayment for all preventive services covered under Original Medicare at zero cost sharing: – Abdominal Aortic Aneurysm screening – Bone Mass Measurement – Cardiovascular Screening – Cervical and Vaginal Cancer Screening (Pap Test and Pelvic Exam) – Colorectal Cancer Screening – Diabetes Screening – Influenza Vaccine – Hepatitis B Vaccine – HIV Screening – Breast Cancer Screening (Mammogram) – Medical Nutrition Therapy Services – Personalized Prevention Plan Services (Annual Wellness Visits) – Pneumococcal Vaccine – Prostate Cancer Screening (Prostate Specific Antigen (PSA) test only) – Smoking Cessation (Counseling to stop smoking) – Welcome to Medicare Physical Exam (Initial Preventive Physical Exam) • HIV screening is covered for people with Medicare who are pregnant and people at increased risk for the infection, including anyone who asks for the test. Medicare covers this test once every 12 months or up to three times during a pregnancy. Please contact plan for details. **In-Network** • The plan covers the following supplemental education/wellness programs: – Written health education materials, including Newsletters – Additional Smoking Cessation – Health Club Membership/Fitness Classes – Nursing Hotline **Out-of-Network** • **0%** to **30%** of the cost for Medicare-covered preventive services • **50%** of the cost for supplemental education/wellness programs

(Preventive Services - Continued on next page)

PREVENTIVE SERVICES

BENEFIT	ORIGINAL MEDICARE	HumanaChoice H4408-007 (PPO)
	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 Cessation (counseling to stop smoking). Covered if ordered by your doctor. Includes two counseling attempts within a 12-month period. Each counseling attempt includes up to four face-to-face visits. – Welcome to Medicare Physical Exam (initial preventive physical exam). When you join Medicare Part B, then you are eligible as follows. During the first 12 months of your new Part B coverage, you can get either a Welcome to Medicare Physical Exam or an Annual Wellness Visit. After your first 12 months, you can get one Annual Wellness Visit every 12 months.	**See page 39 for additional information about Preventive Services and Wellness/Education Programs**

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 H4408-007 (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** • **20%** of the cost for renal dialysis • **$0** copayment for kidney disease education services **Out-of-Network** • **30%** of the cost for kidney disease education services • **20%** of the cost for 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** • **0%** to **20%** of the cost for Part B-covered drugs (not including Part B-covered chemotherapy drugs). • **20%** of the cost for Part B-covered chemotherapy drugs. • **0%** to **30%** of the cost for 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)

OTHER SERVICES

BENEFIT	ORIGINAL MEDICARE	HumanaChoice H4408-007 (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 H4408-007 (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. • If you request a formulary exception for a drug and HumanaChoice H4408-007 (PPO) approves the exception, you will pay Tier 3: Non-Preferred Brand Drugs cost sharing for that drug. **In-Network** • **$0** deductible. **Initial Coverage** • You pay the following until total yearly drug costs reach **$2,930**: **Retail Pharmacy** • Tier 1: Preferred Generic Drugs – **$8** copayment for a one-month (30-day) supply of drugs in this tier – **$24** copayment for a three-month (90-day) supply of drugs in this tier • Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information. • Tier 2: Preferred Brand Drugs – **$42** copayment for a one-month (30-day) supply of drugs in this tier – **$126** copayment for a three-month (90-day) supply of drugs in this tier

(Other Services - Continued on next page)

OTHER SERVICES

BENEFIT	ORIGINAL MEDICARE	HumanaChoice H4408-007 (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 3: Non-Preferred Brand Drugs – **$80** copayment for a one-month (30-day) supply of drugs in this tier – **$240** 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: Specialty Tier Drugs – **33%** coinsurance for a one-month (30-day) supply of drugs in this tier **Long Term Care Pharmacy** • Tier 1: Preferred Generic Drugs – **$8** copayment for a one-month (34-day) supply of drugs in this tier • Tier 2: Preferred Brand Drugs – **$42** copayment for a one-month (34-day) supply of drugs in this tier • Tier 3: Non-Preferred Brand Drugs – **$80** copayment for a one-month (34-day) supply of drugs in this tier • Tier 4: Specialty Tier Drugs – **33%** coinsurance for a one-month (34-day) supply of drugs in this tier **Mail Order** • Tier 1: Preferred Generic Drugs – **$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. – **$8** 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 H4408-007 (PPO)
Outpatient Prescription Drugs (continued)		
		– **$24** copayment for a three-month (90-day) supply of drugs in this tier from a non-preferred mail order pharmacy. • Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information. • <u>Tier 2: Preferred Brand Drugs</u> – **$42** copayment for a one-month (30-day) supply of drugs in this tier from a preferred mail order pharmacy. – **$116** copayment for a three-month (90-day) supply of drugs in this tier from a preferred mail order pharmacy. – **$42** copayment for a one-month (30-day) supply of drugs in this tier from a non-preferred mail order pharmacy. – **$126** 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. • <u>Tier 3: Non-Preferred Brand Drugs</u> – **$80** copayment for a one-month (30-day) supply of drugs in this tier from a preferred mail order pharmacy. – **$230** copayment for a three-month (90-day) supply of drugs in this tier from a preferred mail order pharmacy. – **$80** copayment for a one-month (30-day) supply of drugs in this tier from a non-preferred mail order pharmacy. – **$240** 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. • <u>Tier 4: Specialty Tier Drugs</u>

