2023

Summary of Benefits

Humana Gold Plus SNP-DE H5619-076 (HMO D-SNP)

Southern Indiana
Clark, Floyd and Harrison counties

Our service area includes the following county/counties in Indiana: Clark, Floyd, Harrison.

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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

- ☐ The Evidence of Coverage (EOC) provides a complete list of all coverage and services. It is important to review plan coverage, costs and benefits before you enroll. 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.
- ☐ Review the pharmacy directory to make sure the pharmacy you use for any prescription medicines is in the network. If the pharmacy is not listed, you will likely have to select a new pharmacy for your prescriptions.
- ☐ Review the formulary to make sure your drugs are covered.

Understanding Important Rules

- ☐ Benefits, premiums and/or copayments/co-insurance may change on January 1, 2024.
- ☐ Except in emergency or urgent situations, we do not cover services by out-of-network providers (doctors who are not listed in the provider directory).
- ☐ This plan is a dual eligible special needs plan (D-SNP). Your ability to enroll will be based on verification that you are entitled to both Medicare and medical assistance from a state plan under Medicaid. This plan may enroll FBDE, QMB, QMB+, SLMB+.

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Southern Indiana
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Our service area includes the following county/counties in Indiana: Clark, Floyd, Harrison.

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Let's talk about Humana Gold Plus SNP-DE H5619-076 (HMO D-SNP)

Find out more about the Humana Gold Plus SNP-DE H5619-076 (HMO D-SNP) plan - including the health and drug services it covers - in this easy-to-use guide.

Humana Gold Plus SNP-DE H5619-076 (HMO D-SNP) is a Coordinated Care plan HMO with a Medicare contract and a contract with the Indiana Medicaid program. 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".

As a member you must select an in-network doctor to act as your Primary Care Provider (PCP). Humana Gold Plus SNP-DE H5619-076 (HMO D-SNP) has a network of doctors, hospitals, pharmacies and other providers. If you use providers who aren't in our network, the plan may not pay for these services. You have access to Care Managers. Care Managers are nurses or care coordinators who support your health and well-being by providing additional services including: acute and chronic-care management, telephonic and in-person health support, assistance in coordinating Medicare and Medicaid benefits, educational resources and workshops, and support for families and caregivers.

To be eligible

To enroll in Humana Gold Plus SNP-DE H5619-076 (HMO D-SNP), a Dual Eligible Special Needs Plan, you must be entitled to Medicare Part A and enrolled in Medicare Part B, live in our service area and also receive certain levels of assistance from the Indiana Medicaid. If you receive both Medicare and Medicaid benefits, this means you are dual eligible.

Humana Gold Plus SNP-DE H5619-076 (HMO D-SNP) may enroll FBDE, QMB, QMB+, SLMB+.

Qualified Medicare Beneficiary (QMB): Helps pay Medicare Part A and Part B premiums, and other cost sharing (like deductibles, coinsurance, and copayments).

Qualified Medicare Beneficiary Plus (QMB+): Helps pay Medicare Part A and Part B premiums, and other cost-sharing (like deductibles, coinsurance, and copayments) and provides full Medicaid benefits for Medicaid services provided by Medicaid providers.

Specified Low-Income Medicare Beneficiary Plus (SLMB+): Helps pay Part B premiums and provides full Medicaid benefits for Medicaid services provided by Medicaid providers.

Full Benefit Dual Eligible (FBDE): Financial assistance may be available to pay Medicare Part A Premiums, and/or Medicare Part B Premiums, and other cost-sharing (like deductibles, coinsurance, and copayments) and provides full Medicaid benefits.

Plan name:

Humana Gold Plus SNP-DE H5619-076 (HMO D-SNP)

More about Humana Gold Plus SNP-DE H5619-076 (HMO D-SNP)

As a member of this plan, you will not be responsible for cost sharing for plan benefits. The Medicaid Comparison Chart shows specific benefits that Medicaid may cover for some dual eligible members. You will work with your Humana care coordinator to understand and access these benefits from the Indiana Medicaid after any Humana Gold Plus SNP-DE H5619-076 (HMO D-SNP) benefits are used. The Covered Medical and Hospital Benefits chart shows the benefits you will receive from Humana.

