2024

Summary of Benefits

HumanaChoice Value H2029-001 (PPO)

Puerto Rico
Puerto Rico Island Wide

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Our service area is Puerto Rico.

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 **1-800-681-3625 (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 **1-800-681-3625 (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

- ☐ 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, 2025.
- ☐ **Effect on Current Coverage.** If you are currently enrolled in a Medicare Advantage plan, your current Medicare Advantage healthcare coverage will end once your new Medicare Advantage coverage starts. If you have Tricare, your coverage may be affected once your new Medicare Advantage coverage starts. Please contact Tricare for more information. If you have a Medigap plan, once your Medicare Advantage coverage starts, you may want to drop your Medigap policy because you will be paying for coverage you cannot use.
- ☐ Our plan allows you to see providers outside of our network (non-contracted providers). However, while we will pay for covered services, 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.

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Let's talk about HumanaChoice Value H2029-001 (PPO)

Find out more about the HumanaChoice Value H2029-001 (PPO) plan - including the health and drug services it covers - in this easy-to-use guide.

HumanaChoice Value H2029-001 (PPO) is a Medicare Advantage PPO 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, please refer to the plan's Evidence of Coverage on our website, **Humana.com/plandocuments**.

To be eligible

To join HumanaChoice Value H2029-001 (PPO), you must be entitled to Medicare Part A, be enrolled in Medicare Part B and live in our service area.

Plan name:

HumanaChoice Value H2029-001 (PPO)

How to reach us:

If you're a member of this plan, call toll-free: **1-866-773-5959 (TTY: 711)**.

If you're **not** a member of this plan, call toll free: **1-800-681-3625 (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 HumanaChoice Value H2029-001 (PPO)

Do you have Medicare and Medicaid? If you are a dual-eligible beneficiary enrolled in both Medicare and your state Medicaid program, you may not have to pay the medical costs displayed in this booklet and your prescription drug costs may 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). HumanaChoice Value H2029-001 (PPO) 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

PLAN COSTS	
Monthly plan premium	**$44** If you receive premium assistance, your plan premium may be reduced. You must keep paying your Medicare Part B premium.
Medical deductible	This plan does not have a deductible.
Pharmacy (Part D) deductible	**$0** deductible.
Maximum out-of-pocket responsibility	**$6,700** in-network **$10,000** combined in- and out-of-network The most you pay for copays, coinsurance and other costs for covered medical services for the year.

Covered Medical and Hospital Benefits

	IN-NETWORK	OUT-OF-NETWORK
INPATIENT HOSPITAL CARE		
Your plan covers an unlimited number of days for an inpatient stay.	**$0** copay per admit	**20%** of the cost
OUTPATIENT HOSPITAL COVERAGE Services listed below may also be covered at other places of treatment. Please refer to specific services listed in this document for additional information.		
Advanced imaging services (MRI, MRA, PET and CT scan)	**$50** copay	**20%** of the cost
Basic radiological services (X-rays)	**10%** of the cost	**20%** of the cost
Cardiac rehabilitation services	**$30** copay	**20%** of the cost
Chemotherapy drugs	**10%** of the cost	**20%** of the cost
Diagnostic colonoscopy	**$50** copay	**20%** of the cost
Diagnostic mammography	**$50** copay	**20%** of the cost
Diagnostic procedures and tests - other	**$50** copay	**20%** of the cost
Lab services	**10%** of the cost	**20%** of the cost
Medicare Part B covered drugs	**10%** of the cost	**20%** of the cost
Mental health services	**$50** copay	**20%** of the cost

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.)

