Summary of Benefits

Optional Supplemental Benefits

HumanaChoice H5216-019 (PPO)

Kentucky, West Virginia, Indiana

Our service area includes the following county/counties in Indiana: Adams, Allen, Bartholomew, Brown, Cass, Clark, Crawford, Daviess, Decatur, DeKalb, Dubois, Elkhart, Floyd, Fulton, Gibson, Grant, Harrison, Huntington, Jackson, Jefferson, Jennings, Kosciusko, La Porte, Lagrange, Lawrence, Marshall, Martin, Miami, Monroe, Noble, Orange, Pike, Posey, Pulaski, Ripley, Scott, Spencer, St. Joseph, Starke, Steuben, Vanderburgh, Wabash, Warrick, Washington, Wells, Whitley

Kentucky: Anderson, Bath, Bourbon, Boyle, Bullitt, Clark, Fayette, Franklin, Hardin, Henderson, Henry, Jackson, Jefferson, Jessamine, Lincoln, Madison, Marion, McCracken, Menifee, Montgomery, Nelson, Oldham, Powell, Scott, Shelby, Spencer, Webster, Woodford West Virginia: Berkeley, Boone, Braxton, Cabell, Clay, Fayette, Hardy, Jefferson, Kanawha, Lewis, Lincoln, Mason, Mercer, Monroe, Morgan, Nicholas, Pendleton, Putnam, Roane, Upshur, Wayne, Webster.

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)**.

Unde	rstanding 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.
Unde	rstanding 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.



Let's talk about HumanaChoice H5216-019 (PPO)

Find out more about the HumanaChoice H5216-019 (PPO) plan - including the health and drug services it covers - in this easy-to-use guide.

HumanaChoice H5216-019 (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 H5216-019 (PPO), you must be entitled to Medicare Part A, be enrolled in Medicare Part B and live in our service area.

Plan name:

HumanaChoice H5216-019 (PPO)

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 HumanaChoice H5216-019 (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 H5216-019 (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

P	LAN	C)S	T

Monthly plan premium	\$41 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	\$5,800 in-network \$9,550 combined in- and out-of-network	
	The most you pay for copays, coinsurance and other costs for covered medical services for the year.	

Co Co

Covered Medical and Hospital Benefits

V		
	IN-NETWORK	OUT-OF-NETWORK
INPATIENT HOSPITAL CARE		
Your plan covers an unlimited number of days for an inpatient stay.	\$390 copay per day for days 1-5 \$0 copay per day for days 6-90	50% of the cost
OUTPATIENT HOSPITAL COVERAGE Services listed below may also be co- listed in this document for addition	overed at other places of treatment.	Please refer to specific services
Advanced imaging services (MRI, MRA, PET and CT scan)	\$300 copay	50% of the cost
Basic radiological services (X-rays)	\$125 copay	50% of the cost
Cardiac rehabilitation services	\$10 copay	50% of the cost
Chemotherapy drugs	20% of the cost	50% of the cost
Diagnostic colonoscopy	\$0 copay	50% of the cost
Diagnostic mammography	\$0 copay	50% of the cost
Diagnostic procedures and tests - other	\$105 copay	50% of the cost
Lab services	\$0 copay	50% of the cost
Medicare Part B covered drugs	20% of the cost	20% of the cost
Mental health services	\$95 copay	50% 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 services 50%** of the cost **\$525** copay Occupational therapy **\$40** copay 50% of the cost Opioid treatment program **\$95** copay **50%** of the cost services Physical therapy **\$40** copay 50% of the cost **Pulmonary rehabilitation 50%** of the cost **\$10** copay services Renal dialysis services 20% of the cost 20% of the cost Sleep study (facility based) **50%** of the cost **\$105** copay Speech therapy **50%** of the cost **\$40** copay Substance abuse care **50%** of the cost **\$95** copay Supervised exercise therapy **\$10** copay **50%** of the cost (SET) for Peripheral Artery Disease (PAD) Surgery services **50%** of the cost **\$390** copay Therapeutic radiology 20% of the cost **50%** of the cost (Radiation therapy) **Wound care 50%** of the cost **\$45** copay **AMBULATORY SURGERY CENTER**