Be sure to show the Indiana Medicaid ID card in addition to your Humana membership card to make your provider aware that you also have Medicaid coverage. You may be required to pay a small Medicaid specific co-payment. Your services are paid first by Humana and then by Medicaid.

How to reach us:

If you have questions about your benefits or your level of eligibility for assistance from Medicaid, you should contact Humana's Customer Care department or the Indiana Medicaid for further details.

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**.

Medicaid benefits last validated on 07/01/2022 and are subject to change.

For the most current Indiana Medicaid coverage information, please visit the Indiana Medicaid website at **https://www.in.gov/medicaid/** or call the Medicaid Hotline at 1-800-457-4584 (TTY: 711).

A healthy partnership

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

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Monthly Premium, Deductible and Limits

Monthly plan premium	**$0** You must keep paying your Medicare Part B premium. Your Part A and/or Part B premium may be paid on your behalf by the Indiana Medicaid Program.
Medical deductible	This plan does not have a deductible.
Pharmacy (Part D) deductible	**$0** if you qualify for "Extra Help"
Maximum out-of-pocket responsibility	This plan does not have a maximum out-of-pocket responsibility.

Covered Medical and Hospital Benefits

	WHAT YOU PAY ON THIS HUMANA PLAN
ACUTE INPATIENT HOSPITAL CARE	
	$0 copay
OUTPATIENT HOSPITAL COVERAGE	
Outpatient surgery at outpatient hospital	**$0** copay
Outpatient surgery at ambulatory surgical center	**$0** copay
DOCTOR OFFICE VISITS	
Primary care provider (PCP)	**$0** copay
Specialists	**$0** copay
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

You do not need a referral to receive covered services from plan providers. Certain procedures, services and drugs may need advance approval from your plan. This is called a "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.

Covered Medical and Hospital Benefits (cont.)

	WHAT YOU PAY ON THIS HUMANA PLAN
	• 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 Any additional preventive services approved by Medicare during the contract year will be covered.
EMERGENCY CARE	
Emergency room If you are admitted to the hospital within 24 hours, you do not have to pay your share of the cost for the emergency care.	**$0** 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.	**$0** copay
DIAGNOSTIC SERVICES, LABS AND IMAGING	
Diagnostic mammography	**$0** copay
Diagnostic radiology	**$0** copay
Lab services	**$0** copay
Diagnostic tests and procedures	**$0** copay
Outpatient X-rays	**$0** copay
Radiation therapy	**$0** copay
HEARING SERVICES	
Medicare-covered hearing	**$0** copay
Routine hearing	**HER945** • **$0** copay for routine hearing exams up to 1 every year.

You do not need a referral to receive covered services from plan providers. Certain procedures, services and drugs may need advance approval from your plan. This is called a "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.

