

Summary of Benefits

Humana Gold Choice[®]
H8145-087 (PFFS)

South
Select Counties in Mississippi

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Our service area includes the following county/counties in Mississippi: Calhoun, Chickasaw, Clay, Greene, Hancock, Harrison, Hinds, Holmes, Jackson, Lauderdale, Lawrence, Madison, Monroe, Noxubee, Rankin, Scott, Walthall, Washington, Wilkinson.



Let's talk about **Humana Gold Choice®** **H8145-087 (PFFS)**

Find out more about the Humana Gold Choice H8145-087 (PFFS) plan - including the health and drug services it covers - in this easy-to-use guide.

Humana Gold Choice H8145-087 (PFFS) is a Medicare Advantage PFFS plan with a Medicare contract. Enrollment in this Humana plan depends on contract renewal.

The benefit information provided is a summary of what we cover and what you pay. It doesn't list every service that we cover or list every limitation or exclusion. For a complete list of services we cover, ask us for the "Evidence of Coverage" or you will receive one after you enroll.

To be eligible

To join Humana Gold Choice H8145-087 (PFFS), you must be entitled to Medicare Part A, be enrolled in Medicare Part B and live in our service area.

Plan name:

Humana Gold Choice H8145-087 (PFFS)

How to reach us:

If you're a member of this plan, call toll-free: **1-800-457-4708 (TTY: 711)**.

If you're **not** a member of this plan, call toll free: **1-800-833-2364 (TTY: 711)**.

October 1 - February 14:

Call 7 days a week from 8 a.m. - 8 p.m.

February 15 - September 30:

Call Monday - Friday, 8 a.m. - 8 p.m.

Or visit our website:

Humana.com/medicare.

As a member it's a good idea to select a doctor as your Primary Care Provider (PCP). Humana Gold Choice H8145-087 (PFFS) has a network of doctors, hospitals, pharmacies and other providers. If you use providers who aren't in our network, you may be subject to higher copayments/coinsurance.



A healthy partnership

Get more from your plan — with extra services and resources provided by Humana!

This document is available in other formats such as Braille and large print.

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Póngase en contacto con un agente de ventas certificado de Humana al 1-800-833-2364 (TTY: 711).



Monthly Premium, Deductible and Limits

	IN-NETWORK	OUT-OF-NETWORK
PLAN COSTS		
Monthly premium You must keep paying your Medicare Part B premium.	\$95	
Medical deductible		\$750 out-of-network All services not covered by Original Medicare, Ambulance services, Emergency Room services, Urgently Needed Services at Urgent Care Centers and Immunizations (Flu & Pneumonia) do not apply to the out-of-network deductible.
Pharmacy (Part D) deductible	\$315 only applies to Tier 3, Tier 4, Tier 5.	
Maximum out-of-pocket responsibility The most you pay for copays, coinsurance and other costs for medical services for the year.	\$6,700 combined in- and out-of-network	\$6,700 combined in- and out-of-network



Covered Medical and Hospital Benefits

	IN-NETWORK	OUT-OF-NETWORK
ACUTE INPATIENT HOSPITAL CARE		
	\$225 copay per day for days 1-5 \$0 copay per day for days 6-90 Your plan covers an unlimited number of days for an inpatient stay.	30% of the cost
OUTPATIENT HOSPITAL COVERAGE		
Surgery services at outpatient hospital	25% of the cost	30% of the cost
Surgery services at ambulatory surgical center	20% of the cost	30% of the cost
DOCTOR OFFICE VISITS		
Primary care provider (PCP)	\$15 copay	30% of the cost
Specialists	\$45 copay	30% of the cost



Covered Medical and Hospital Benefits (cont.)

	IN-NETWORK	OUT-OF-NETWORK
PREVENTIVE CARE		
	Our plan covers many preventive services at no cost when you see an in-network provider, including: • Abdominal aortic aneurysm screening • Alcohol misuse counseling • Bone mass measurement • Breast cancer screening (mammogram) • Cardiovascular disease (behavioral therapy) • Cardiovascular screenings • Cervical and vaginal cancer screening • Colorectal cancer screenings (colonoscopy, fecal occult blood test, flexible sigmoidoscopy) • Depression screening • Diabetes screenings • HIV screening • Medical nutrition therapy services • Obesity screening and counseling • Prostate cancer screenings (PSA) • Sexually transmitted infections screening and counseling • Tobacco use cessation counseling (counseling for people with no sign of tobacco-related disease) • Vaccines, including flu shots, hepatitis B shots, pneumococcal shots • "Welcome to Medicare" preventive visit (one-time) • Annual Wellness Visit • Lung cancer screening • Routine physical exam Any additional preventive services approved by Medicare during the contract year will be covered.	\$0 or 30% of the cost, depending on the service and where service is provided
EMERGENCY CARE		
Emergency room	\$80 copay	\$80 copay



Covered Medical and Hospital Benefits (cont.)