	IN-NETWORK	OUT-OF-NETWORK
Nuclear medicine services	**$50** copay	**20%** of the cost
Occupational therapy	**$40** copay	**20%** of the cost
Opioid treatment program services	**$50** copay	**20%** of the cost
Physical therapy	**$40** copay	**20%** of the cost
Pulmonary rehabilitation services	**$15** copay	**20%** of the cost
Renal dialysis services	**20%** of the cost	**20%** of the cost
Sleep study (facility based)	**$50** copay	**20%** of the cost
Speech therapy	**$40** copay	**20%** of the cost
Substance abuse care	**$50** copay	**20%** of the cost
Supervised exercise therapy (SET) for Peripheral Artery Disease (PAD)	**$25** copay	**20%** of the cost
Surgery services	**$50** copay	**20%** of the cost
Therapeutic radiology (Radiation therapy)	**10%** of the cost	**20%** of the cost
Wound care	**$20** copay	**20%** of the cost
AMBULATORY SURGERY CENTER		
Diagnostic colonoscopy	**$8** copay	**20%** of the cost
Surgery services	**$0** copay	**20%** of the cost
DOCTOR OFFICE VISITS		
Primary care provider (PCP)	**$0** copay	**20%** of the cost
Specialist's office	**$8** copay	**20%** of the cost
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 screening & counseling • Annual Wellness Visit (AWV) • Bone mass measurement	**$0** copay or **20%** of the cost, depending on the service and where service is provided Any additional preventive services approved by Medicare during the contract year will be covered.

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.

	IN-NETWORK	OUT-OF-NETWORK
	• Breast cancer screening (mammogram) • Cardiovascular disease risk reduction visit • Cardiovascular disease screenings • Cervical and vaginal cancer screening • Colorectal cancer screening • Depression screening • Diabetes screenings • Diabetes self-management training • Glaucoma screening • HIV screening • Immunizations • Lung Cancer Screening • Medical nutrition therapy • Medicare Diabetes Prevention Program (MDPP) • Obesity screening and therapy • Prostate cancer screening • Routine physical exam • Sexually transmitted infections (STIs) screening and counseling • Smoking and tobacco use cessation (counseling to stop smoking or tobacco use) • "Welcome to Medicare" preventive visit Any additional preventive services approved by Medicare during the contract year will be covered.	
EMERGENCY CARE		
Emergency services at 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.	**$75** copay	**$75** copay

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Covered Medical and Hospital Benefits (cont.)

	IN-NETWORK	OUT-OF-NETWORK
Physician and professional services at emergency room	**$0** copay	**$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.	**$15** copay at an urgent care center	**$15** copay at an urgent care center
DIAGNOSTIC SERVICES, LABS AND IMAGING		
Advanced imaging services (MRI, MRA, PET and CT scan)		
• Freestanding radiological facility	**$8** copay	**20%** of the cost
• Primary care physician's office	**$0** copay	**20%** of the cost
• Specialist's office	**$8** copay	**20%** of the cost
Basic radiological services (X-rays)		
• Freestanding radiological facility	**10%** of the cost	**20%** of the cost
• Primary care physician's office	**$0** copay	**20%** of the cost
• Specialist's office	**$8** copay	**20%** of the cost
• Urgent care center	**$15** copay	**20%** of the cost
Diagnostic colonoscopy at an ambulatory surgery center	**$8** copay	**20%** of the cost
Diagnostic mammography		
• Freestanding radiological facility	**$0** copay	**20%** of the cost
• Specialist's office	**$8** copay	**20%** of the cost
Diagnostic procedures and tests		
• Primary care physician's office	**$0** copay	**20%** of the cost
• Specialist's office	**$8** copay	**20%** of the cost
• Urgent care center	**$15** copay	**20%** of the cost
Lab services		
• Freestanding laboratory	**10%** of the cost	**20%** of the cost
• Primary care physician's office	**$0** copay	**20%** of the cost
• Specialist's office	**$0** copay	**20%** of the cost
• Urgent care center	**10%** of the cost	**20%** of the cost

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.)