Our plan covers many preventive services at no cost when you see an in-network provider including:

• Abdominal aortic aneurysm screening

\$0 copay

\$340 copay

\$10 copay

\$45 copay

- Alcohol misuse screening & counseling
- Annual Wellness Visit (AWV)
- Bone mass measurement

\$0 copay or **50%** of the cost, depending on the service and where service is provided

50% of the cost

50% of the cost

50% of the cost

50% of the cost

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.

Diagnostic colonoscopy

DOCTOR OFFICE VISITS

Primary care provider (PCP)

Surgery services

Specialist's office

PREVENTIVE CARE

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.

\$120 copay

\$120 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.

	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.	\$60 copay at an urgent care center	\$60 copay at an urgent care center
DIAGNOSTIC SERVICES, LABS ANI	D IMAGING	
Advanced imaging services		
(MRI, MRA, PET and CT scan)Freestanding radiological facility	\$200 copay	50% of the cost
 Primary care physician's office 	\$200 copay	50% of the cost
Specialist's office	\$200 copay	50% of the cost
Basic radiological services		
(X-rays)Freestanding radiological facility	\$50 copay	50% of the cost
 Primary care physician's office 	\$10 copay	50% of the cost
Specialist's office	\$45 copay	50% of the cost
• Urgent care center	\$60 copay	50% of the cost
Diagnostic colonoscopy at an ambulatory surgery center	\$0 copay	50% of the cost
Diagnostic mammography		
 Freestanding radiological facility 	\$0 copay	50% of the cost
 Specialist's office 	\$45 copay	50% of the cost
Diagnostic procedures and tests		
Primary care physician's office	\$10 copay	50% of the cost
Specialist's officeUrgent care center	\$45 copay \$60 copay	50% of the cost 50% of the cost
Lab services	400 copay	JU/0 OF LIFE COSE
 Freestanding laboratory 	\$0 copay	50% of the cost
 Primary care physician's office 	\$0 copay	50% of the cost
 Specialist's office 	\$0 copay	50% of the cost
 Urgent care center 	\$60 copay	50% 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 Repetits

	IN-NETWORK	OUT-OF-NETWORK
Nuclear medicine and services at a freestanding radiological facility	\$250 copay	50% of the cost
Sleep studyMember's homeSpecialist's office	\$0 copay \$105 copay	50% of the cost 50% of the cost
 Therapeutic Radiology (Radiation therapy) Freestanding radiological facility Specialist's office 	20% of the cost \$45 copay	50% of the cost 50% of the cost
HEARING SERVICES		
Medicare-covered hearing	\$45 copay	50% of the cost
Mandatory supplemental hearing benefit	 \$0 copay for routine hearing exams up to 1 per year. \$499 copay for each Advanced level hearing aid up to 1 per ear per year. \$799 copay for each Premium level hearing aid up to 1 per ear per year. 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 Rechargeable style options available for an additional \$50 per aid. You must see a TruHearing provider to use this benefit. Call 1-844-255-7144 to schedule an appointment (for TTY, dial 711). 	

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

DENTAL SERVICES

The cost-share indicated below is what you pay for the covered service. Additional dental benefits are available with a separate monthly premium. Please see the "Optional Supplemental Benefits" page for details.

Medicare-covered dental

Mandatory supplemental dental benefit

Limitations and exclusions may apply. Submitted claims are subject to a review process which may include a clinical review and dental history to approve coverage. 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. Information regarding each plan is available at Humana.com/sb.