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	WHAT YOU PAY ON THIS HUMANA PLAN
	• **$0** copay for each Advanced level hearing aid up to 1 per ear every 3 years. Hearing aid purchase includes: • Unlimited follow-up provider visits during first year following TruHearing hearing aid purchase • 60-day trial period • 3-year extended warranty • 80 batteries per aid for non-rechargeable models **You must see a TruHearing provider to use this benefit. Call 1-844-255-7144 to schedule an appointment (for TTY, dial 711).**
DENTAL SERVICES	
Medicare-covered dental	**$0** copay
Routine dental Dental services are subject to our standard claims review procedures which could include dental history to approve coverage. Dental benefits under this plan may not cover all American Dental Association procedure codes. Information regarding each plan is available at **Humana.com/sb**. Network dentists have agreed to provide services at contracted fees (the in-network fee schedules, or INFS). If a member visits a participating network dentist, the member will not receive a bill for charges more than the negotiated fee schedule on covered services (coinsurance payment still applies). Use the HumanaDental Medicare network for the Mandatory Supplemental Dental. The provider locator can be found at	**DEN346** • **$0** copay for scaling and root planing (deep cleaning) up to 1 per quadrant every 3 years. • **$0** copay for comprehensive oral evaluation or periodontal exam, occlusal adjustment, scaling for moderate inflammation up to 1 every 3 years. • **$0** copay for bridges, complete dentures, crown recementation, denture recementation, panoramic film or diagnostic x-rays, partial dentures up to 1 every 5 years. • **$0** copay for crown, root canal, root canal retreatment up to 1 per tooth per lifetime. • **$0** copay for bitewing x-rays, intraoral x-rays up to 1 set(s) per year. • **$0** copay for adjustments to dentures, denture rebase, denture reline, denture repair, emergency diagnostic exam, tissue conditioning up to 1 per year. • **$0** copay for emergency treatment for pain, fluoride treatment, oral surgery, periodic oral exam, prophylaxis (cleaning) up to 2 per year. • **$0** copay for periodontal maintenance up to 4 per year. • **$0** copay for amalgam and/or composite filling, necessary anesthesia with covered service, simple or surgical extraction up to unlimited per year. • **$3000** maximum benefit coverage amount per year for preventive and comprehensive benefits.

You do not need a referral to receive covered services from plan providers. Certain procedures, services and drugs may need advance approval from your plan. This is called a "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.

Covered Medical and Hospital Benefits (cont.)

	WHAT YOU PAY ON THIS HUMANA PLAN
Humana.com > Find a Doctor > from the Search Type drop down select Dental > under Coverage type select All Dental Networks > enter zip code > from the network drop down select HumanaDental Medicare.	
VISION SERVICES	
Medicare-covered vision services	**$0** copay
Medicare-covered diabetic eye exam	**$0** copay
Medicare-covered glaucoma screening	**$0** copay
Medicare-covered eyewear (post-cataract)	**$0** copay
Routine vision The provider locator for routine vision can be found at **Humana.com** > Find a Doctor > select Vision care icon > Vision coverage through Medicare Advantage plans.	**VIS733** • **$0** copay for routine exam up to 1 per year. • **$300** maximum benefit coverage amount per year for contact lenses or eyeglasses-lenses and frames, fitting for eyeglasses-lenses and frames. • Eyeglass lens options may be available with the maximum benefit coverage amount up to 1 pair per year. • Maximum benefit coverage amount is limited to one time use per year.
MENTAL HEALTH SERVICES	
Inpatient Your plan covers up to 190 days in a lifetime for inpatient mental health care in a psychiatric hospital	**$0** copay
Outpatient group and individual therapy visits	**$0** copay
SKILLED NURSING FACILITY (SNF)	
Your plan covers up to 100 days in a SNF	**$0** copay
PHYSICAL THERAPY	
	$0 copay

You do not need a referral to receive covered services from plan providers. Certain procedures, services and drugs may need advance approval from your plan. This is called a "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.

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Covered Medical and Hospital Benefits (cont.)

	WHAT YOU PAY ON THIS HUMANA PLAN
AMBULANCE	
Ambulance	**$0** copay
TRANSPORTATION	
	$0 copay for plan approved location up to 24 one-way trip(s) per year. This benefit is not to exceed 150 miles per trip. The member *must* contact transportation vendor to arrange transportation and should contact Customer Care to be directed to their plan's specific transportation provider.
MEDICARE PART B DRUGS	
Chemotherapy drugs	**$0** copay
Other Part B drugs	**$0** copay

Prescription Drug Benefits

PRESCRIPTION DRUGS	
Medicare Part D Drugs	See chart below for plan coverage information for prescription drugs

$0 Rx Copay Benefit If you qualify for "Extra Help", you will pay **$0** for all Medicare Part D covered prescription drugs on your formulary, for all tiers, and through all stages.