	IN-NETWORK	OUT-OF-NETWORK
Nuclear medicine and services at a freestanding radiological facility	**$8** copay	**20%** of the cost
Sleep study		
• Member's home	**$0** copay	**20%** of the cost
• Specialist's office	**$8** copay	**20%** of the cost
Therapeutic Radiology (Radiation therapy)		
• Freestanding radiological facility	**10%** of the cost	**20%** of the cost
• Specialist's office	**10%** of the cost	**20%** of the cost
HEARING SERVICES		
Medicare-covered hearing	**$8** copay	**20%** of the cost
Mandatory supplemental hearing benefit	**HER763** • **$0** copay for fitting/evaluation, routine hearing exams up to 1 per year. • **$500** combined in and out of network maximum benefit coverage amount for each hearing aid(s) (all types) up to 1 per ear per year.	**HER763** • **$0** copay for fitting/evaluation, routine hearing exams up to 1 per year. • **$500** combined in and out of network maximum benefit coverage amount for each hearing aid(s) (all types) up to 1 per ear per year. • Benefits received out-of-network are subject to any in-network benefit maximums, limitations, and/or exclusions. If a provider who is not in our network is not willing to bill us directly, you may have to pay upfront and submit a request for reimbursement. See Chapter 2 Payment Requests Contact Information in your Evidence of Coverage or visit **Humana.com** for information on requesting reimbursement.
DENTAL SERVICES The cost-share indicated below is what you pay for the covered service.		
Medicare-covered dental	**$8** copay	**20%** of the cost

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Covered Medical and Hospital Benefits (cont.)

	IN-NETWORK	OUT-OF-NETWORK
Mandatory supplemental dental benefit Limitations and exclusions may apply. Dental benefits under this plan may not cover all ADA procedure codes. Any services received that are not listed will not be covered by the plan and will be the member's responsibility. The member is responsible for any amount above the dental coverage limit. Benefits are offered on a calendar year basis. Any amount unused at the end of the year will expire. In-network dentists have agreed to provide covered services at contracted rates (per the in-network fee schedules, or INFS). If a member visits a participating network dentist, the member cannot be billed for charges that exceed the negotiated fee schedule (annual maximum still applies). Out-of-network dentists have not agreed to provide services at contracted fees. Benefits received out-of-network are subject to any in-network benefit maximums, limitations and/or exclusions. Members may be billed by the out-of-network provider for any amount greater than the payment made by Humana to the provider. Network providers agree to bill us directly. If a provider who is not in our network is not willing to bill us	**DEN548** • **0%** of the cost for bitewing x-rays up to 1 set(s) every 2 years. • **0%** of the cost for periodontal surgery up to 1 per quadrant every 3 years. • **0%** of the cost for amalgam or composite filling up to 1 per tooth every 3 years. • **0%** of the cost for comprehensive oral exam, cone beam CT imaging, panoramic film up to 1 every 3 years. • **0%** of the cost for crown, implant supported prosthetics up to 1 per tooth every 5 years. • **0%** of the cost for bridges, complete dentures, complete or partial denture reline, partial dentures up to 1 every 5 years. • **0%** of the cost for implant services, other restorative services - core buildup and prefabricated post and core up to 1 per tooth per lifetime. • **0%** of the cost for scaling and root planing (deep cleaning) up to 1 per quadrant per year. • **0%** of the cost for periodontal debridement up to 1 per year. • **0%** of the cost for pulp vitality test up to 2 per quadrant per year. • **0%** of the cost for periodic oral exam, periodontal maintenance, prophylaxis (cleaning) up to 2 per year. • **0%** of the cost for complete or partial denture repair up to 3 per year.	**DEN548** • **50%** of the cost for bitewing x-rays up to 1 set(s) every 2 years. • **50%** of the cost for periodontal surgery up to 1 per quadrant every 3 years. • **50%** of the cost for amalgam or composite filling up to 1 per tooth every 3 years. • **50%** of the cost for comprehensive oral exam, cone beam CT imaging, panoramic film up to 1 every 3 years. • **50%** of the cost for crown, implant supported prosthetics up to 1 per tooth every 5 years. • **50%** of the cost for bridges, complete dentures, complete or partial denture reline, partial dentures up to 1 every 5 years. • **50%** of the cost for implant services, other restorative services - core buildup and prefabricated post and core up to 1 per tooth per lifetime. • **50%** of the cost for scaling and root planing (deep cleaning) up to 1 per quadrant per year. • **50%** of the cost for periodontal debridement up to 1 per year. • **50%** of the cost for pulp vitality test up to 2 per quadrant per year. • **50%** of the cost for periodic oral exam, periodontal maintenance, prophylaxis (cleaning) up to 2 per year. • **50%** of the cost for complete or partial denture repair up to 3 per 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.