(Other Services - Continued on next page)

OTHER SERVICES

BENEFIT	ORIGINAL MEDICARE	HumanaChoice H4408-007 (PPO)
Outpatient Prescription Drugs (continued)		
		– **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. **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. • You pay the following: **Retail Pharmacy** • Tier 1: Preferred Generic Drugs – **$8** copayment for a one-month (30-day) supply of select drugs covered in this tier – **$24** 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: Preferred Brand Drugs – **$42** copayment for a one-month (30-day) supply of select drugs covered in this tier – **$126** 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: Non-Preferred Brand Drugs – **$80** copayment for a one-month (30-day) supply of select drugs covered in this tier – **$240** 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: Specialty Tier Drugs

(Other Services - Continued on next page)

OTHER SERVICES

BENEFIT	ORIGINAL MEDICARE	HumanaChoice H4408-007 (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 Drugs – **$8** copayment for a one-month (34-day) supply of select drugs covered in this tier • Tier 2: Preferred Brand Drugs – **$42** copayment for a one-month (34-day) supply of select drugs covered in this tier • Tier 3: Non-Preferred Brand Drugs – **$80** copayment for a one-month (34-day) supply of select drugs covered in this tier • Tier 4: Specialty Tier Drugs – **33%** coinsurance for a one-month (34-day) supply of select drugs covered in this tier **Mail Order** • Tier 1: Preferred Generic Drugs – **$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 – **$8** copayment for a one-month (30-day) supply of select drugs covered in this tier from a non-preferred mail order pharmacy – **$24** 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: Preferred Brand Drugs – **$42** copayment for a one-month (30-day) supply of select drugs covered in this tier from a preferred mail order pharmacy – **$116** copayment for a three-month (90-day) supply of select drugs covered in this tier from a preferred mail order pharmacy

(Other Services - Continued on next page)

OTHER SERVICES

BENEFIT	ORIGINAL MEDICARE	HumanaChoice H4408-007 (PPO)
Outpatient Prescription Drugs (continued)		
		– **$42** copayment for a one-month (30-day) supply of select drugs covered in this tier from a non-preferred mail order pharmacy – **$126** 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: Non-Preferred Brand Drugs – **$80** copayment for a one-month (30-day) supply of select drugs covered in this tier from a preferred mail order pharmacy – **$230** copayment for a three-month (90-day) supply of select drugs covered in this tier from a preferred mail order pharmacy – **$80** copayment for a one-month (30-day) supply of select drugs covered in this tier from a non-preferred mail order pharmacy – **$240** 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 4: Specialty Tier Drugs – **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. • After your total yearly drug costs reach **$2,930,** 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 **86%** of the plan's costs for

(Other Services - Continued on next page)

OTHER SERVICES

BENEFIT	ORIGINAL MEDICARE	HumanaChoice H4408-007 (PPO)
Outpatient Prescription Drugs (continued)		
		generic drugs until your yearly out-of-pocket drug costs reach **$4,700.** **Catastrophic Coverage** • After your yearly out-of-pocket drug costs reach **$4,700,** you pay the greater of: – **5%** coinsurance, or – **$2.60** copayment for generic (including brand drugs treated as generic) and a **$6.50** copayment for all other drugs. **Out-of-Network** • Plan drugs may be covered in special circumstances, for instance, illness while traveling outside of the plan's service area where there is no network pharmacy. You may have to pay more than your normal cost-sharing amount if you get your drugs at an out-of-network pharmacy. In addition, you will likely have to pay the pharmacy's full charge for the drug and submit documentation to receive reimbursement from HumanaChoice H4408-007 (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 **$2,930**: • Tier 1: Preferred Generic Drugs – **$8** copayment for a one-month (30-day) supply of drugs in this tier • Tier 2: Preferred Brand Drugs – **$42** copayment for a one-month (30-day) supply of drugs in this tier • Tier 3: Non-Preferred Brand Drugs – **$80** copayment for a one-month (30-day) supply of drugs in this tier • Tier 4: Specialty Tier Drugs – **33%** coinsurance for a one-month (30-day) supply of drugs in this tier

(Other Services - Continued on next page)

