Summary of Benefits Optional Supplemental Benefits

HumanaChoice H5525-051 (PPO)

Pennsylvania Select counties in Pennsylvania

H5525_SB_MAPD_PPO_051001_2024_M

Our service area includes the following county/counties in Pennsylvania: Adams, Allegheny, Armstrong, Beaver, Bedford, Berks, Blair, Bradford, Butler, Cambria, Cameron, Carbon, Centre, Clarion, Clearfield, Clinton, Columbia, Crawford, Cumberland, Dauphin, Elk, Erie, Fayette, Forest, Franklin, Fulton, Greene, Huntingdon, Jefferson, Juniata, Lackawanna, Lancaster, Lawrence, Lebanon, Lehigh, Luzerne, Lycoming, McKean, Mercer, Mifflin, Monroe, Montour, Northampton, Perry, Potter, Schuylkill, Snyder, Somerset, Sullivan, Susquehanna, Tioga, Union, Venango, Warren, Washington, Wayne, Westmoreland, Wyoming, York.

Pre-Enrollment Checklist

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

Understanding the Benefits

The Evidence of Coverage (EOC) provides a complete list of all coverage and services. It is important to review plan coverage, costs and benefits before you enroll. Visit **Humana.com/medicare** or call **1-800-833-2364 (TTY: 711)** to view a copy of the EOC.

Review the provider directory (or ask your doctor) to make sure the doctors you see now are in the network. If they are not listed, it means you will likely have to select a new doctor.

Review the pharmacy directory to make sure the pharmacy you use for any prescription medicines is in the network. If the pharmacy is not listed, you will likely have to select a new pharmacy for your prescriptions.

Review the formulary to make sure your drugs are covered.

Understanding Important Rules

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

Find out more about the HumanaChoice H5525-051 (PPO) plan - including the health and drug services it covers - in this easy-to-use guide.

HumanaChoice H5525-051 (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 H5525-051 (PPO), you must be entitled to Medicare Part A, be enrolled in Medicare Part B and live in our service area.

Plan name:

HumanaChoice H5525-051 (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 H5525-051 (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 H5525-051 (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!

A Monthly Premium, Deductible and Limits

PL/	AN	COSTS	

Monthly plan premium	\$0 You must keep paying your Medicare Part B premium.	
Part B premium reduction	Your plan will reduce your Monthly Part B premium by up to \$10 but by no more than Original Medicare's Part B Premium for 2024.	
Medical deductible	 \$100 combined The following services listed are excluded from the combined in-network and out-of-network deductible: In-Network only: Ambulance Services Chemotherapy Drugs and Administration Diabetic Monitoring Supplies Diagnostic Colonoscopy Diagnostic Mammography Lab Services Medicare Part B Covered Drugs Primary Care Physician's Office Specialist's Office Both In-Network and Out-of-Network: Emergency Room Services Medicare Covered Preventive Services (including Immunizations (Flu & Pneumonia)) Services not covered by Original Medicare Urgently Needed Services at Urgent Care Centers 	
Pharmacy (Part D) deductible	\$0 deductible.	
Maximum out-of-pocket responsibility	\$7,800 in-network \$10,750 combined in- and out-of-network The most you pay for copays, coinsurance and other costs for covered medical services for the 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