Covered Medical and Hospital Benefits (cont.)

	IN-NETWORK	OUT-OF-NETWORK
directly, you may have to pay upfront and submit a request for reimbursement. The coinsurance level will apply to the average negotiated in-network fee schedule (INFS) in your area. See Chapter 2 Payment Requests Contact Information in your Evidence of Coverage or visit **Humana.com** for information on requesting reimbursement. When visiting an out-of-network provider there could be a difference between Humana's reimbursement and the dentist's charges. Members are responsible for this difference when visiting an out-of-network provider; this is known as balanced billing.	• **0%** of the cost for intraoral x-rays up to 6 per year. • **0%** of the cost for adjustments to dentures, extractions, root canal up to unlimited per year. • **$1,500** combined maximum benefit coverage amount per year for adjustments to dentures, bridges, complete dentures, complete or partial denture reline, complete or partial denture repair, crown, implant services, implant supported prosthetics, other restorative services - core buildup and prefabricated post and core, partial dentures comprehensive benefits.	• **50%** of the cost for intraoral x-rays up to 6 per year. • **50%** of the cost for adjustments to dentures, extractions, root canal up to unlimited per year. • **$1,500** combined maximum benefit coverage amount per year for adjustments to dentures, bridges, complete dentures, complete or partial denture reline, complete or partial denture repair, crown, implant services, implant supported prosthetics, other restorative services - core buildup and prefabricated post and core, partial dentures comprehensive benefits. • Benefits received out-of-network are subject to any in-network benefit maximums, limitations, and/or exclusions.
VISION SERVICES		
Eyewear (post cataract surgery)	**$0** copay	**$0** copay
Medicare-covered diabetic eye exam	**$0** copay	**20%** of the cost
Medicare-covered vision services	**$8** copay	**20%** of the cost

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Covered Medical and Hospital Benefits (cont.)

	IN-NETWORK	OUT-OF-NETWORK
Mandatory supplemental vision benefit	**VIS317** • **$40** combined maximum benefit coverage amount per year for routine exam 1 per year. • **$500** combined maximum benefit coverage amount per year for contact lenses and/or eyeglasses-lenses and frames up to unlimited pair(s) per year, fitting for eyeglasses-lenses and frames up to unlimited per year. • Eyeglasses include ultraviolet protection and scratch resistant coating.	**VIS317** • **$40** combined maximum benefit coverage amount per year for routine exam 1 per year. • **$500** combined maximum benefit coverage amount per year for contact lenses and/or eyeglasses-lenses and frames up to unlimited pair(s) per year, fitting for eyeglasses-lenses and frames up to unlimited per year. • Eyeglasses include ultraviolet protection and scratch resistant coating. • 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	**$0** copay per admit	**20%** of the cost
Therapy visits		
• Partial hospitalization	**$0** copay	**20%** of the cost
• Specialist's office	**$8** copay	**20%** 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 **$25** copay per day for days 21-100	**20%** of the cost for days 1-100
PHYSICAL THERAPY		
Comprehensive outpatient rehab facility	**$20** copay	**20%** of the cost
Specialist's office	**$20** copay	**20%** of the cost

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Covered Medical and Hospital Benefits (cont.)