OTHER SERVICES

BENEFIT	ORIGINAL MEDICARE	HumanaChoice H4408-007 (PPO)
Outpatient Prescription Drugs (continued)		
		• You will not be reimbursed for the difference between the Out-of-Network Pharmacy charge and the plan's In-Network allowable amount. **Additional Out-of-Network Coverage Gap** • You will be reimbursed for these drugs purchased out-of-network up to the plan's cost of the drug minus the following: • Tier 1: Preferred Generic Drugs – **$8** copayment for a one-month (30-day) supply of select drugs covered in this tier • Tier 2: Preferred Brand Drugs – **$42** copayment for a one-month (30-day) supply of select drugs covered in this tier • Tier 3: Non-Preferred Brand Drugs – **$80** copayment for a one-month (30-day) supply of select drugs covered in this tier • Tier 4: Specialty Tier Drugs – **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 **$4,700,** you will be reimbursed for drugs purchased out-of-network up to the plan's cost of the drug minus your cost share, which is the greater of: – **5%** coinsurance, or – **$2.60** copayment for generic (including brand drugs treated as generic) and a **$6.50** 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 40 for additional information about Outpatient Prescription Drugs**

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

ADDITIONAL BENEFITS

BENEFIT	ORIGINAL MEDICARE	HumanaChoice H4408-007 (PPO)
(26) **Dental Services**	• Preventive dental services (such as cleaning) not covered.	**General** • Authorization rules may apply. **In-Network** • In general, preventive dental benefits (such as cleaning) not covered. • However, this plan covers preventive dental benefits for an extra cost (see "Optional Benefits.") • **$40** copayment for Medicare-covered dental benefits **Out-of-Network** • **30%** of the cost for comprehensive dental benefits
(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. – **$40** copayment for Medicare-covered diagnostic hearing exams **Out-of-Network** • **30%** of the cost for 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 eyeglasses or contact lenses after cataract surgery – **$0** to **$40** copayment for exams to diagnose and treat diseases and conditions of the eye. – **$0** copayment for up to 1 supplemental routine eye exam(s) every year **Out-of-Network** • **30%** of the cost for eye exams. • **$0** copayment for eye exams. • **$0** copayment for eye wear. **See page 40 for additional information about Vision Services**

(Additional Benefits - Continued on next page)

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

ADDITIONAL BENEFITS

BENEFIT	ORIGINAL MEDICARE	HumanaChoice H4408-007 (PPO)
Over-the-Counter Items	• Not covered.	**General** • Please visit our plan website to see our list of covered Over-the-Counter items. • OTC items may be purchased only for the enrollee. • Please contact the plan for specific instructions for using this benefit. **See page 40 for additional information about Over-the-Counter items**
Transportation (Routine)	• Not covered.	**In-Network** • This plan does not cover supplemental routine transportation.
Acupuncture	• 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 H4408-007 (PPO)
OPTIONAL SUPPLEMENTAL PACKAGE #1		
Premium and Other Important Information		**General** • Package: 1 - MyOption Dental High PPO: • **$24** monthly premium, in addition to your **$47** 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 40 for additional information about Optional Supplemental Benefits**
Dental Services		**In-Network** • **$0** copayment for the following preventive dental benefits: – 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** • **30%** of the cost for preventive dental services • **55%** to **75%** of the cost for comprehensive dental services **In and Out-of-Network** • **$1,500** plan coverage limit for comprehensive dental benefits every year. This limit applies to both in-network and out-of-network benefits. • Contact the plan for availability of additional in-network and out-of-network comprehensive dental benefits. • **$1,500** plan coverage limit for preventive dental benefits every year. This limit applies to both in-network and out-of-network benefits.

(Optional Supplemental Benefits - Continued on next page)

OPTIONAL SUPPLEMENTAL BENEFITS

BENEFIT	ORIGINAL MEDICARE	HumanaChoice H4408-007 (PPO)
OPTIONAL SUPPLEMENTAL PACKAGE #2		
Premium and Other Important Information		**General** • Package: 2 - MyOption Dental Low PPO: • **$15** monthly premium, in addition to your **$47** monthly plan premium and the monthly Medicare Part B premium, for the following optional benefits: – Preventive Dental – Comprehensive Dental • **$1,000** plan coverage limit every year for these benefits. **See page 40 for additional information about Optional Supplemental Benefits**
Dental Services		**In-Network** • **$0** copayment for the following preventive dental benefits: – 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** • **30%** of the cost for preventive dental services • **55%** of the cost for comprehensive dental services **In and Out-of-Network** • **$1,000** plan coverage limit for comprehensive dental benefits every year. This limit applies to both in-network and out-of-network benefits. • Contact the plan for availability of additional in-network and out-of-network comprehensive dental benefits. • **$1,000** plan coverage limit for preventive dental benefits every year. This limit applies to both in-network and out-of-network benefits.
OPTIONAL SUPPLEMENTAL PACKAGE #3		
Premium and Other Important Information		**General** • Package: 3 - MyOption Vision: • **$15** monthly premium, in addition to your **$47** monthly plan premium and the monthly Medicare Part B premium, for the following optional benefits: – Eye Exams