	IN-NETWORK	OUT-OF-NETWORK
Urgently needed services Urgently needed services are provided to treat a non-emergency, unforeseen medical illness, injury or condition that requires immediate medical attention.	\$35 copay at an urgent care center	30% of the cost at an urgent care center
OUTPATIENT CARE AND DIAGNOSTIC SERVICES, LABS AND IMAGING Cost share may vary depending on the service and where service is provided		
Diagnostic Mammography	\$45 copay or 20% to 25% of the cost	30% of the cost
Diagnostic radiology	\$225 copay	30% of the cost
Lab services	\$0 to \$35 copay or 25% of the cost	30% of the cost
Diagnostic tests and procedures	\$0 to \$45 copay or 25% of the cost	30% of the cost
Outpatient X-rays	\$15 to \$45 copay or 20% to 25% of the cost	30% of the cost
Radiation Therapy	20% of the cost	30% of the cost
HEARING SERVICES		
Medicare covered hearing	\$45 copay	30% of the cost
DENTAL SERVICES		
Medicare covered dental	\$45 copay	30% of the cost
Routine dental	• 0% coinsurance for bitewing x-rays up to 1 set(s) per year. • 0% coinsurance for periodic oral exam or comprehensive oral evaluation, prophylaxis (cleaning) up to 1 per year. • 0% coinsurance for necessary anesthesia with covered service up to unlimited per year.	• 50% coinsurance for bitewing x-rays up to 1 set(s) per year. • 50% coinsurance for periodic oral exam or comprehensive oral evaluation, prophylaxis (cleaning) up to 1 per year. • 50% coinsurance for necessary anesthesia with covered service up to unlimited per year. • Benefits received out-of-network are subject to any in-network benefit maximums, limitations, and/or exclusions.
VISION SERVICES		
Medicare covered vision services	\$45 copay	30% of the cost
Diabetic Eye Exam	\$0 copay	30% of the cost
Glaucoma screening	\$0 copay	30% of the cost



Covered Medical and Hospital Benefits (cont.)

	IN-NETWORK	OUT-OF-NETWORK
Eyewear (post-cataract)	\$0 copay	\$0 copay
Routine vision	• \$0 copayment for refraction, routine exam up to 1 per year. • \$40 combined maximum benefit coverage amount per year for refraction, routine exam.	• \$0 copayment for refraction, routine exam up to 1 per year. • \$40 combined maximum benefit coverage amount per year for refraction, routine exam. • Benefits received out-of-network are subject to any in-network benefit maximums, limitations, and/or exclusions.
MENTAL HEALTH SERVICES		
Inpatient Your plan covers up to 190 days in a lifetime for inpatient mental health care in a psychiatric hospital	\$225 copay per day for days 1-5 \$0 copay per day for days 6-90	30% of the cost
Outpatient group and individual therapy visits Cost share may vary depending on where service is provided.	\$40 copay or 20% to 25% of the cost	30% of the cost
SKILLED NURSING FACILITY (SNF)		
Your plan covers up to 100 days in a SNF	\$0 copay per day for days 1-20 \$164.50 copay per day for days 21-100	30% of the cost
PHYSICAL THERAPY		
	\$15 copay	30% of the cost
AMBULANCE		
Ambulance (ground)	\$265 per date of service	\$265 per date of service
TRANSPORTATION		
	Not covered	Not covered



Prescription Drug Benefits

MEDICARE PART B DRUGS

Chemotherapy drugs	20% of the cost	20% of the cost
Other part B drugs	20% of the cost	20% of the cost

PRESCRIPTION DRUGS

Pharmacy (Part D) Deductible

\$315 only applies to Tier 3, Tier 4, Tier 5.

Initial coverage (after you pay your deductible, if applicable)

You pay the following until your total yearly drug costs reach \$3,750. Total yearly drug costs are the total drug costs paid by both you and our plan.