IN-NETWORK

OUT-OF-NETWORK

INPATIENT HOSPITAL CARE

Your plan covers an unlimited number of days for an inpatient stay. **\$362** copay per day for days 1-7 **\$0** copay per day for days 8-90 30% 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)	\$300 copay	30% of the cost
Basic radiological services (X-rays)	\$125 copay	30% of the cost
Cardiac rehabilitation services	\$10 copay	30% of the cost
Chemotherapy drugs	20% of the cost	30% of the cost
Diagnostic colonoscopy	\$0 copay	30% of the cost
Diagnostic mammography	\$0 copay	30% of the cost
Diagnostic procedures and tests - other	\$105 copay	30% of the cost
Lab services	\$0 copay	30% of the cost
Medicare Part B covered drugs	20% of the cost	30% of the cost
Mental health services	\$85 copay	30% of the cost
Nuclear medicine services	\$300 copay	30% of the cost
Occupational therapy	\$35 copay	30% of the cost
Opioid treatment program services	\$85 copay	30% of the cost
Physical therapy	\$35 copay	30% of the cost
Pulmonary rehabilitation services	\$10 copay	30% of the cost
Renal dialysis services	20% of the cost	20% of the cost
Sleep study (facility based)	\$105 copay	30% of the cost
Speech therapy	\$35 copay	30% of the cost
Substance abuse care	\$85 copay	30% of the cost
Supervised exercise therapy (SET) for Peripheral Artery Disease (PAD)	\$10 copay	30% 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
Surgery services	\$350 copay	30% of the cost
Therapeutic radiology (Radiation therapy)	20% of the cost	30% of the cost
Wound care	\$95 copay	30% of the cost
AMBULATORY SURGERY CENTER		
Diagnostic colonoscopy	\$0 copay	30% of the cost
Surgery services	\$395 copay	30% of the cost
DOCTOR OFFICE VISITS		
Primary care provider (PCP)	\$0 copay	30% of the cost
Specialist's office	\$35 copay	30% 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 Breast cancer screening (mammogram) Cardiovascular disease risk reduction visit Cardiovascular disease screenings Cervical and vaginal cancer screening Depression screening Diabetes self-management training Glaucoma screening HIV screening Immunizations 	\$0 copay or 30% 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.

- Lung Cancer Screening
- Medical nutrition therapy

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 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. 	OUT-OF-NETWORK
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.	\$100 copay	\$100 copay
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.	\$55 copay at an urgent care center	\$55 copay at an urgent care center
DIAGNOSTIC SERVICES, LABS AND	IMAGING	
 Advanced imaging services (MRI, MRA, PET and CT scan) Freestanding radiological facility 	\$200 copay	30% of the cost
Primary care physician's officeSpecialist's office	\$200 copay \$200 copay	30% of the cost 30% of the cost

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	IN-NETWORK	OUT-OF-NETWORK
Basic radiological services (X-rays)		
 Freestanding radiological facility 	\$50 copay	30% of the cost
Primary care physician's office	\$0 copay	30% of the cost
 Specialist's office 	\$35 copay	30% of the cost
Urgent care center	\$55 copay	\$55 copay
Diagnostic colonoscopy at an ambulatory surgery center	\$0 copay	30% of the cost
Diagnostic mammography		
 Freestanding radiological facility 	\$0 copay	30% of the cost
 Specialist's office 	\$35 copay	30% of the cost
Diagnostic procedures and tests		
 Primary care physician's office 	\$0 copay	30% of the cost
 Specialist's office 	\$35 copay	30% of the cost
Urgent care center	\$55 copay	\$55 copay
Lab services	_	
Freestanding laboratory	\$0 copay	30% of the cost
Primary care physician's office	\$0 copay	30% of the cost
Specialist's office	\$0 copay	30% of the cost
Urgent care center	\$55 copay	\$55 copay
Nuclear medicine and services at a freestanding radiological facility	\$250 copay	30% of the cost
Sleep study		
Member's home	\$0 copay	30% of the cost
Specialist's office	\$35 copay	30% of the cost
Therapeutic Radiology (Radiation therapy)		
 Freestanding radiological facility 	20% of the cost	30% of the cost
 Specialist's office 	\$35 copay	30% of the cost
HEARING SERVICES		
Medicare-covered hearing	\$35 copay	30% of the cost

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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
Mandatory supplemental hearing benefit	 HER937 \$0 copay for routine hearing exams up to 1 per year. \$699 copay for each Advanced level hearing aid up to 1 per ear per year. \$999 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). 	
DENITAL CEDVICES		

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	\$35 copay	30% of the cost
Mandatory supplemental dental	 DEN350 \$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. 	 DEN350 \$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.

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.)

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 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

IN-NETWORK

- **\$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.

OUT-OF-NETWORK

- \$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.
- 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.

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OUT-OF-NETWORK

Covered Medical and Hospital Benefits (cont.)