(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 H4408-007 (PPO)
		– Eye Wear • **$290** plan coverage limit every year for these benefits. **See page 40 for additional information about Optional Supplemental Benefits**
Vision Services		**In-Network** • **$0** copayment for – up to 1 pair(s) of glasses every year – up to 1 pair(s) of contacts every year – up to 1 pair(s) of lenses every year – up to 1 frame(s) every year – **$0** copayment for up to 1 supplemental routine eye exam(s) every year
OPTIONAL SUPPLEMENTAL PACKAGE #4		
Premium and Other Important Information		**General** • Package: 4 - MyOption Plus: • **$26** monthly premium, in addition to your **$47** monthly plan premium and the monthly Medicare Part B premium, for the following optional benefits: – Preventive Dental – Comprehensive Dental – Eye Exams – Eye Wear **See page 40 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 H4408-007 (PPO)
Dental Services		**In-Network** • **$0** copayment for the following preventive dental benefits: – 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** • **30%** of the cost for preventive dental services • **55%** of the cost for comprehensive dental services **In and Out-of-Network** • **$1,000** plan coverage limit for comprehensive dental benefits every year. This limit applies to both in-network and out-of-network benefits. • Contact the plan for availability of additional in-network and out-of-network comprehensive dental benefits.
Vision Services		**In-Network** • **$0** copayment for – up to 1 pair(s) of glasses every year – up to 1 pair(s) of contacts every year – up to 1 pair(s) of lenses every year – up to 1 frame(s) every year – **$0** copayment for up to 1 supplemental routine eye exam(s) every year

SECTION III - ABOUT YOUR PLAN
HumanaChoice H4408-007 (PPO)

This section further explains some of the benefits of your plan. To get a complete list of benefits, limitations, and exclusions, call HumanaChoice H4408-007 (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
- Over-the-counter drugs and supplies

Deductible

While most covered out-of-network expenses apply toward your deductible, the following don't:

- Outpatient Part D prescription drugs
- Routine vision services
- Your Optional Supplemental Benefit monthly premium(s) and services
- Over-the-counter drugs and supplies

The following covered out-of-network expenses aren't subject to your out-of-network deductible: flu shots, pneumococcal vaccines, emergency room and ambulance services.

② Doctor and Hospital Choice

Choosing a doctor

As a HumanaChoice H4408-007 (PPO) member, it's a good idea to select a doctor to act as your primary care physician (PCP). Although you don't have to have a PCP, it's important to have someone focus on your total healthcare. A PCP can provide much of your care. He or she can help ensure you get preventive care, provide timely access to services and coordinate with other doctors if needed. This helps you improve and manage your health.

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 (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 (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 (PPO) service areas and help you find an in-network provider.

Authorization Requirements

Your provider will need an authorization from HumanaChoice H4408-007 (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 H4408-007 (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	**$20** copayment	**30%** of the cost
Specialist's office	**$40** copayment	**30%** of the cost
Immediate care facility	**$40** copayment	**30%** of the cost

For Coumadin services received at an in-network specialist's office, you pay: **$20** copayment and **30%** of the cost at an out-of-network specialist's office

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	**$75** copayment	**30%** of the cost
Partial hospitalization at a hospital facility	**$40** copayment	**30%** of the cost

⑬ Outpatient Services/Surgery

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

	In-Network	Out-of-Network
Radiation therapy	**20%** of the cost	**30%** of the cost
Advanced imaging	**$150** copayment	**30%** of the cost
Cardiac rehabilitation	**$20** copayment	**30%** of the cost
Pulmonary rehabilitation	**$20** copayment	**30%** of the cost
Chemotherapy	**20%** of the cost	**30%** of the cost
Coumadin services	**$20** copayment	**30%** of the cost

Nuclear medicine	**$150** copayment	**30%** of the cost
Physical, occupational, or speech-language therapy	**$20** copayment	**30%** of the cost
Surgical services	**$225** copayment	**30%** of the cost
Renal dialysis services	**20%** of the cost	**20%** of the cost
All other hospital facility services	**$75** 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	**$20** copayment	**30%** of the cost
Specialist's office	**$40** copayment	**30%** of the cost
Immediate care facility	**$40** copayment	**30%** of the cost
Freestanding lab	**$0** copayment	**30%** of the cost
Hospital facility as an outpatient	**$75** copayment	**30%** of the cost

Diagnostic procedures and tests	**In-Network**	**Out-of-Network**
Primary care doctor's office	**$20** copayment	**30%** of the cost
Specialist's office	**$40** copayment	**30%** of the cost
Immediate care facility	**$40** copayment	**30%** of the cost
Hospital facility as an outpatient	**$75** copayment	**30%** of the cost