	Preferred Retail Pharmacy	Standard Retail Pharmacy	Preferred Mail Order	Standard Mail Order
30-day supply				
Tier 1: Preferred Generic	\$5 copay	\$10 copay	\$5 copay	\$10 copay
Tier 2: Generic	\$15 copay	\$20 copay	\$15 copay	\$20 copay
Tier 3: Preferred Brand	\$47 copay	\$47 copay	\$47 copay	\$47 copay
Tier 4: Non-Preferred Drug	\$100 copay	\$100 copay	\$100 copay	\$100 copay
Tier 5: Specialty	26% of the cost	26% of the cost	26% of the cost	26% of the cost
90-day supply				
Tier 1: Preferred Generic	\$15 copay	\$30 copay	\$0 copay	\$30 copay
Tier 2: Generic	\$45 copay	\$60 copay	\$0 copay	\$60 copay
Tier 3: Preferred Brand	\$141 copay	\$141 copay	\$131 copay	\$141 copay
Tier 4: Non-Preferred Drug	\$300 copay	\$300 copay	\$290 copay	\$300 copay

Specialty drugs are limited to a 30 day supply.

Certain drugs may need advance approval before your plan will cover any of the costs. This is called “prior authorization” or “preauthorization.” Please contact your PCP or refer to the Evidence of Coverage (EOC) for services that require a prior authorization from the plan.

Cost sharing may change depending on the pharmacy you choose, when you enter another phase of the Part D benefit and if you qualify for “Extra Help.” To find out if you qualify for “Extra Help,” please contact the Social Security Office at 1-800-772-1213 Monday — Friday, 7 a.m. — 7 p.m. TTY users should call 1-800-325-0778. For more information on the additional pharmacy-specific cost-sharing and the phases of the benefit, please call us or access our “Evidence of Coverage” online.

If you reside in a long-term care facility, you pay the same as at a standard retail pharmacy.

You may get drugs from an out-of-network pharmacy but may pay more than you pay at an in-network pharmacy.

Days’ Supply Available

Unless otherwise specified, you can get your Part D medicine in the following days’ supply amounts:

- One month supply (up to 30 days)*
- Two month supply (31-60 days)
- Three month supply (61-90 days)

*Long term care pharmacy (one month supply = 31 days)

Coverage Gap

After you enter the coverage gap, you pay **35 percent** of the plan's cost for covered brand name drugs and **44 percent** of the plan's cost for covered generic drugs until your costs total **\$5,000** — which is the end of the coverage gap. Not everyone will enter the coverage gap.

Catastrophic Coverage

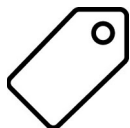
After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach **\$5,000**, you pay the greater of:

- **5%** of the cost, or
- **\$3.35** copay for generic (including brand drugs treated as generic) and a **\$8.35** copayment for all other drugs



Additional benefits

	IN-NETWORK	OUT-OF-NETWORK
Medicare covered foot care	\$45 copay	30% of the cost
MEDICAL EQUIPMENT/SUPPLIES		
Durable medical equipment (like wheelchairs or oxygen)	20% of the cost	20% of the cost
Medical Supplies	20% of the cost	20% of the cost
Prosthetics (artificial limbs or braces)	20% of the cost	20% of the cost
Diabetic monitoring supplies Cost share may vary depending on where service is provided.	\$0 copay or 10% to 20% of the cost	20% of the cost
REHABILITATION SERVICES		
Physical, occupational and speech therapy	\$15 copay	30% of the cost
Cardiac rehabilitation	\$15 copay	30% of the cost
Pulmonary rehabilitation	\$15 copay	30% of the cost



More benefits with **your plan**

Enjoy some of these extra benefits included in your plan.

Meals

Well Dine Meal Program - Humana's meal program for members following an inpatient stay in the hospital or nursing facility

HumanaFirst nurse advice line

Health advice from a registered nurse, available 24 hours a day, seven days a week.

Over-the-counter (OTC) allowance

Up to **\$30** every 3 months for the purchase of OTC supplies from Humana Pharmacy mail delivery.

Go365™ by Humana

Rewards for completing preventive health screenings and health and wellness activities.

Fitness benefit

SilverSneakers® Fitness Program – Basic fitness center membership including fitness classes.