Pharmacy options		
Mail Order	**Mail Order cost-sharing** **$0**	CenterWell Pharmacy™, Walmart Mail, PillPack Other pharmacies are available in our network. To find pharmacy mail order options go to **Humana.com/pharmacyfinder**
Retail	**Retail cost-sharing**	All network retail pharmacies
For generic drugs (including brand drugs treated as generic), either:	**30-day supply** **$0**	**90-day supply*** **$0**
For all other drugs, either:	**$0**	**$0**

Other pharmacies are available in our network.
*Some drugs are limited to a 30-day supply

You do not need a referral to receive covered services from plan providers. Certain procedures, services and drugs may need advance approval from your plan. This is called a "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.

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 pharmacy-specific cost-sharing, please call us or refer to Chapter 6 of the Evidence of Coverage for more details.

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

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

Catastrophic Coverage

After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach **$7,400**, you pay nothing for all drugs.

Additional Benefits

	WHAT YOU PAY ON THIS HUMANA PLAN
Medicare-covered foot care (podiatry)	**$0** copay
Medicare-covered chiropractic services	**$0** copay
MEDICAL EQUIPMENT/SUPPLIES	
Durable medical equipment (like wheelchairs or oxygen)	**$0** copay
Medical Supplies	**$0** copay
Prosthetics (artificial limbs or braces)	**$0** copay
Diabetic monitoring supplies	**$0** copay
REHABILITATION SERVICES	
Occupational and speech therapy	**$0** copay
Cardiac rehabilitation	**$0** copay
Pulmonary rehabilitation	**$0** copay
TELEHEALTH SERVICES (in addition to Original Medicare)	
Primary care provider (PCP)	**$0** copay
Specialist	**$0** copay
Urgent care services	**$0** copay
Substance abuse or behavioral health services	**$0** copay

Medicaid Benefit Comparison

The benefits described in the Covered Medical and Hospital Benefits sections above are covered by Humana Gold Plus SNP-DE H5619-076 (HMO D-SNP). Below is a comparison of benefits that some Medicaid eligible individuals could receive directly from the Indiana Medicaid. For each benefit listed below, you can see what the Indiana Medicaid covers and what our plan covers. All Medicaid benefits are subject to Medicaid eligibility guidelines and requirements, and are available only to full dual eligible individuals. If you have questions about your Medicaid eligibility and what benefits you are entitled to, review your member handbook or contact the Indiana Medicaid at 1-800-457-4584.

BENEFIT	MEDICAID BENEFIT	OUR PLAN BENEFIT
Acute inpatient hospital care	Covered	Covered
Ambulance	Covered	Covered
Ambulatory surgical center	Covered	Covered
Dentures	Covered	Covered
Diagnostic services/labs/imaging	Covered	Covered
Doctor office visits (Primary care provider (PCP)/specialists	Covered	Covered
Emergency care	Covered	Covered
Eyeglasses	Covered	Covered
Hearing aids	Covered	Covered
Home and community based waiver service programs	Covered	Not Covered
Inpatient hospital, nursing facility and intermediate care facility services in institutions for mental diseases (MD), age 65 and older	Covered	Covered with limitations
Inpatient psychiatric services, under age 21	Covered	Covered with limitations
Intermediate care facility for intellectual disabilities (ICF-IDD)	Covered	Not Covered
Intermediate care facility services for individuals with intellectual disabilities	Covered	Covered with limitations
Mental health services (outpatient group therapy and individual therapy visit)	Covered	Covered

BENEFIT	MEDICAID BENEFIT	OUR PLAN BENEFIT
Nursing facility services, other than in an institution for mental diseases	Covered	Covered with limitations
Outpatient hospital coverage	Covered	Covered
Personal emergency response system (PERS)	Not Covered	Covered
Physical therapy	Covered	Covered
Prescription drugs – Medicare Part B drugs	Covered	Covered
Prescription drugs – outpatient prescription drugs; Medicare covered & non-Medicare covered	Covered	Covered
Preventive care (e.g., flu vaccine, diabetic screenings)	Covered	Covered
Routine non-emergency medical transportation	Covered	Covered
Skilled nursing facility	Covered	Covered
Urgently needed services	Covered	Covered

More benefits with **your plan**

Enjoy some of these extra benefits included in your plan.
This is a summary of what we cover. It doesn't list every service that we cover or list every limitation or exclusion. The Evidence of Coverage (EOC) provides a complete list of coverage and services. Visit **Humana.com/medicare** to view a copy of the EOC or call **1-800-833-2364**.