X-rays and diagnostic radiology services	**In-Network**	**Out-of-Network**
Primary care doctor's office	**$20** copayment	**30%** of the cost
Specialist's office	**$40** copayment	**30%** of the cost
Freestanding radiological center	**$50** copayment	**30%** of the cost
Hospital facility as an outpatient	**$75** copayment	**30%** of the cost
Immediate care facility	**$40** 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 radiology center	**$150** copayment	**30%** of the cost
Hospital facility as an outpatient	**$150** copayment	**30%** of the cost

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

Therapeutic radiology services (Radiation Therapy)	**In-Network**	**Out-of-Network**
Specialist's office	**$40** copayment	**30%** of the cost
Freestanding radiology facility	**$50** copayment	**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 and Wellness/Education Programs

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

Stop-Smoking Program

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

Humana Active Outlook®

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

HumanaFirst® 24 Hour Nurse Advice Line

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

SilverSneakers® Fitness Program

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

Well Dine Inpatient Meal Program

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

OTHER SERVICES

(24) Kidney Disease and Conditions

You pay the following for kidney disease education services:

	In-Network	**Out-of-Network**
Primary care doctor's office	**$0** copayment	**30%** of the cost
Specialist's office	**$0** copayment	**30%** of the cost

(25) Outpatient Prescription Drugs

Drugs covered under Medicare Part B

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

If you use an out-of-network doctor, you pay **30%** of the cost.

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

Drugs covered under Medicare Part D

Drugs covered in the gap are limited to select home infusion drugs used as an alternative to inpatient treatment. Your cost for the medication is the same before and during the coverage gap. Contact HumanaChoice H4408-007 (PPO) to see if a certain drug is covered or visit **Humana-Medicare.com**.

ADDITIONAL BENEFITS

(28) Vision Services

Benefit includes :

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

	In-Network	Out-of-Network
Medicare-covered vision services	**$40** copayment	**30%** of the cost
Glaucoma screening, one per year	**$0** copayment	**30%** of the cost

Over-the-Counter Items

Health and Wellness Products

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

OPTIONAL SUPPLEMENTAL BENEFITS

For more information on customizing your Humana Medicare Advantage coverage, for an additional monthly premium, please see the 2012 Optional Supplemental Benefits book. Ask your agent or call us if you need help finding this information.

HUMANA.

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

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

Humana.com

2012
Optional Supplemental Benefits

HumanaChoice℠
H4408-007 (PPO)

Knoxville
Knoxville Metro Area

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 (OSB). For an additional premium, each of these extra benefit choices let 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 Dental – High PPO

The MyOption Dental – High PPO benefit makes it easy for you to plan for your dental care. The benefit has a **$50** deductible and **100 percent** coverage for two routine exams every year with an in-network provider.

The benefit covers some of the cost for basic procedures, like fillings and extractions (pulling teeth). It can also help pay 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 **$24.00**. Here's how the benefit works:

COVERED DENTAL SERVICES	You Pay	You Pay	Total Annual Benefit (Medicare Advantage Plan and OSB)
Preventative and Diagnostic Dental Services	**In-Network***	**Out-of-Network****	**All benefit limitations are per calendar year**
Oral Examinations	**0%**	**30%**	Two per year
Dental Prophylaxis (Cleanings)	**0%**	**30%**	Two per year
Bitewing X-ray	**0%**	**30%**	One per year
Basic Dental Services (Minor Restorative)			
Amalgam Restorations (Fillings)	**50%**	**55%**	Two per year
Composite Resin Restorations (Fillings) - Covered on front teeth only	**50%**	**55%**	
Extractions, non-surgical	**50%**	**55%**	Up to two per year
Crown or Bridge Re-cement	**50%**	**55%**	One per year
Periodontal Scaling and Root Planing (Deep Cleaning)	**50%**	**55%**	One procedure per quadrant every three years
Emergency Treatment for Pain	**50%**	**55%**	Up to two per year

COVERED DENTAL SERVICES	You Pay	You Pay	Total Annual Benefit (Medicare Advantage Plan and OSB)
Major Dental Services (Endodontics, Periodontics, and Oral Surgery)			
Root Canal Treatment	**70%**	**75%**	One per year
Crowns	**70%**	**75%**	One per year
Complete Dentures (Including routine post-delivery care)	**70%**	**75%**	One every five years
Partial Denture	**70%**	**75%**	One per year
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 contracted fees – the in-network fee schedules, or INFS. If you visit a dentist in the network, you won't receive a bill for more than your share of the fee schedule. You may still be charged a copayment.

**Non-network dentists haven't agreed to provide services at contracted fees. If you see an out-of-network dentist, your copayment may be higher. You may need to pay more because out-of-network dentists generally charge higher fees than network dentists do.