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

\$45 copay

DEN351

- **\$0** copay for comprehensive oral evaluation or periodontal exam up to 1 every 3 years.
- \$0 copay for panoramic film or diagnostic x-rays up to 1 every 5 years.
- **\$0** copay for bitewing x-rays, intraoral x-rays up to 1 set(s) per year.
- \$0 copay for emergency diagnostic exam up to 1 per year.
- \$0 copay for fluoride treatment, periodic oral exam, prophylaxis (cleaning) up to 2 per year.
- **\$0** copay for periodontal maintenance up to 4 per year.
- \$0 copay for necessary anesthesia with covered service up to unlimited per year.
- **\$25** copay per tooth for amalgam and/or composite filling up to 2 per year.
- \$1,000 combined maximum benefit coverage amount per year for preventive and comprehensive benefits.

50% of the cost

DEN351

- **\$0** copay for comprehensive oral evaluation or periodontal exam up to 1 every 3 years.
- **\$0** copay for panoramic film or diagnostic x-rays up to 1 every 5 years.
- \$0 copay for bitewing x-rays, intraoral x-rays up to 1 set(s) per year.
- \$0 copay for emergency diagnostic exam up to 1 per year.
- **\$0** copay for fluoride treatment, periodic oral exam, prophylaxis (cleaning) up to 2 per year.
- **\$0** copay for periodontal maintenance up to 4 per year.
- **\$0** copay for necessary anesthesia with covered service up to unlimited per year.
- **\$25** copay per tooth for amalgam and/or composite filling up to 2 per year.
- \$1,000 combined maximum benefit coverage amount per year for preventive and comprehensive benefits.
- Benefits received out-of-network are subject to any in-network benefit maximums, limitations, and/or exclusions.

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

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. Please see below for provider locator instructions. Network providers agree to bill us directly. 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. 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.

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

The Mandatory Supplemental
Dental benefits are provided
through the Humana Dental
Medicare Network. The provider
locator can be found at
Humana.com > Find a doctor >
Select the Dentist icon from the
menu > Enter Zip code > From
the Distance drop down select
the preferred distance > From the
look up method select All Dental
Networks > Then select
HumanaDental Medicare.

	VIS	ION	SER	VICES
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Eyewear (post cataract surgery)	\$0 copay	\$0 copay
Medicare-covered diabetic eye exam	\$0 copay	50% of the cost
Medicare-covered vision services	\$45 copay	50% of the cost

The provider location for
Medicare-covered vision can be
found at **Humana.com** > Find a
Doctor > select the Medical icon >
enter Zip Code > select look up
Method > Medicare or
Medicare-Medicaid > select your
plan Network > select Search
Category > Specialty Physician

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.

Mandatory supplemental vision benefit

The provider locator for the Humana Medicare Insight Network for Mandatory supplemental benefit vision can be found at **Humana.com** > Find a Doctor > select Vision care icon > Vision coverage through Medicare Advantage plans.

IN-NETWORK

VIS751

- **\$0** copay for routine exam up to 1 per year.
- **\$75** combined maximum benefit coverage amount per year for routine exam.
- \$100 combined maximum benefit coverage amount per year for contact lenses or eyeglasses-lenses and frames, fitting for eyeglasses-lenses and frames.
- \$150 maximum benefit coverage amount per year at PLUS Provider 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.
- Maximum benefit coverage amounts cannot be combined.
 PLUS providers are part of the

Humana Medicare Insight Network and are indicated in the provider locator search results.

OUT-OF-NETWORK VIS751

- **\$0** copay for routine exam up to 1 per year.
- \$75 combined maximum benefit coverage amount per year for routine exam.
- \$100 combined 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.
- Benefits received out-of-network are subject to any in-network benefit maximums, limitations, and/or exclusions.
- Maximum benefit coverage amounts cannot be combined.

MENTAL HEALTH SERVICES

Inpatient

Your plan covers up to 190 days in a lifetime for inpatient mental health care in a psychiatric hospital **\$390** copay per day for days 1-4 **\$0** copay per day for days 5-90

50% of the cost

Therapy visits

Partial hospitalization
 Specialist's office
 \$55 copay
 \$40 copay
 50% of the cost
 50% 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.