IN-NFTWORK

	IN-NETWORK	OUT-OF-NETWORK
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.		
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.		
VISION SERVICES		
Eyewear (post cataract surgery)	\$0 copay	\$0 copay
Medicare-covered diabetic eye exam	\$0 copay	30% 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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	IN-NETWORK	OUT-OF-NETWORK
Medicare-covered vision services 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	\$35 copay	30% of the cost
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.	 VIS694 \$0 copay for routine exam up to 1 per year. \$75 combined maximum benefit coverage amount per year for routine exam. \$50 maximum benefit coverage amount per year for contact lenses or eyeglasses-lenses and frames, fitting for eyeglasses-lenses and frames. \$100 maximum benefit coverage amount per year at PLUS Provider for contact lenses or eyeglasses-lenses and frames, fitting for eyeglasses-lenses and frames. \$100 maximum benefit coverage amount per year at PLUS Provider for contact lenses or eyeglasses-lenses and frames. \$100 maximum benefit coverage amount per year at PLUS Provider for contact lenses or 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 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. 	 VIS694 \$0 copay for routine exam up to 1 per year. \$75 combined maximum benefit coverage amount per year for routine exam. \$50 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 up to 1 pair 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.

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Covered Medical and Hospital Benefits (cont.)				
	IN-NETWORK	OUT-OF-NETWORK		
MENTAL HEALTH SERVICES				
Inpatient Your plan covers up to 190 days in a lifetime for inpatient mental health care in a psychiatric hospital	\$387 copay per day for days 1-5 \$0 copay per day for days 6-90	30% of the cost		
Therapy visitsPartial hospitalizationSpecialist's office	\$55 copay \$35 copay	30% of the cost 30% of the cost		
SKILLED NURSING FACILITY (SNF)				
Your plan covers up to 100 days in a SNF	\$0 copay per day for days 1-20 \$203 copay per day for days 21-100	30% of the cost for days 1-100		
PHYSICAL THERAPY				
Comprehensive outpatient rehab facility	\$20 copay	30% of the cost		
Specialist's office	\$20 copay	30% of the cost		
AMBULANCE				
	\$300 copay per date of service	\$300 copay per date of service		
TRANSPORTATION				
	Not covered			

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Covered Medical and Hospital Benefits (cont.)				
	IN-NETWORK	OUT-OF-NETWORK		
MEDICARE PART B DRUGS				
Allergy shots and serumPrimary care physician's officeSpecialist's office	\$0 copay \$0 copay	\$0 copay \$0 copay		
Chemotherapy drugs at a specialist's office	20% of the cost	30% 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	20% of the cost	30% of the cost
• Primary care physician's office	20% of the cost	30% of the cost
Specialist's office	20% of the cost	30% of the cost

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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: Tier 1 drugs Tier 2 drugs Insulin			
Excluded drug coverage	Additional drug coverage for the following: Erectile dysfunction (ED) drugs Anti-Obesity 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.

 \oslash Prescription Drug Benefits

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	\$10	\$30	\$0	\$0
Tier 2: Generic	\$5	\$15	\$20	\$60	\$5	\$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.

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

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.

Insulin Cost-Sharing

	Includes all	s t-Sharing in-network armacies	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	\$35	\$105	\$35	\$105	\$35	\$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**.

*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 1 (Preferred Generic) - All Drugs

Tier 2 (Generic) - All Drugs

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.	
Anti-Obesity drugs	Covered at Tier 2 cost-share amount.	
Prescription Vitamins	Covered at Tier 1 cost-share amount.	

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 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)	\$15 copay	30% of the cost
Podiatry services (Medicare-covered)	\$35 copay	30% of the cost
Acupuncture services (Medicare-covered)	\$35 copay for acupuncture for chronic low back pain visits up to 20 visit(s) per year.	30% 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 	20% of the cost 10% of the cost \$0 copay	30% of the cost 30% 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	30% of the cost
Prosthetics devices and related supplies at prosthetics provider	20% of the cost	30% of the cost
REHABILITATION SERVICES		
Cardiac rehabilitation services at a specialist's office	\$10 copay	30% of the cost
 Occupational therapy Comprehensive outpatient rehab facility 	\$20 copay	30% of the cost
Specialist's office	\$20 copay	30% of the cost
Physical therapyComprehensive outpatient rehab facility	\$20 copay	30% of the cost
Specialist's office	\$20 copay	30% of the cost
Pulmonary rehabilitation services at a specialist's office	\$10 copay	30% of the cost

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Speech therapy		
Comprehensive outpatient rehab facility	\$20 copay	30% of the cost
Specialist's office	\$20 copay	30% of the cost
Supervised exercise therapy (SET) for Peripheral Artery Disease (PAD) at a specialist's office	\$10 copay	30% of the cost
TELEHEALTH SERVICES (in addition	on to Original Medicare)	
Primary care physician's office	\$0 copay	Not Covered
Specialist's office	\$35 copay	Not Covered
Substance abuse or behavioral health services	\$0 copay	Not Covered
Urgent care services	\$55 copay	Not Covered

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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.