	IN-NETWORK	OUT-OF-NETWORK
AMBULANCE		
Air	**20%** of the cost	**20%** of the cost
Ground	**$100** copay per date of service	**$100** copay per date of service
TRANSPORTATION		
	$0 copay for plan approved location up to 24 one-way trip(s) per year. This benefit offers unlimited 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		
Allergy shots and serum		
• Primary care physician's office	**$0** copay	**$0** copay
• Specialist's office	**$0** copay	**$0** copay
Chemotherapy drugs at a specialist's office	**10%** of the cost	**20%** of the cost
Other Part B drugs Some rebatable Part B drugs may be subject to a lower coinsurance. You pay no more than $35 for a one-month (up to 30-day) supply for all Part B insulin covered by our plan, and if your plan has a deductible it does not apply to Part B insulin.		
• Pharmacy	**10%** of the cost	**20%** of the cost
• Primary care physician's office	**10%** of the cost	**20%** of the cost
• Specialist's office	**10%** of the cost	**20%** of the cost

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Prescription Drug Benefits

PLAN HIGHLIGHTS	
$0 copays	**$0** copays at select pharmacy locations and tiers. Additional details below
Deductible	**$0** Deductible
Insulin costs	You won't pay more than **$0** for a one-month (up to 30-day) supply of each insulin product covered by your plan
Additional gap coverage	Additional gap coverage for the following: Insulin
Excluded drug coverage	Additional drug coverage for the following: Erectile dysfunction (ED) drugs Prescription Vitamins
$0 vaccines	**$0** copay for adult Part D covered vaccines recommended by the Advisory Committee on Immunization Practices (ACIP)

DEDUCTIBLE

This plan has a **$0** deductible.

INITIAL COVERAGE

You pay the following until your total yearly drug costs for covered drugs reach **$5,030**. Total yearly drug costs are the total drug costs paid by both you and our plan. Once you reach this amount, you will enter the Coverage Gap.

Pharmacy Cost-Sharing						
	Retail Cost-Sharing Includes all in-network retail pharmacies		**Standard Mail-Order Cost-Sharing**		**Preferred Mail-Order Cost-Sharing** CenterWell Pharmacy™	
Day supply	**30-day**	**90-day***	**30-day**	**90-day***	**30-day**	**90-day***
Tier 1: Preferred Generic	$0	$0	$0	$0	$0	$0
Tier 2: Generic	$0	$0	$0	$0	$0	$0
Tier 3: Preferred Brand	$25	$75	$26	$78	$25	$65
Tier 4: Non-Preferred Drug	$40	$120	$40	$120	$40	$110
Tier 5: Specialty Tier	33%	N/A	33%	N/A	33%	N/A
Tier 6: Select Care Drugs	$0	$0	$0	$0	$0	$0

Other pharmacies are available in your network. To find which pharmacies are available in your network, go to **Humana.com/pharmacyfinder**.
*Some drugs are limited to a 30-day supply.

You won't pay more than **$0** for a one-month (up to 30-day) supply of each plan-covered insulin product regardless of cost-sharing tier.

Insulin Cost-Sharing						
	Retail Cost-Sharing Includes all in-network retail pharmacies		**Standard Mail-Order Cost-Sharing**		**Preferred Mail-Order Cost-Sharing** CenterWell Pharmacy™	
Day supply	**30-day**	**90-day***	**30-day**	**90-day***	**30-day**	**90-day***
Tier 3: Preferred Brand	$0	$0	$0	$0	$0	$0
Tier 5: Specialty Tier	$0	N/A	$0	N/A	$0	N/A

Other pharmacies are available in your network. To find which pharmacies are available in your network, go to **Humana.com/pharmacyfinder**.

*Some drugs are limited to a 30-day supply.

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COVERAGE GAP

After you enter the coverage gap, you pay **25 percent** of the plan's cost for covered brand name drugs and **25 percent** of the plan's cost for covered generic drugs until your out-of-pocket costs total **$8,000** — which is the end of the coverage gap. Not everyone will enter the coverage gap.