\$10 copay per day for days 1-20 \$203 copay per day for days 21-100	OUT-OF-NETWORK 50% of the cost for days 1-100
\$10 copay per day for days 1-20 \$203 copay per day for days	50% of the cost for days 1-100
\$203 copay per day for days	50% of the cost for days 1-100
\$20 copay	50% of the cost
\$20 copay	50% of the cost
\$300 copay per date of service	\$300 copay per date of service
Not covered	
\$0 copay \$0 copay	\$0 copay \$0 copay
20% of the cost	50% of the cost
20% of the cost 20% of the cost	20% of the cost 20% of the cost 20% of the cost
	\$20 copay \$300 copay per date of service Not covered \$0 copay \$0 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.

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 \$35 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 \$0 vaccines **\$0** copay for adult Part D covered vaccines recommended by the Advisory Committee on

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.

Immunization Practices (ACIP)

Pharmacy Cost-Sharing						
	Retail Cost-Sharing Includes all in-network retail pharmacies		vork Cost-Sharing		Cost-S	Mail-Order haring Pharmacy™
Day supply	30-day	90-day*	30-day	90-day*	30-day	90-day*
Tier 1: Preferred Generic	\$5	\$15	\$10	\$30	\$5	\$0
Tier 2: Generic	\$15	\$45	\$20	\$60	\$15	\$0
Tier 3: Preferred Brand	\$47	\$141	\$47	\$141	\$47	\$131
Tier 4: Non-Preferred Drug	\$100	\$300	\$100	\$300	\$100	\$290
Tier 5: Specialty Tier	33%	N/A	33%	N/A	33%	N/A

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

You won't pay more than **\$35** for a one-month (up to 30-day) supply of each plan-covered insulin product regardless of cost-sharing tier.

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

Insulin Cost-Sharing Retail Cost-Sharing Standard Mail-Order **Preferred Mail-Order** Includes all in-network Cost-Sharing **Cost-Sharing** retail pharmacies CenterWell Pharmacy™ Day supply 30-day 90-day* 30-day 90-dav* 30-day 90-day* Tier 3: Preferred Brand \$35 \$35 \$105 \$35 \$105 \$105 Tier 5: Specialty Tier \$35 N/A \$35 N/A \$35 N/A

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

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 drugs.

EXTRA HELP

If you receive "Extra Help" for your drugs you will have a **\$0** deductible.

Prior to reaching your annual **\$8,000** out-of-pocket limit you will pay one of the following depending on your level of "Extra Help:"

- \$4.50 for generic/preferred multi-source drug or biosimilar; \$11.20 for any other drug; OR
- \$1.55 for generic/preferred multi-source drug or biosimilar; \$4.60 for any other drug; OR
- **\$0** for all drugs

After reaching your annual **\$8,000** out-of-pocket limit, you will pay **\$0** for the remainder of the calendar year, regardless of the level of "Extra Help" you receive. Additional information will be available on your LIS rider.

Cost sharing may change depending on the pharmacy you choose, when you enter another phase of the Part D benefit and if you qualify for "Extra Help." To find out if you qualify for "Extra Help," please contact the Social Security Office at 1-800-772-1213 Monday — Friday, 7 a.m. — 7 p.m. TTY users should call

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

1-800-325-0778. 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)	\$20 copay	50% of the cost
Podiatry services (Medicare-covered)	\$45 copay	50% of the cost
Acupuncture services (Medicare-covered)	\$45 copay for acupuncture for chronic low back pain visits up to 20 visit(s) per year.	50% 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 suppliesDiabetic supplierNetwork retail pharmacyPreferred diabetic supplier	20% of the cost 10% of the cost \$0 copay	50% of the cost 50% of the cost Not Covered
Durable medical equipment (DME) and related supplies	20% of the cost	20% of the cost
Medical supplies at medical supplier	20% of the cost	50% of the cost
Prosthetics devices and related supplies at prosthetics provider	20% of the cost	50% of the cost
REHABILITATION SERVICES		
Cardiac rehabilitation services at a specialist's office	\$10 copay	50% of the cost
• Comprehensive outpatient rehab facility	\$20 copay	50% of the cost
 Specialist's office 	\$20 copay	50% of the cost