MyOption Dental – Low PPO

The MyOption Dental – Low PPO benefit makes it easy for you to plan for your dental care. The benefit has a **$50** deductible and **100 percent** coverage for two routine exams every year with an in-network provider.

The benefit also provides **50 percent** coverage for basic procedures like fillings and extractions (pulling teeth). There's a maximum annual benefit of **$1,000**, and there's no waiting period before your coverage begins. The premium is **$15.00**. Here's how the benefit works:

COVERED DENTAL SERVICES	You Pay	You Pay	Total Annual Benefit (Medicare Advantage Plan and OSB)
Preventative and Diagnostic Dental Services	**In-Network***	**Out-of-Network****	**All benefit limitations are per calendar year**
Oral Examinations	**0%**	**30%**	Two per year

COVERED DENTAL SERVICES	You Pay	You Pay	Total Annual Benefit (Medicare Advantage Plan and OSB)
Preventative and Diagnostic Dental Services	**In-Network***	**Out-of-Network****	**All benefit limitations are per calendar year**
Dental Prophylaxis (Cleanings)	**0%**	**30%**	Two per year
Bitewing X-ray	**0%**	**30%**	One per year
Basic Dental Services (Minor Restorative)			
Amalgam Restorations (Fillings)	**50%**	**55%**	Two per year
Composite Resin Restorations (Fillings) - Covered on front teeth only	**50%**	**55%**	
Extractions, non-surgical	**50%**	**55%**	Up to two per year
Crown or Bridge Re-cement	**50%**	**55%**	One per year
Emergency Treatment for Pain	**50%**	**55%**	Up to two 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 contracted fees – the in-network fee schedules, or INFS. If you visit a dentist in the network, you won't receive a bill for more than your share of the fee schedule. You may still be charged a copayment.

**Non-network dentists haven't agreed to provide services at contracted fees. If you see an out-of-network dentist, your copayment may be higher. You may need to pay more because out-of-network dentists generally charge higher fees than network dentists do.

MyOption Vision

The MyOption Vision benefit makes it easy to plan for your vision care. There's no deductible and no copayment for one routine eye exam each year, if you wear glasses. You also get **$290** each year to use for frames, lenses, and lens options or contact lenses.

There's no waiting period before your coverage begins. The premium for this OSB is **$15.00**. Here's how the benefit works:

COVERED VISION BENEFITS	EyeMed Network Vision Provider*	Non-EyeMed Network Vision Provider**
Routine exam for members who wear eye glasses with refraction/dilation as necessary	**$0** copayment	All costs over plan approved amount

COVERED VISION BENEFITS	EyeMed Network Vision Provider*	Non-EyeMed Network Vision Provider**
Frame, lens, and lens options	**$290** benefit (combined in and out-of-network)	**$290** reimbursement (combined in and out-of-network)
Contact lenses (in lieu of frames; includes materials only for conventional and disposable)	**$290** benefit (combined in and out-of-network)	**$290** reimbursement (combined in and out-of-network)
Frequency:		
Examinations	Once every 12 months	
Frame & 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 contracted fees. If you visit a provider in the network, you won't receive a bill for more than your share of the fee schedule. You may still be charged a copayment.

**Non-network providers haven't agreed to provide services at contracted fees. If you see an out-of-network provider, your costs may be higher. You may need to pay more because out-of-network providers generally charge higher fees than network providers.

MyOption Plus

MyOption Plus makes it easy to plan for both your dental and vision care. For dental care, this plan has a **$50** deductible and covers the full cost for two routine dental exams each year. For vision care, this benefit has no deductible and no copayment for one routine eye exam each year, if you wear glasses. You also get a **$290** allowance each year to use for frames, lenses, and lens options or contact lenses.

There's no waiting period before your coverage begins. The premium for this OSB is **$26.00**. Here's how the benefit works:

COVERED DENTAL SERVICES	You Pay	You Pay	Total Annual Benefit (Medicare Advantage Plan and OSB)
Preventative and Diagnostic Dental Services	**In-Network***	**Out-of-Network****	**All benefit limitations are per calendar year**
Oral Examinations	**0%**	**30%**	Two per year
Dental Prophylaxis (Cleanings)	**0%**	**30%**	Two per year
Bitewing X-ray	**0%**	**30%**	One per year

OPTIONAL SUPPLEMENTAL BENEFITS (continued)