Humana Flex Allowance

$1000 annual allowance on a prepaid card to use toward out of pocket costs for the plan's preventive and comprehensive dental, vision, or hearing services including copays.
Members can use this benefit at participating providers where the primary business is Dental Care, Vision Services, or Hearing Services and Visa® is accepted.
Cannot be used for procedures such as cosmetic dentistry and teeth whitening. Unused amount expires at the end of the plan year.

Allowance amounts cannot be combined with other benefit allowances. Limitations and restrictions may apply.

Humana Healthy Options Allowance

$125 automatically loaded on a prepaid card every month to use toward the purchase of food, over-the-counter (OTC) products, and home supplies from a national network of retailers. The card may also be used to pay for non-medical transportation, general supports for living (such as rent assistance, internet, and utilities), social needs, aging support and assistive devices, pest control, and pet care and supplies. Unused funds will roll over to the next month and expire at the end of the plan year. Allowance amounts cannot be combined with other benefit allowances. Limitations and restrictions may apply.

Humana Spending Account Card

The allowances listed below will be loaded onto this prepaid card. Each allowance is separate from any other allowance listed. Allowances shown are accessed by using this card. Allowance amounts cannot be combined with other benefit allowances. Limitations and restrictions may apply.

*Healthy Options Allowance
*Humana Flex Allowance

HMO Travel Benefit

Members can receive in-network benefits when services are received from a participating HMO National Network provider during their travels to other states and Puerto Rico.

Special Supplemental Benefits for the Chronically Ill (SSBCI) Humana Flexible Care Assistance

Humana Flexible Care Assistance is available to members with chronic health conditions, who are participating in care management services, and meet program criteria. Eligible members may receive medical expense assistance and other additional benefits, either primarily health related or non-primarily health related, to address the member's unique individual needs. Benefits are limited up to **$1,000** per year and must be coordinated and authorized by a care manager. There is no cost to participate.

Chiropractic services
Routine chiropractic:
$0 copay per visit for up to 12 visits.

Smoking cessation program
To further assist in your effort to quit smoking or tobacco product use, we cover one additional counseling quit attempt within a 12-month period as a service with no cost to you. This is in addition to the two counseling attempts provided by Medicare and includes up to four face-to-face visits. This service can be used for either preventive measures or for diagnosis with a tobacco related disease.

Routine foot care
$0 copay per visit for up to 6 visits

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

Personal Emergency Response System
The personal emergency response system provides help in emergency situations. The medical alert service comes with an installed in-home communication device and a wearable button. You have the choice between a push button unit (with or without AutoAlert fall detection) or a wrist unit (without AutoAlert).

Rewards and Incentives
Go365 by Humana® a Rewards and Incentive program for completing certain preventive health screenings and health and wellness activities.

Wigs (related to chemotherapy treatment)
Up to an unlimited maximum benefit per year.

SilverSneakers® fitness program
Basic fitness center membership including fitness classes.

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Find out **more**

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

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.

Humana has been approved by the National Committee for Quality Assurance (NCQA) to operate as a Special Needs Plan (SNP) until 12/31/2023 based on a review of Humana's Model of Care.

Your provider may choose to submit to the Indiana Medicaid for consideration of additional secondary payment for an amount applied to deductibles, coinsurance, or copayments. If you are Cost Share Protected, providers are required by federal regulation to accept Humana Gold Plus SNP-DE H5619-076 (HMO D-SNP) primary payment and the Indiana Medicaid secondary payment as payment in full for covered Medicare Part A and Part B services – even when the Medicaid payment is zero or a provider chooses to not submit to Medicaid.