Physical therapy			
Comprehensive outpatient rehab facility	\$20 copay	50% of the cost	
Specialist's office	\$20 copay	50% of the cost	
Pulmonary rehabilitation services at a specialist's office	\$10 copay	50% of the cost	
Speech therapy			
 Comprehensive outpatient rehab facility 	\$20 copay	50% of the cost	
 Specialist's office 	\$20 copay	50% of the cost	
Supervised exercise therapy (SET) for Peripheral Artery Disease (PAD) at a specialist's office	\$10 copay	50% of the cost	
TELEHEALTH SERVICES (in addition	on to Original Medicare)		
Primary care physician's office	\$0 copay	Not Covered	
Specialist's office	\$45 copay	Not Covered	
Substance abuse or behavioral health services	\$0 copay	Not Covered	
Urgent care services	\$60 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 **1-800-833-2364**.

Travel Coverage

The PPO national network gives you in-network coverage across the country, so you can see any doctor who accepts the plan terms and conditions. You'll be able to travel with ease or split your time between locations. Visit **Humana.com** or contact Customer Care on the back of your ID card if you need help finding an in-network provider.

Humana Well Dine® Meal Program

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

Over-the-Counter (OTC) mail order

\$50 quarterly allowance to buy approved over-the-counter health and wellness products available through our OTC Mail Order provider.

Unused amount expires at the end of the quarter.

- Quarterly allowance amounts are available to use at the beginning of January, April, July, and October.
- Limitations and restrictions may apply.

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.



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.

\$34.20 Monthly premium

MyOption DEN204

MyOption DEN204 is an optional supplemental benefit package (OSB) that can be purchased for an additional monthly premium to replace any routine dental benefits that are offered within your Medicare Advantage plan. If purchased, the OSB will entirely replace the dental coverage defined in your benefits package. This means, you should disregard any language in the Mandatory Supplemental Dental Benefit section contained in Chapter 4 of the EOC. When you enroll, you will receive a new ID card showing your new DEN204 listed on the back. Any claim paid under the current year Mandatory Supplemental Benefit will apply toward the annual OSB maximum plan benefit.

\$52.50 Monthly premium

MyOption DEN205

MyOption DEN205 is an optional supplemental benefit package (OSB) that can be purchased for an additional monthly premium to replace any routine dental benefits that are offered within your Medicare Advantage plan. If purchased, the OSB will entirely replace the dental coverage defined in your benefits package. This means, you should disregard any language in the Mandatory Supplemental Dental Benefit section contained in Chapter 4 of the EOC. When you enroll, you will receive a new ID card showing your new DEN205 listed on the back. Any claim paid under the current year Mandatory Supplemental Benefit will apply toward the annual OSB maximum plan benefit.

\$59.20 Monthly premium

MyOption DEN432

MyOption DEN432 is an optional supplemental benefit package (OSB) that can be purchased for an additional monthly premium to replace any routine dental benefits that are offered within your Medicare Advantage plan. If purchased, the OSB will entirely replace the dental coverage defined in your benefits package. This means, you should disregard any language in the Mandatory Supplemental Dental Benefit section contained in Chapter 4 of the EOC. When you enroll, you will receive a new ID card showing your new DEN432 listed on the back. Any claim paid under the current year Mandatory Supplemental Benefit will apply toward the annual OSB maximum plan benefit.

Optional Supplemental Benefits

HumanaChoice H5216-019 (PPO)

Kentucky, West Virginia, Indiana

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.

