

Summary of Benefits

Optional Supplemental Benefits

Humana Gold Choice[®] H8145-108 (PFFS)

South
Select Counties in Virginia

Humana[®]

Pre-Enrollment Checklist

Before making an enrollment decision, it is important that you fully understand our benefits and rules. If you have any questions, you can call and speak to a customer service representative at **1-800-833-2364 (TTY: 711)**.

Understanding the Benefits

- ☐ Review the full list of benefits found in the Evidence of Coverage (EOC), especially for those services that you routinely see a doctor. Visit **Humana.com/medicare** or call **1-800-833-2364 (TTY: 711)** to view a copy of the EOC.
- ☐ Review the provider directory (or ask your doctor) to make sure the doctors you see now are in the network. If they are not listed, it means you will likely have to select a new doctor.

Understanding Important Rules

- ☐ In addition to your monthly plan premium, you must continue to pay your Medicare Part B premium. This premium is normally taken out of your Social Security check each month.
- ☐ Benefits, premiums and/or copayments/co-insurance may change on January 1, 2020.
- ☐ Our plan allows you to see providers outside of our network (non-contracted providers). However, while we will pay for covered services provided by a non-contracted provider, the provider must agree to treat you. Except in an emergency or urgent situations, non-contracted providers may deny care. In addition, you may pay a higher co-pay for services received by non-contracted providers.

2019

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Our service area includes the following county/counties in Virginia: Bristol City, Buchanan, Dickenson, Grayson, Lee, Russell, Smyth, Tazewell, Washington, Wise, Wythe.



Let's talk about Humana Gold Choice H8145-108 (PFFS)

Find out more about the Humana Gold Choice H8145-108 (PFFS) plan - including the health and drug services it covers - in this easy-to-use guide.

Humana Gold Choice H8145-108 (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 H8145-108 (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 H8145-108 (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 - March 31:

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

April 1 - September 30:

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

Or visit our website:

Humana.com/medicare.

More about Humana Gold Choice H8145-108 (PFFS)

Do you have Medicare and Medicaid? If you are a dual-eligible beneficiary enrolled in both Medicare and the state's program, you may not have to pay the medical costs displayed in this booklet and your prescription drug costs will be lower, too.

If you have Medicaid, be sure to show your Medicaid ID card in addition to your Humana membership card to make your provider aware that you may have additional coverage. Your services are paid first by Humana and then by Medicaid.

As a member it's a good idea to select a doctor as your Primary Care Provider (PCP). Humana Gold Choice H8145-108 (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!



Monthly Premium, Deductible and Limits

	IN-NETWORK	OUT-OF-NETWORK
PLAN COSTS		
Monthly plan premium You must keep paying your Medicare Part B premium.	\$0	
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.
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		
	\$295 copay per day for days 1-6 \$0 copay per day for days 7-90 Your plan covers an unlimited number of days for an inpatient stay.	35% of the cost
OUTPATIENT HOSPITAL COVERAGE		
Outpatient surgery at outpatient hospital	25% of the cost	35% of the cost
Outpatient surgery at ambulatory surgical center	20% of the cost	35% of the cost
DOCTOR OFFICE VISITS		
Primary care provider (PCP)	\$15 copay	35% of the cost
Specialists	\$40 copay	35% of the cost



Covered Medical and Hospital Benefits (cont.)

	IN-NETWORK	OUT-OF-NETWORK
PREVENTIVE CARE	<p>Our plan covers many preventive services at no cost when you see an in-network provider including:</p> <ul style="list-style-type: none"> • 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 • Medicare diabetes prevention program <p>Any additional preventive services approved by Medicare during the contract year will be covered.</p>	<p>\$0 or 35% of the cost, depending on the service and where service is provided</p>



Covered Medical and Hospital Benefits (cont.)

	IN-NETWORK	OUT-OF-NETWORK
EMERGENCY CARE		
Emergency room	\$90 copay	\$90 copay
Urgently needed services Urgently needed services are provided to treat a non-emergency, unforeseen medical illness, injury or condition that requires immediate medical attention.	\$40 copay at an urgent care center	35% 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	\$40 copay or 20% to 25% of the cost	35% of the cost
Diagnostic radiology	\$180 to \$245 copay or 20% to 25% of the cost	35% of the cost
Lab services	\$0 to \$40 copay or 25% of the cost	35% of the cost
Diagnostic tests and procedures	\$0 to \$40 copay or 25% of the cost	35% of the cost
Outpatient X-rays	\$15 to \$40 copay or 20% to 25% of the cost	35% of the cost
Radiation Therapy	\$40 or 20% of the cost	35% of the cost
HEARING SERVICES		
Medicare covered hearing	\$40 copay	35% of the cost
DENTAL SERVICES Additional dental benefits are available with a separate monthly premium. Please see the "Optional Supplemental Benefits" page for details.		
Medicare covered dental	\$40 copay	35% of the cost
VISION SERVICES		
Medicare covered vision services	\$40 copay	35% of the cost
Diabetic Eye Exam	\$0 copay	35% of the cost
Glaucoma screening	\$0 copay	35% of the cost
Eyewear (post-cataract)	\$0 copay	35% of the cost



Covered Medical and Hospital Benefits (cont.)