If you are cost-share protected by the Indiana Medicaid, Humana Gold Plus SNP-DE H5619-076 (HMO D-SNP) providers aren't allowed to collect or bill you for services and items covered under Medicare Part A and Part B, including deductibles, coinsurance, and copayments – even when Medicaid payment is zero or a provider chooses to not submit to Medicaid. If a provider asks you to pay, that's against the law. You may however be responsible for a small Medicaid copayment.

If you are cost-share protected and you are billed or asked to pay the provider for deductibles, coinsurance, or copayments on covered Medicare Part A and Part B services tell your provider you are cost-share protected and can't be charged. If you have already made payment you have the right to a refund. If your provider will not stop billing, you can call us at 1-800-457-4708 or you can call Medicare at 1-800-Medicare (1-800-633-4227), (TTY 1-877-486-2048). Humana or Medicare can ask your provider to stop billing you and refund any payment you have made.

Telehealth services shown are in addition to the Original Medicare covered telehealth. Your cost may be different for Original Medicare telehealth.

Limitations on telehealth services, also referred to as virtual visits or telemedicine, vary by state. These services are not a substitute for emergency care and are not intended to replace your primary care provider or other providers in your network. Any descriptions of when to use telehealth services are for informational purposes only and should not be construed as medical advice. Please refer to your evidence of coverage for additional details on what your plan may cover or other rules that may apply.

Plans may offer supplemental benefits in addition to Part C benefits and Part D benefits.

Notes

Notes

Important

At Humana, it is important you are treated fairly.

Humana Inc. and its subsidiaries do not discriminate or exclude people because of their race, color, national origin, age, disability, sex, sexual orientation, gender, gender identity, ancestry, ethnicity, marital status, religion, or language. Discrimination is against the law. Humana and its subsidiaries comply with applicable federal civil rights laws. If you believe that you have been discriminated against by Humana or its subsidiaries, there are ways to get help.

- You may file a complaint, also known as a grievance:
  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 their Complaint Portal, available at **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf**, or 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.**
- **California residents:** You may also call California Department of Insurance toll-free hotline number: **1-800-927-HELP (4357)**, to file a grievance.

Auxiliary aids and services, free of charge, are available to you. 1-877-320-1235 (TTY: 711)

Humana provides 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.

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Multi-Language Insert

Multi-language Interpreter Services

English: We have free interpreter services to answer any questions you may have about our health or drug plan. To get an interpreter, just call us at 1-877-320-1235 (TTY: 711). Someone who speaks English can help you. This is a free service.

Spanish: Tenemos servicios de intérprete sin costo alguno para responder cualquier pregunta que pueda tener sobre nuestro plan de salud o medicamentos. Para hablar con un intérprete, por favor llame al 1-877-320-1235 (TTY: 711). Alguien que hable español le podrá ayudar. Este es un servicio gratuito.

Chinese Mandarin: 我们提供免费的翻译服务，帮助您解答关于健康或药物保险的任何疑问。如果您需要此翻译服务，请致电 1-877-320-1235 (TTY: 711)。我们的中文工作人员很乐意帮助您。这是一项免费服务。

Chinese Cantonese: 您對我們的健康或藥物保險可能存有疑問，為此我們提供免費的翻譯服務。如需翻譯服務，請致電 1-877-320-1235 (TTY: 711)。我們講中文的人員將樂意為您提供幫助。這是一項免費服務。

Tagalog: Mayroon kaming libreng serbisyo sa pagsasaling-wika upang masagot ang anumang mga katanungan ninyo hinggil sa aming planong pangkalusugan o panggamot. Upang makakuha ng tagasaling-wika, tawagan lamang kami sa 1-877-320-1235 (TTY: 711). Maaari kayong tulungan ng isang nakakapagsalita ng Tagalog. Ito ay libreng serbisyo.

French: Nous proposons des services gratuits d'interprétation pour répondre à toutes vos questions relatives à notre régime de santé ou d'assurance-médicaments. Pour accéder au service d'interprétation, il vous suffit de nous appeler au 1-877-320-1235 (TTY: 711). Un interlocuteur parlant Français pourra vous aider. Ce service est gratuit.