The information in this booklet will tell you about the benefits you can add to your plan. You can add these extra benefits when you sign up for your Medicare Advantage plan. You can also add these benefits after Medicare open enrollment ends on December 7 by contacting your agent or calling OSB sales at 1-888-413-7026. OSB sales is available from 8 a.m. – 8 p.m. local time, seven days a week October 1 – March 31, and Monday through Friday April 1 – September 30.

MyOption (DEN204)

The MyOption Dental benefit helps make it easy for you to plan for your dental care.

This benefit has no deductible.

Here's how the benefit works:

Monthly Premium	\$34.20 Humana pays up to \$2,000 per calendar year		
Maximum Benefit			
Covered Dental Services	In-Network* You Pay	Out-Of- Network** You Pay	Benefit Limitations
	Preventive De	ental Services	
Periodic oral exam	0%	0%	Two per year
Emergency diagnostic exam	0%	0%	One per year
Bitewing X-rays	0%	0%	One per year
Intraoral X-rays (inside the mouth)	0%	0%	One per year
Full mouth or panoramic X-rays	0%	0%	One every five years
Prophylaxis (cleaning)	0%	0%	Two per year
Periodontal maintenance	0%	0%	Four per year
Fluoride	0%	0%	Two per year
Bas	sic Dental Services	(Minor Restorati	ve)
Amalgam restoration (silver filings)	\$25 Per tooth	\$25 Per tooth	
Composite resin restoration (white filings)	\$25 Per tooth	\$25 Per tooth	Unlimited per year

Covered Dental Services	In-Network* You Pay	Out-Of- Network** You Pay	Benefit Limitations
Ва	sic Dental Service:	s (Minor Restorati	ve)
Extraction, erupted tooth or exposed root	\$25 Per tooth	\$25 Per tooth	Unlimited nor year
Surgical removal of erupted tooth	\$25 Per tooth	\$25 Per tooth	Unlimited per year
Recement crown	\$25	\$25	One every five years
Recement bridge	\$25	\$25	One every five years
Palliative (emergency) treatment of dental pain	\$25	\$25	Two per year
Anesthesia	0%	0%	Unlimited per year
Major Dental Se	rvices (Endodontio	s, Periodontics, a	nd Oral Surgery)
Periodontal scaling and root planing	\$25	\$25	One per quadrant every three years
Scaling – moderate or severe gingival inflammation	\$25	\$25	One every three years
Root Canal	50%	50%	One per tooth per lifetime
Root Canal retreatment	50%	50%	One per tooth per lifetime
Crowns	50%	50%	
Onlay	50%	50%	One per tooth per lifetime
Inlay – alternate benefit only	50%	50%	
Other restorative services - core buildup and prefabricated post and core	50%	50%	One per tooth per lifetime
Bridges - pontic	50%	50%	One every five years
Bridges - crown	50%	50%	Two every five years
Occlusal adjustment – limited	50%	50%	0.000 0.000 0.000
Occlusal adjustment – complete	50%	50%	One every three years
Oral Surgery	50%	50%	Two per year

Limitations and exclusions may apply. Submitted claims are subject to a review process which may include a clinical review and dental history to approve coverage. 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. Information regarding each plan is available at **Humana.com/sb**.

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 (but coinsurance payment 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. Please see below for provider locator instructions. Network providers agree to bill us directly. 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. The coinsurance level will apply to the average negotiated in-network fee schedule INFS or usual and customary fees 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.

The Mandatory Supplemental Dental benefits are provided through the Humana Dental Medicare Network. The provider locator can be found at Humana.com > Find a doctor > Select the Dentist icon from the menu > From the Distance drop down select the preferred distance > Enter Zip code > From the look up method select All Dental Networks > Then select HumanaDental Medicare.

MyOption (DEN205)

The MyOption Dental benefit helps make it easy for you to plan for your dental care.

This benefit has no deductible.