Find out **more**



You can see our plan's **provider and pharmacy directory** at our website at **www.humana.com/members/tools** or call us at the number listed at the beginning of this booklet and we will send you one.



You can see our plan's **drug formulary** at our website at **www.humana.com/medicare/medicare_prescription_drugs/medicare_drug_tools/medicare_drug_list/** or call us at the number listed at the beginning of this booklet and we will send you one.

This information is not a complete description of benefits. Contact the plan for more information. Limitations, copayments and restrictions may apply. Benefits, premiums and/or member cost-share may change on January 1 of each year. You must continue to pay your Medicare Part B premium.

To find out more about the coverage and costs of Original Medicare, look in the current "Medicare & You" handbook. View it online at <http://www.medicare.gov> or get a copy by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, seven days a week. TTY users should call 1-877-486-2048.

A Private Fee-for-Service plan is not Medicare supplement insurance. Providers who do not contract with our plan are not required to see you except in an emergency.

The provider/pharmacy network may change at any time. You will receive notice when necessary.

Humana®

Humana.com

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This image shows a blank sheet of white paper designed for handwriting practice. It features a series of horizontal lines spaced evenly down the page. At the very top, there is a dashed line, followed by a solid line, and then several more solid lines below. The lines are thin and light gray or blue in color. There is no text or other markings on the page.

Discrimination is Against the Law

Humana Inc. and its subsidiaries comply with applicable Federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability, or sex. Humana Inc. and its subsidiaries do not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Humana Inc. and its subsidiaries provide:

- Free auxiliary aids and services, such as qualified sign language interpreters, video remote interpretation, and written information in other formats to people with disabilities when such auxiliary aids and services are necessary to ensure an equal opportunity to participate.
- Free language services to people whose primary language is not English when those services are necessary to provide meaningful access, such as translated documents or oral interpretation.

If you need these services, call 1-800-281-6918 or if you use a TTY, call 711.

If you believe that Humana Inc. and its subsidiaries have failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

Discrimination Grievances
P.O. Box 14618
Lexington, KY 40512 - 4618

If you need help filing a grievance, call 1-800-281-6918 or if you use a TTY, call 711.

You can also file a civil rights complaint with the **U.S. Department of Health and Human Services**, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at **<https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>**, or by mail or phone at:

U.S. Department of Health and Human Services

200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201

1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at **<http://www.hhs.gov/ocr/office/file/index.html>**

Multi-Language Interpreter Services

English: ATTENTION: If you do not speak English, language assistance services, free of charge, are available to you. Call **1-800-281-6918 (TTY: 711)**.

Español (Spanish): ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al **1-800-281-6918 (TTY: 711)**.

繁體中文 (Chinese): 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 **1-800-281-6918 (TTY: 711)**。

Tiếng Việt (Vietnamese): CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số **1-800-281-6918 (TTY: 711)**.

한국어 (Korean): 주의 : 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. **1-800-281-6918 (TTY: 711)** 번으로 전화해 주십시오.

Tagalog (Tagalog – Filipino): PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa **1-800-281-6918 (TTY: 711)**.

Русский (Russian): ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните **1-800-281-6918 (телетайп: 711)**.

Kreyòl Ayisyen (French Creole): ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele **1-800-281-6918 (TTY: 711)**.

Français (French): ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le **1-800-281-6918 (ATS : 711)**.

Polski (Polish): UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer **1-800-281-6918 (TTY: 711)**.

Português (Portuguese): ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para **1-800-281-6918 (TTY: 711)**.

Italiano (Italian): ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero **1-800-281-6918 (TTY: 711)**.

Deutsch (German): ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: **1-800-281-6918 (TTY: 711)**.

日本語 (Japanese): 注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。**1-800-281-6918 (TTY : 711)** まで、お電話にてご連絡ください。

فارسی (Farsi):

توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. **1-800-281-6918 (TTY: 711)** تماس بگیرید.

Diné Bizaad (Navajo): Díí baa akó nínízin: Díí saad bee yánílti'go Diné Bizaad, saad bee áká'ánída'áwo'déé', t'áá jiik'eh, éí ná hóló, koji' hódíílnih **1-800-281-6918 (TTY: 711)**.

العربية (Arabic):

ملحوظة: إذا كنت تتحدث اللغة العربية، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم **1-800-281-6918 (هاتف الضم: 711)**.

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