COVERED DENTAL SERVICES	You Pay	You Pay	Total Annual Benefit (Medicare Advantage Plan and OSB)
Basic Dental Services (Minor Restorative)			
Amalgam Restorations (Fillings)	**50%**	**55%**	Two per year
Composite Resin Restorations (Fillings) - Covered on front teeth only	**50%**	**55%**	
Extractions, non-surgical	**50%**	**55%**	Up to two per year
Crown or Bridge Re-cement	**50%**	**55%**	One per year
Emergency Treatment for Pain	**50%**	**55%**	Up to two per year
COVERED VISION BENEFITS	**EyeMed Network Vision Provider***	**Non-EyeMed Network Vision Provider****	**All benefit limitations are per calendar year**
Routine exam for members who wear eyeglasses with refraction/dilation as necessary	**$0** copayment	All costs over plan approved amount	One every 12 months
Frame, lens, and lens options	**$290** benefit (combined in and out-of-network)	**$290** reimbursement (combined in and out-of-network)	One every 12 months
Contact lenses (in lieu of frames; includes materials only for conventional or disposable)	**$290** benefit (combined in and out-of-network)	**$290** reimbursement (combined in and out-of-network)	One every 12 months

Covered dental and 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 contracted fees – the in-network fee schedules, or INFS. If you visit a provider in the network, you won't receive a bill for more than your share of the fee schedule. You may still be charged a copayment.

**Non-network providers haven't agreed to provide services at contracted fees. If you see an out-of-network providers, your costs may be higher. You may need to pay more because out-of-network providers generally charge higher fees than network providers.

HUMANA.

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

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.com

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2012
Value-Added Services

HumanaChoice℠
H4408-007 (PPO)

Knoxville
Knoxville Metro Area

HUMANA®

Value-Added Services

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

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

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

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

HumanaDental Discount

You can save on dental services 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 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 **www.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 is not intended to replace any other dental coverage.
- If your dentist leaves the network, you'll need to select 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.

Humana's Discount Hearing Program

As a Humana member, you have access to discounts and services from Humana's national hearing aid providers, TruHearing and HearUSA. Discounts and services are applied when you purchase your hearing aid. You must call one of the provider's listed below to schedule an appointment in order to receive the discount. Please check with the providers below for locations and available discounts in your area. Florida has an exclusive agreement with HearX/HearUSA.

How the discount works
TruHearing

Call TruHearing toll-free at **1-888-403-3937** or use the TTY number **1-800-975-2674**, to make an appointment to get the Value Added Program discount.

- More than 3,000 providers in the US
- 100 percent digital hearing aids using the latest technology from three leading manufacturers
- Free hearing screening. The free screening is a basic four-tone test that determines whether there is a measurable hearing loss. If there is a loss, then the provider may recommend a complete comprehensive hearing evaluation.
- Free DVD when you make an appointment
- Up to a **60 percent** discount on all hearing aids
- Free supply of batteries (48 cells per aid) when you buy; and an additional 40 cells per aid when you re-enroll with Humana
- Three year repair warranty
- Three year one-time loss/damage coverage (deductible applies)
- Try hearing aid for 45 days. Money back if you aren't happy.
- Payment plans, including 12-month no-interest financing, available upon approved credit

WANT TO SAVE MORE? Save an additional $600 - $2000 per pair of aids off our current Health Plan pricing, through membership in the new MEMBER*PLUS* program. For just $108 one-time annual fee, you and your dependents are covered; and for just $79 each, you can add up to four extended family members – parent, aunt, grandparent, brother, etc. With enrollment and purchase, you receive a free supply of batteries (40 cells per aid) with a retail value of $80-$100. For complete program details and to enroll, go to www.truhearingmemberplus.com.

Be sure to use Group Number MPHU-MANA for enrollment in MEMBER*PLUS*

Contact information

To get more information or schedule a free screening, call TruHearing at **1-888-403-3937**, Monday through Friday, 8 a.m. to 8 p.m. Central time. If you use a TTY, call **1-800-975-2674**, Monday through Friday, 8 a.m. to 8 p.m. Central time.

How the discount works

HearUSA

Call HearUSA toll-free at **1-800-333-3389** or use the TTY number **1-888-300-3277**, to make an appointment to get the Value Added Program discount.

- Access to an accredited network of over 2,000 providers nationwide. Please call the number under **Contact information** to schedule your appointment to ensure your discount.
- Complete hearing exam at no charge ($135 value).
- Humana-negotiated discounts provide:
  - The latest digital hearing aids from a variety of manufacturers.
  - Fixed prices across 5 levels of technology, regardless of style or size of the hearing aid.
  - Standard prices that are not inflated to claim higher discounts.
- Comprehensive three-year warranty, including loss and damage.
- Free two-year supply of batteries (up to 96 cells).
- In-office service at no charge for the life of the hearing aids.
- 30-day money-back guarantee.
- **0 percent** financing available.
- A **20 percent** discount on accessories & assisted listening devices is also available by calling 1-800-432-7872 or through www.hearingshop.com. Please be sure to use checkout code "EARHUMANA."

Contact information

For a list of HearUSA providers in your area, visit www.hearusa.com or call HearUSA toll-free at **1-800-333-3389**, Monday through Friday, 8:30 a.m. to 8:30 p.m. Eastern time. If you use a TTY, call **1-888-300-3277**, Monday through Friday, 8:30 a.m. to 8:30 p.m. Eastern time.