Vietnamese: Chúng tôi có dịch vụ thông dịch miễn phí để trả lời các câu hỏi về chương sức khỏe và chương trình thuốc men. Nếu quí vị cần thông dịch viên xin gọi 1-877-320-1235 (TTY: 711) sẽ có nhân viên nói tiếng Việt giúp đỡ quí vị. Đây là dịch vụ miễn phí.

German: Unser kostenloser Dolmetscherservice beantwortet Ihren Fragen zu unserem Gesundheits- und Arzneimittelplan. Unsere Dolmetscher erreichen Sie unter 1-877-320-1235 (TTY: 711). Man wird Ihnen dort auf Deutsch weiterhelfen. Dieser Service ist kostenlos.

Korean: 당사는 의료 보험 또는 약품 보험에 관한 질문에 답해 드리고자 무료 통역 서비스를 제공하고 있습니다 . 통역 서비스를 이용하려면 전화 1-877-320-1235 (TTY: 711) 번으로 문의해 주십시오 . 한국어를 하는 담당자가 도와 드릴 것입니다 . 이 서비스는 무료로 운영됩니다 .

Russian: Если у вас возникнут вопросы относительно страхового или медикаментного плана, вы можете воспользоваться нашими бесплатными услугами переводчиков. Чтобы воспользоваться услугами переводчика, позвоните нам по телефону 1-877-320-1235 (TTY: 711). Вам окажет помощь сотрудник, который говорит по-русски. Данная услуга бесплатная.

Arabic: إننا نقدم خدمات المترجم الفوري المجانية للإجابة عن أي أسئلة تتعلق بالصحة أو جدول الأدوية لدينا. للحصول على مترجم فوري، ليس عليك سوى الاتصال بنا على 1-877-320-1235 (TTY: 711). سيقوم شخص ما يتحدث العربية بمساعدتك. هذه خدمة مجانية.

Hindi: हमारे स्वास्थ्य या दवा की योजना के बारे में आपके किसी भी प्रश्न के जवाब देने के लिए हमारे पास मुफ्त दुभाषिया सेवाएँ उपलब्ध हैं. एक दुभाषिया प्राप्त करने के लिए, बस हमें 1-877-320-1235 (TTY: 711) पर फोन करें. कोई व्यक्ति जो हिन्दी बोलता है आपकी मदद कर सकता है. यह एक मुफ्त सेवा है.

Italian: È disponibile un servizio di interpretariato gratuito per rispondere a eventuali domande sul nostro piano sanitario e farmaceutico. Per un interprete, contattare il numero 1-877-320-1235 (TTY: 711). Un nostro incaricato che parla Italianovi fornirà l'assistenza necessaria. È un servizio gratuito.

Portugues: Dispomos de serviços de interpretação gratuitos para responder a qualquer questão que tenha acerca do nosso plano de saúde ou de medicação. Para obter um intérprete, contacte-nos através do número 1-877-320-1235 (TTY: 711). Irá encontrar alguém que fale o idioma Português para o ajudar. Este serviço é gratuito.

French Creole: Nou genyen sèvis entèprèt gratis pou reponn tout kesyon ou ta genyen konsènan plan medikal oswa dwòg nou an. Pou jwenn yon entèprèt, jis rele nou nan 1-877-320-1235 (TTY: 711). Yon moun ki pale Kreyòl kapab ede w. Sa a se yon sèvis ki gratis.

Polish: Umożliwiamy bezpłatne skorzystanie z usług tłumacza ustnego, który pomoże w uzyskaniu odpowiedzi na temat planu zdrowotnego lub dawkowania leków. Aby skorzystać z pomocy tłumacza znającego język polski, należy zadzwonić pod numer 1-877-320-1235 (TTY: 711). Ta usługa jest bezpłatna.

Japanese: 当社の健康健康保険と薬品処方薬プランに関するご質問にお答えするために、無料の通訳サービスがありますございます。通訳をご用命になるには、1-877-320-1235 (TTY: 711) にお電話ください。日本語を話す人者が支援いたします。これは無料のサービスです。

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