Chiropractic services

- In-network: \$0 copay for routine chiropractic visits up to unlimited visit(s) per year.
- Out-of-network: **30%** coinsurance for routine chiropractic visits up to unlimited visit(s) per year.
 Benefits received out-of-network are subject to any in-network benefit maximums, limitations, and/or exclusions.

Routine foot care

- In-network: **\$25** copay for routine podiatry visits up to 12 visit(s) per year.
- Out-of-network: **\$25** copay for routine podiatry visits up to 12 visit(s) per year.

Benefits received out-of-network are subject to any in-network benefit maximums, limitations, and/or exclusions.

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.



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.



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.



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.

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 H5525-051 (PPO)

Pennsylvania Select counties in Pennsylvania

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	\$29.40			
Maximum Benefit	Humana pays up to \$2,000 per calendar year			
Covered Dental Services	In-Network* You Pay	Out-Of- Network** You Pay	Benefit Limitations	
	Preventive De	ntal 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	
Ba	sic Dental Services	s (Minor Restorativ	e)	
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
Ba	sic Dental Services	s (Minor Restorativ	ve)
Extraction, erupted tooth or exposed root	\$25 Per tooth	\$25 Per tooth	
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, ar	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
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	\$44.50				
Maximum Benefit	Humana pays up	Humana pays up to \$2,000 per calendar year			
Covered Dental Services	In-Network* You Pay You Pay You Pay				
	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		

Covered Dental Services	In-Network* You Pay	Out-Of- Network** You Pay	Benefit Limitations
	Preventive De	ental 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
Ba	sic Dental Services	s (Minor Restorativ	re)
Amalgam restoration (silver filings)	0%	0%	Liplicated 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, an	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 Services (Endodontics, Periodontics, and 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%	One every five years		
Immediate denture (including routine post-delivery care) – maxillary (upper) or mandibular (lower)	50%	50%			
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%	One per year		
Partial denture adjustment – maxillary (upper) or mandibular (lower)	50%	50%			
Reline complete denture – maxillary (upper) or mandibular (lower)	50%	50%	One per year		
Reline partial denture – maxillary (upper) or mandibular (lower)	50%	50%			

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Covered Dental Services	In-Network* You Pay	Out-Of- Network** You Pay	Benefit Limitations		
Major Dental Services (Endodontics, Periodontics, and 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%	One per year		
Repair partial denture base – maxillary (upper) or mandibular (lower)	50%	50%			
Repair partial denture framework – maxillary (upper) or mandibular (lower)	50%	50%			
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 every three years		
Occlusal adjustment – complete	50%	50%			
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	\$53.60
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.

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Notes	

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Humana.

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

- You may file a complaint, also known as a grievance: Discrimination Grievances, P.O. Box 14618, Lexington, KY 40512-4618. If you need help filing a grievance, call 1-877-320-1235 or if you use a TTY, call 711.
- You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through their Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or at U.S. Department of Health and Human Services, 200 Independence Avenue, SW, Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019, 800-537-7697 (TDD). Complaint forms are available at https://www.hhs.gov/ocr/office/file/index.html.
- **California residents:** You may also call California Department of Insurance toll-free hotline number: **1-800-927-HELP (4357)**, to file a grievance.

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

Humana provides free auxiliary aids and services, such as qualified sign language interpreters, video remote interpretation, and written information in other formats to people with disabilities when such auxiliary aids and services are necessary to ensure an equal opportunity to participate.

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Important

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 (TTY: 711) 1235-320-1877. 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 Part B Premium Reduction benefit pays part or all of your Part B premium and the amount may change based on the amount you pay for Part B.

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.

Humana Inc.

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

Important information about your plan

Humana.com

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