	IN-NETWORK	OUT-OF-NETWORK
Routine vision VIS775 The provider locator can be found at Humana.com > Find a Doctor > from the Search Type drop down select Vision > Eyemed Select Network.	<ul style="list-style-type: none"> • \$0 copayment for routine exam, refraction up to 1 per year. • \$40 combined maximum benefit coverage amount per year for refraction, routine exam. 	<ul style="list-style-type: none"> • \$0 copayment for routine exam, refraction 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	\$295 copay per day for days 1-5 \$0 copay per day for days 6-90	35% 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	35% 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 \$167 copay per day for days 21-100	35% of the cost
PHYSICAL THERAPY		
Cost share may vary depending on the service and where service is provided.	\$15 or 25% of the cost	35% of the cost
AMBULANCE		
Ambulance (ground)	20% of the cost	20% of the cost
TRANSPORTATION		
	Not covered	Not covered



Prescription Drug Benefits

MEDICARE PART B DRUGS

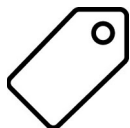
Chemotherapy drugs	20% of the cost	20% of the cost
Other part B drugs	20% of the cost	20% of the cost

PRESCRIPTION DRUGS

Your plan covers Part B drugs including, but not limited to, chemotherapy and some drugs administered by your provider. However, this plan does not cover Part D prescription drugs.

**Additional benefits**

	IN-NETWORK	OUT-OF-NETWORK
Medicare-covered foot care (podiatry)	\$40 copay	35% of the cost
Medicare-covered chiropractic services	\$20 copay	35% 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 Cost share may vary depending on the service and where service is provided.	\$15 or 25% of the cost	35% of the cost
Cardiac rehabilitation Cost share may vary depending on the service and where service is provided.	\$15 or 25% of the cost	35% of the cost
Pulmonary rehabilitation Cost share may vary depending on the service and where service is provided.	\$15 or 25% of the cost	35% of the cost



More benefits with **your plan**

Enjoy some of these extra benefits included in your plan.

Well Dine Meal Program

Humana's meal program for members following an inpatient stay in the hospital or nursing facility

SilverSneakers® fitness program

Basic fitness center membership including fitness classes.

HumanaFirst® Nurse Hotline

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

Over-the-Counter (OTC) mail order

Up to **\$25** allowance every 3 months for the purchase of OTC supplies from Humana Pharmacy mail delivery.

Virtual Visits - Medical

Access to doctors and other practitioners via phone and/or video technology for diagnosis and treatment of certain non-emergency medical issues.

You pay a **\$10** copay to receive a remote medical consultation.

Virtual Visits – Mental and Behavioral Health

Access to doctors and other mental health professionals via phone and/or video technology for diagnosis and treatment of certain non-emergency mental or behavioral issues.

You pay a **\$20** copay to receive a remote mental and behavioral consultation.

Go365™ by Humana

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



Optional **Supplemental Benefits**

Customize your coverage for an extra monthly premium when you enroll. You can choose from the following to help create your Medicare plan.

\$21.40

MyOption Dental - High DEN838

Includes benefits for preventive, basic, and major services at both in-network (HumanaDental Medicare network) and out-of-network dentists. These benefits have an additional monthly premium.

Humana MyOption optional supplemental benefits (OSB) are only available to members of certain Humana Medicare Advantage (MA) plans. Members of Humana plans that offer OSBs may enroll in OSBs throughout the year. Benefits may change on January 1 each year. Enrollees must use network providers for specific OSBs when stated in the Evidence of Coverage (EOC); otherwise, covered services may be received from non-network providers at a higher cost. Enrollees must continue to pay the Medicare Part B premium, their Humana plan premium and the OSB premium.



Find out **more**



You can see our plan's **provider 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.

This information is not a complete description of benefits. Call 1-800-457-4708 (TTY: 711) for more information.

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.

This information is available in a different format, including Braille, large print, and audio tapes. Please call Customer Care at the number listed in the beginning of this document if you need plan information in another format.

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-833-2364 (TTY: 711).

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

Limitations on healthcare and prescription services delivered via virtual visits and communications options vary by state. Virtual visit services are not a substitute for emergency care and not intended to replace your primary care provider or other providers in your network. This material is provided for informational use only and should not be construed as medical advice or used in place of consulting a licensed medical professional.