Beltone

As a Humana member, you are entitled to participate in the Beltone/Humana Hearing Care Program. You must call the provider to schedule an appointment in order to receive the discount.

How the discount works

Call Beltone to schedule an appointment in order to receive the discount.

Humana Hearing Care Discount Program – 2012 Summary

Retail price each	$2,495.00	$1,995.00	$1,495.00	$995.00
Products	Reach, True 9	Identity, True 6	Change, Force	Access, Turn
Channels	17 & 9	9 & 6	6	6
Features available	Feedback Eraser, Speech Spotter Pro, Adaptive Directionality, Smart Beam, Monitored Directionality, Wind Noise Reduction, Adaptive Anti-Feedback Control, Satisfaction Manager, Data Logging, Learning Volume Control, Sound Cleaner	Speech Pattern Detection, Feedback Eraser, Adaptive Directionality, Wide Dynamic Range Curvilinear Compression, Smart Gain, Wind Noise Suppression, Data Logging, multi-memory, Learning Volume Control	WDRC, Automatic feedback cancellation, Speech Pattern Detection with Noise Reduction, Data Logging, Multi-memory, Automatic Compression Adaptor	WDRC, Curvilinear Compression, Silencer System, Multi-memory, Gain Explorer, Noise Reduction

- Free annual hearing screening and hearing exams ($135 value)
- Up to **50 percent** off suggested retail pricing for specified technology levels
- Free In-home service, if needed (where available)
- BelCare™ patient satisfaction plan includes:
    - Lifetime Care™ Program
    - Two-year hearing loss change protection
    - Authorized service at any U.S. Beltone location
- Free Two-year supply of batteries (96 cells) with purchase ($120 value)
- Free Three-year manufacturer's warranty on all products (up to $290 value)
- Three-year Loss, Stolen & Damage coverage included
- 45-day credit return with money-back guarantee
- Unlimited support for fitting and training on your hearing aids
- Exclusive Patient Financing Program available:
    - Low fixed monthly payments with up to 60 months to pay
    - No-interest promotions available
    - Based on approved credit, some minimums apply
- Nationwide network of hearing care providers

Contact information

To get more information, or for your nearest provider location, call Beltone at **1-800-BELTONE (1-800-235-8663)**, Monday through Friday from 8 a.m. to 8 p.m., Eastern Time, or go online at www.beltone.com. If you have a speech or hearing impairment and use a TTY, call **711**. You can call seven days a week from 8 a.m. to 8 p.m. Our automated phone system may answer your call on Saturdays, Sundays, and some public holidays. Just leave a message and select the reason for your call from the automated list. We'll call back by the end of the next business day. Please have your Humana ID card handy when you call.

Complementary and Alternative Medicine

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

Services include:

- **Acupuncture** - A trained professional inserts and rotates very thin needles at key points on the body to stimulate various organs and systems.
- **Massage** - Using scientific manual techniques, a massage therapist manipulates soft tissues of the body to normalize those tissues.
- **Chiropractic** - A chiropractor diagnoses spinal misalignments and corrects 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 we encourage you to tell your primary care physician about any treatment you're considering. If you're already seeing a CAM professional who isn't on the HWHN list, you can nominate that individual online for network consideration.

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 *My*Humana, 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 www.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 prescriptions/medicines. Dependent upon your purchase, you may be limited to a certain amount.

Contact Information

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

Vision Discount Program

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

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

How the discount works

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

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

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

Contact information

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

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

Nutrisystem® Discount

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

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

How the discount works

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

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

Contact information

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

Lifeline® Medical Alert Systems

Every day, Lifeline® helps thousands of people live more independent, active lives at home. In partnership with Humana, Lifeline offers a monthly rate of **$38.00** for its standard medical alert service to all Humana members. You can also take advantage of a **free** activation rate – a $90.00 value.

How the discount works

Standard Lifeline Service

Installation and enrollment fee

- Regular rate for self installations: $90.00
- Humana members' installation rate: **Free**

Monthly fee

- Regular rate: $42.00
- Humana members: **$38.00**

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 assistance, a push of a button signals the Lifeline monitoring center. One of our professionals will speak to you over our Home Communicator phone to determine what help is needed and dispatch the appropriate responders. Responders are your family members, friends, or neighbors, as well as emergency service personnel 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 are located 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.

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: _____

For more information, visit
Humana-Medicare.com
or call 1-800-898-0371

FOLD

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

HUMANA
DENTAL

In addition to the HumanaDental network, the following networks are available in the respective states: DenteMax in District of Columbia, Connecticut, Maryland, Michigan, Massachuetts, New Jersey, New York, Pennsylvania & Virginia, MN Premier in Minnesota, Diversified in Nevada, ADP in Wisconsin

Notes

Notes

Notes

HUMANA.

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

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

Humana.com

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HUMANA.

– Medicare
– Group health benefits
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