Here's how the benefit works:

Monthly Premium	\$52.50			
Maximum Benefit	Humana pays up	Humana pays up to \$2,000 per calendar year		
Covered Dental Services	In-Network* You Pay	Out-Of- Network** You Pay	Benefit Limitations	
Preventive Dental Services				
Periodic oral exam	0%	0%	Two per year	
Emergency diagnostic exam	0%	0%	One per year	
Bitewing X-rays	0%	0%	One per year	

Covered Dental Services	In-Network* You Pay	Out-Of- Network** You Pay	Benefit Limitations
	Preventive De	ntal Services	
Intraoral X-rays (inside the mouth)	0%	0%	One per year
Full mouth or panoramic X-rays	0%	0%	One every five years
Prophylaxis (cleaning)	0%	0%	Two per year
Periodontal maintenance	0%	0%	Four per year
Fluoride	0%	0%	Two per year
Bas	sic Dental Services	(Minor Restorativ	/e)
Amalgam restoration (silver filings)	0%	0%	Unlimited per year
Composite resin restoration (white filings)	0%	0%	Unlimited per year
Extraction, erupted tooth or exposed root	0%	0%	Unlimited per year
Surgical removal of erupted tooth	0%	0%	Unlimited per year
Recement inlay, onlay or partial coverage restoration	\$25	\$25	
Recement indirectly fabricated or prefabricated post and core	\$25	\$25	One every five years
Recement crown	\$25	\$25	
Recement bridge	\$25	\$25	One every five years
Palliative (emergency) treatment of dental pain	\$25	\$25	Two per year
Anesthesia	0%	0%	Unlimited per year
Major Dental Se	rvices (Endodontic	s, Periodontics, ar	nd Oral Surgery)
Periodontal scaling and root planing	0%	0%	One per quadrant every three years
Scaling – moderate or severe gingival inflammation	0%	0%	One every three years
Root canal	50%	50%	One per tooth per lifetime
Root canal retreatment	50%	50%	One per tooth per lifetime

Covered Dental Services	In-Network* You Pay	Out-Of- Network** You Pay	Benefit Limitations
Major Dental Se	rvices (Endodontic	s, Periodontics, ar	nd Oral Surgery)
Crowns	50%	50%	
Onlay	50%	50%	One per tooth per lifetime
Inlay – alternate benefit only	50%	50%	
Other restorative services - core buildup and prefabricated post and core	50%	50%	One per tooth per lifetime
Bridges - pontic	50%	50%	One every five years
Bridges - crown	50%	50%	Two every five years
Complete denture (including routine post-delivery care) – maxillary (upper) or mandibular (lower)	50%	50%	
Immediate denture (including routine post-delivery care) – maxillary (upper) or mandibular (lower)	50%	50%	One every five years
Partial dentures (including routine post-delivery care) – resin or metal, maxillary (upper) or mandibular (lower)	50%	50%	One every five years
Unilateral partial denture (including routine post-delivery care)	50%	50%	
Complete denture adjustment – maxillary (upper) or mandibular (lower)	50%	50%	
Partial denture adjustment – maxillary (upper) or mandibular (lower)	50%	50%	One per year
Reline complete denture – maxillary (upper) or mandibular (lower)	50%	50%	One per year
Reline partial denture – maxillary (upper) or mandibular (lower)	50%	50%	, ,

Covered Dental Services	In-Network* You Pay	Out-Of- Network** You Pay	Benefit Limitations
Major Dental Se	rvices (Endodontio	cs, Periodontics, a	nd Oral Surgery)
Rebase complete denture – maxillary (upper) or mandibular (lower)	50%	50%	One per year
Rebase partial denture – maxillary (upper) or mandibular (lower)	50%	50%	
Repair complete denture base – maxillary (upper) or mandibular (lower)	50%	50%	
Repair partial denture base – maxillary (upper) or mandibular (lower)	50%	50%	
Repair partial denture framework – maxillary (upper) or mandibular (lower)	50%	50%	One per year
Replace missing or broken tooth	50%	50%	
Add tooth or clasp to partial denture	50%	50%	
Replace all teeth/acrylic – maxillary (upper) or mandibular (lower)	50%	50%	
Tissue conditioning – maxillary (upper) or mandibular (lower)	50%	50%	One per year
Occlusal adjustment – limited	50%	50%	One avery three was:
Occlusal adjustment – complete	50%	50% Une e	One every three years
Oral surgery	50%	50%	Two per year

Limitations and exclusions may apply. Submitted claims are subject to a review process which may include a clinical review and dental history to approve coverage. 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. Information regarding each plan is available at **Humana.com/sb**.