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My Options, My Choice

Adding Benefits to Your Plan

You're unique and have unique needs. That's why Humana offers optional supplemental benefits (OSB). For an extra monthly premium you can customize your Humana Medicare Advantage plan.

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

The information in this booklet will tell you about the benefits you can add to your plan. If you have questions, you can call us at 1-888-866-3154 (TTY: 711). We are available seven days a week, from 8 a.m. - 8 p.m. local time. However, please note that our automated phone system may answer your call during weekends and holidays from April 1 - September 30. Please leave your name and telephone number, and we will call you back by the end of the next business day.

MyOptionSM Dental – High (DEN838)

The MyOptionSM Dental – High benefit helps make it easy for you to plan for your dental care.

Here's how the benefit works:

Monthly Premium	\$21.40		
Maximum Benefit	Humana pays up to \$2,000 per calendar year		
Covered Dental Services	In-Network* You Pay	Out-Of-Network** You Pay	Benefit Limitations Per Calendar Year
Preventive and Diagnostic Dental Services			
Oral examinations	0%	50%	Two per year
Periodontal exam	0%	50%	One procedure every three years
Dental prophylaxis (cleanings)	0%	50%	Two per year
Fluoride treatment	0%	50%	Two per year
Bitewing X-ray	0%	50%	One set per year
Intraoral X-ray	0%	50%	One set per year
Panoramic or diagnostic X-rays	0%	50%	One set every five years
Basic Dental Services (Minor Restorative)			
Amalgam (silver) restorations (fillings)	50%	55%	Two per year
Composite resin restorations (white fillings)	50%	55%	
Extractions (pulling teeth), simple or surgical	50%	55%	Two per year

OPTIONAL SUPPLEMENTAL BENEFITS (continued)

Covered Dental Services	In-Network* You Pay	Out-Of-Network** You Pay	Benefit Limitations Per Calendar Year
Basic Dental Services (Minor Restorative)			
Recementation	50%	55%	One procedure every five years
Emergency treatment for pain	50%	55%	Two per year
Anesthesia	0%	50%	Unlimited per calendar year
Major Dental Services (Endodontics, Periodontics, and Oral Surgery)			
Periodontal scaling and root planing (deep cleaning)	70%	75%	One procedure for each quadrant every three years
Periodontal Maintenance	70%	75%	Two procedures per calendar year
Crowns	70%	75%	Two procedures per calendar year

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

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

**If you use an out-of-network dentist, your share of the cost may be higher.

The Humana Dental Optional Supplemental benefits are provided through the Humana Dental Medicare Network. The provider locator can be found at [Humana.com](https://www.humana.com) > Find a Doctor > from the Search Type drop down select Dental > HumanaDental Medicare.

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[Humana.com](https://www.humana.com)

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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, sex, sexual orientation, gender identity, or religion. Humana Inc. and its subsidiaries do not exclude people or treat them differently because of race, color, national origin, age, disability, sex, sexual orientation, gender identity, or religion.

Humana Inc. and its subsidiaries provide: (1) 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; and, (2) 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 **1-877-320-1235** 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, sex, sexual orientation, gender identity, or religion, you can file a grievance with Discrimination Grievances, P.O. Box 14618, Lexington, KY 40512-4618.

If you need help filing a grievance, call **1-877-320-1235** 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, DC 20201, **1-800-368-1019, 800-537-7697 (TDD)**.

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

Multi-Language Interpreter Services

ATTENTION: If you do not speak English, language assistance services, free of charge, are available to you. Call 1-877-320-1235 **(TTY: 711)**... ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-877-320-1235 **(TTY: 711)** 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 1-877-320-1235 **(TTY: 711)**。... CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-877-320-1235 **(TTY: 711)**... 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-877-320-1235 **(TTY: 711)** 번으로 전화해 주십시오 PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-877-320-1235 **(TTY: 711)**... ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-877-320-1235 **(телетайп: 711)**... ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-877-320-1235 **(TTY: 711)**... ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-877-320-1235 **(ATS: 711)**... UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-877-320-1235 **(TTY: 711)**... ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-877-320-1235 **(TTY: 711)**... ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-877-320-1235 **(TTY: 711)**... ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-877-320-1235 **(TTY: 711)**... 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。 1-877-320-1235 **(TTY: 711)** まで、お電話にてご連絡ください。 ...

توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. 1-877-320-1235 **(TTY: 711)** تماس بگیرید.

Díí baa akó nínízin: Díí saad bee yáníłti'go Diné Bizaad, saad bee áká'ánída'áwo'déé', t'áá jiik'eh, éí ná hólq, kóji' hódíłnih 1-877-320-1235 **(TTY: 711)**...

ملحوظة: إذا كنت تتحدث اللغة العربية، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-877-320-1235 **(رقم هاتف الصم والبكم: 711)**.

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Select Counties in Virginia