Under this plan, **you may pay even less** for the following:

Tier 3 (Preferred Brand) - Insulin

Tier 5 (Specialty Tier) - Insulin

For more information on cost sharing in the coverage gap, please call us or access your Evidence of Coverage online.

CATASTROPHIC COVERAGE

After your yearly out-of-pocket drug costs reach **$8,000** you pay **$0** for plan-covered Part D and Excluded drugs.

EXCLUDED DRUG COVERAGE

Erectile dysfunction (ED) drugs	Covered at Tier 1 cost-share amount.
Prescription Vitamins	Covered at Tier 1 cost-share amount.

Cost sharing may change depending on the pharmacy you choose or when you enter another phase of the Part D benefit. For more information on your prescription drug benefit, please call us or access your Evidence of Coverage online.

If you reside at an in-network long-term care facility, you pay the same as you would at an in-network retail pharmacy. Under certain situations you may be able to get drugs from an out-of-network pharmacy but may pay more than you would pay at an in-network pharmacy.

Additional Benefits

	IN-NETWORK	OUT-OF-NETWORK
Chiropractic services (Medicare-covered)	**$15** copay	**20%** of the cost
Podiatry services (Medicare-covered)	**$8** copay	**20%** of the cost
Acupuncture services (Medicare-covered)	**$8** copay for acupuncture for chronic low back pain visits up to 20 visit(s) per year.	**10%** coinsurance for acupuncture for chronic low back pain visits up to 20 visit(s) per year. Benefits received out-of-network are subject to any in-network benefit maximums, limitations, and/or exclusions.

MEDICAL EQUIPMENT/SUPPLIES		
Diabetic monitoring supplies • Diabetic supplier • Network retail pharmacy • Preferred diabetic supplier	 **$0** copay **$0** copay **$0** copay	 **20%** of the cost **20%** of the cost **Not Covered**
Durable medical equipment (DME) and related supplies – High Cost	**5%** of the cost	**20%** of the cost
Durable medical equipment (DME) and related supplies – All Other	**$0** copay	**20%** of the cost
Medical supplies at medical supplier	**$0** copay	**20%** of the cost
Prosthetics devices and related supplies at prosthetics provider	**$0** copay	**20%** of the cost
REHABILITATION SERVICES		
Cardiac rehabilitation services at a specialist's office	**$8** copay	**20%** of the cost
Occupational therapy • Comprehensive outpatient rehab facility • Specialist's office	 **$20** copay **$20** copay	 **20%** of the cost **20%** of the cost
Physical therapy • Comprehensive outpatient rehab facility • Specialist's office	 **$20** copay **$20** copay	 **20%** of the cost **20%** of the cost
Pulmonary rehabilitation services at a specialist's office	**$8** copay	**20%** of the cost
Speech therapy • Comprehensive outpatient rehab facility • Specialist's office	 **$20** copay **$20** copay	 **20%** of the cost **20%** of the cost
Supervised exercise therapy (SET) for Peripheral Artery Disease (PAD) at a specialist's office	**$8** copay	**20%** of the cost
TELEHEALTH SERVICES (in addition to Original Medicare)		
Primary care physician's office	**$0** copay	**Not Covered**
Specialist's office	**$8** copay	**Not Covered**

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Substance abuse or behavioral health services	**$0** copay	**Not Covered**
Urgent care services	**$0** copay	**Not 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/plandocuments** to view a copy of the EOC or call **1-800-681-3625** .

Over-the-Counter (OTC) Allowance

$20 monthly allowance on a prepaid card to buy approved over-the-counter health and wellness products at participating retail locations.

Allowance amount cannot be combined with other allowances which may be on the Card.

Unused amount rolls over to the next month and expires at the end of the plan year.

- The allowance is available to use at the beginning of every month.
- Limitations and restrictions may apply.

See the Humana Spending Account Card section for more details.