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 (but coinsurance payment 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. Please see below for provider locator instructions. Network providers agree to bill us directly. 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. The coinsurance level will apply to the average negotiated in-network fee schedule INFS or usual and customary fees 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.

The Mandatory Supplemental Dental benefits are provided through the Humana Dental Medicare Network. The provider locator can be found at Humana.com > Find a doctor > Select the Dentist icon from the menu > From the Distance drop down select the preferred distance > Enter Zip code > From the look up method select All Dental Networks > Then select HumanaDental Medicare.

MyOption (DEN432)

This dental plan covers certain preventive, basic and major dental services. It is an extra benefit you may choose to add to your Medicare Advantage plan. However, you will have to pay an extra monthly premium for it.

In this plan, you may receive your care from either an in-network or out-of-network dentist. If you use an out-of-network dentist, your share of the cost may be higher.

Monthly Cost	
Monthly Premium	\$59.20
Coverage Information	
Maximum plan benefit (combined in and out-of-network)	\$2,000 per calendar year
Deductible	\$0 per calendar year

You may receive the following dental services:

Plan covers up to **\$2,000** allowance every year for non-Medicare covered preventive and comprehensive dental services. You are responsible for any amount above the dental coverage limit. Any amount unused at the end of the year will expire.

Your benefit can be used for most dental treatments such as:

- Preventive dental services, such as exams, routine cleanings, etc.
- Basic dental services, such as fillings, extractions, etc.
- Major dental services, such as periodontal scaling, crowns, dentures, root canals, bridges, etc.

Note: The allowance cannot be used on cosmetic services and implants.

Limitations and exclusions may apply. Submitted claims are subject to a review process which may include a clinical review and dental history to approve coverage. 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. Information regarding each plan is available at **Humana.com/sb**.

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 (but coinsurance payment 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. Please see below for provider locator instructions. Network providers agree to bill us directly. 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. The coinsurance level will apply to the average negotiated in-network fee schedule INFS or usual and customary fees 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.

The Mandatory Supplemental Dental benefits are provided through the Humana Dental Medicare Network. The provider locator can be found at Humana.com > Find a doctor > Select the Dentist icon from the menu > From the Distance drop down select the preferred distance > Enter Zip code > From the look up method select All Dental Networks > Then select HumanaDental Medicare.

Humana is a Medicare Advantage PPO plan with a Medicare contract. Enrollment in this Humana plan depends on contract renewal. 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 1st 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 premium, and the OSB premium.

Humana.

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.

GHHLNNXEN 0623

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 (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 1-877-320-1235 (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 1-877-320-1235 (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.

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 1-877-320-1235 (ТТҮ: 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 (711 :717) 1235-320-1. 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.

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 1-877-320-1235 (TTY: 711). Irá encontrar alguém que fale o idioma Português para o ajudar. Este serviço é gratuito.

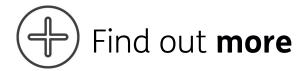
French Creole: Nou genyen sèvis entèprèt gratis pou reponn tout kesyon ou ta genyen konsènan plan medikal oswa dwòg nou an. Pou jwenn yon entèprèt, jis rele nou nan 1-877-320-1235 (TTY: 711). Yon moun ki pale Kreyòl kapab ede w. Sa a se yon sèvis ki gratis.

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、1-877-320-1235 (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。

Form CMS-10802 (Expires 12/31/25)

Form Approved OMB# 0938-1421





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.

All product names, logos, brands and trademarks are property of their respective owners, and any use does not imply endorsement.

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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