Humana Spending Account Card

The Humana Spending Account Card is what you use to spend allowances included in this plan. If your previous plan had a Humana Spending Account Card, please keep using the same card. If your previous plan did not have a Humana Spending Account Card, please activate your card as soon as you receive it in the mail.

Please keep this card even after the allowance is spent as future allowance amounts will be added to this card.

- Humana is not responsible for funds lost due to lost or stolen cards.
- Please see the back of your card for more information.
- Allowance amounts cannot be combined with other benefit allowances on the card.
- Limitations and restrictions may apply.

Bathroom safety device

$0 copayment for one (1) contracted standard bath or shower chair with or without wheels, any size every 5 years to members who meet the medical criteria.
Prior authorization requirements may apply.

Blood pressure monitor

You may receive one blood pressure monitor every five (5) years.

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

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

SilverSneakers® fitness program
Basic fitness center membership including in person and digital fitness classes.

Notes

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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 **1-866-773-5959** 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. 1-866-773-5959 (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 1-866-773-5959 (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 1-866-773-5959 (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 1-866-773-5959 (听障专线 : 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 1-866-773-5959 (聽障專線 : 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 1-866-773-5959 (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 1-866-773-5959 (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 1-866-773-5959 (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 1-866-773-5959 (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 1-866-773-5959 (TTY: 711) 번으로 문의해 주십시오 . 한국어를 하는 담당자가 도와 드릴 것입니다 . 이 서비스는 무료로 운영됩니다 .

Form CMS-10802 (Expires 12/31/25) Form Approved OMB# 0938-1421

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 1-866-773-5959 (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 بخطتنا الصحية أو خطة الأدوية الموصوفة لدينا. للحصول على مترجم فوري، ليس عليك سوى الاتصال بنا على 1-866-773-5959 (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 1-866-773-5959 (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 1-866-773-5959 (TTY: 711). Un nostro incaricato che parla Italianovi fornirà l'assistenza necessaria. È un servizio gratuito.

Portuguese: 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 1-866-773-5959 (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 1-866-773-5959 (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 1-866-773-5959 (TTY: 711). Ta usługa jest bezpłatna.

Japanese：当社の健康保険と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をご用意しています。通訳をご用命になるには、1-866-773-5959 (TTY：711) にお電話ください。日本語を話す者が支援いたします。これは無料のサービスです。

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.

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.

Out-of-network/non-contracted providers are under no obligation to treat Humana members, except in emergency situations. Please call our customer service number or see your Evidence of Coverage for more information, including the cost-sharing that applies to out-of-network services.

The information you need is just a click away.

Visit Humana.com/PlanDocuments to check details about your plan, including benefits and costs.

If you'd like a printed Evidence of Coverage, Provider Directory, or Drug List mailed to you, you can request one online at the website above, or call **1-800-457-4708 (TTY: 711)**, 24 hours a day, seven days a week. Please have your Humana member ID card ready when you call. When asked for the reason you've called, say "Evidence of Coverage," "Drug List" or "Provider Directory."

Activate your secure MyHumana account.

Your online MyHumana account is an important part of your Humana membership. Use it to view your plan details anytime and access important plan documents online, all in one place. It's easy to use and tailored to you.

Already have an account?

Go to **Humana.com/MyHumanaPlan** and log in.

Don't have an account yet?

Create one using the same link above in just minutes.

Complete your Medicare Health Assessment

Reply to nine simple questions about your health. Your answers will help us guide you to tools and resources in your plan that may help you reach your health goals and live the way you want.

Two easy options

Call our automated voice service at **888-445-3379 (TTY: 711)**. Have your eight-digit member ID number handy—it's located on the front of your Humana member ID card.
OR log in to your MyHumana account.

Receiving information about other insurance products

As a Humana member, we may call you to offer other insurance-related products. You can opt out of those future calls by calling the Customer Care number on the back of your ID card.

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Humana Inc.
P.O. Box 14168
Lexington, KY 40512-4168

Important information about your plan

Humana.com

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