2024

Summary of Benefits

Optional Supplemental Benefits

HumanaChoice H5525-051 (PPO)

Greater Philadelphia

Our service area includes the following county/counties in Pennsylvania: Bucks, Chester, Delaware, Montgomery, Philadelphia.

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.

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Let's talk about HumanaChoice H5525-051 (PPO)

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!

Monthly Premium, Deductible and Limits

PLAN 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	**$105** 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 **$11,000** 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.

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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	**$362** copay per day for days 1-7 **$0** copay per day for days 8-90
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	**$300** copay
Basic radiological services (X-rays)	**$125** copay	**$125** copay
Cardiac rehabilitation services	**$10** copay	**$10** copay
Chemotherapy drugs	**20%** of the cost	**20%** of the cost
Diagnostic colonoscopy	**$0** copay	**$0** copay
Diagnostic mammography	**$0** copay	**$0** copay
Diagnostic procedures and tests - other	**$105** copay	**$105** copay
Lab services	**$0** copay	**$0** copay
Medicare Part B covered drugs	**20%** of the cost	**20%** of the cost
Mental health services	**$90** copay	**$90** copay
Nuclear medicine services	**$300** copay	**$300** copay
Occupational therapy	**$40** copay	**$40** copay
Opioid treatment program services	**$90** copay	**$90** copay
Physical therapy	**$40** copay	**$40** copay
Pulmonary rehabilitation services	**$10** copay	**$10** copay
Renal dialysis services	**20%** of the cost	**20%** of the cost
Sleep study (facility based)	**$105** copay	**$105** copay
Speech therapy	**$40** copay	**$40** copay
Substance abuse care	**$90** copay	**$90** copay
Supervised exercise therapy (SET) for Peripheral Artery Disease (PAD)	**$10** copay	**$10** copay

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Covered Medical and Hospital Benefits (cont.)

	IN-NETWORK	OUT-OF-NETWORK
Surgery services	**$395** copay	**$395** copay
Therapeutic radiology (Radiation therapy)	**20%** of the cost	**20%** of the cost
Wound care	**$35** copay	**$35** copay
AMBULATORY SURGERY CENTER		
Diagnostic colonoscopy	**$0** copay	**$0** copay
Surgery services	**$395** copay	**$395** copay
DOCTOR OFFICE VISITS		
Primary care provider (PCP)	**$0** copay	**$0** copay
Specialist's office	**$40** copay	**$40** copay
PREVENTIVE CARE		
	Our plan covers many preventive services at no cost when you see an in-network provider including: • Abdominal aortic aneurysm screening • Alcohol misuse 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 • Colorectal cancer screening • Depression screening • Diabetes screenings • Diabetes self-management training • Glaucoma screening • HIV screening • Immunizations • Lung Cancer Screening • Medical nutrition therapy	**$0** copay Any additional preventive services approved by Medicare during the contract year will be covered.

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Covered Medical and Hospital Benefits (cont.)

	IN-NETWORK	OUT-OF-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.	
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	**$200** copay
• Primary care physician's office	**$200** copay	**$200** copay
• Specialist's office	**$200** copay	**$200** 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.

Covered Medical and Hospital Benefits (cont.)

	IN-NETWORK	OUT-OF-NETWORK
Basic radiological services (X-rays)		
• Freestanding radiological facility	**$50** copay	**$50** copay
• Primary care physician's office	**$0** copay	**$0** copay
• Specialist's office	**$40** copay	**$40** copay
• Urgent care center	**$55** copay	**$55** copay
Diagnostic colonoscopy at an ambulatory surgery center	**$0** copay	**$0** copay
Diagnostic mammography		
• Freestanding radiological facility	**$0** copay	**$0** copay
• Specialist's office	**$40** copay	**$40** copay
Diagnostic procedures and tests		
• Primary care physician's office	**$0** copay	**$0** copay
• Specialist's office	**$40** copay	**$40** copay
• Urgent care center	**$55** copay	**$55** copay
Lab services		
• Freestanding laboratory	**$0** copay	**$0** copay
• Primary care physician's office	**$0** copay	**$0** copay
• Specialist's office	**$0** copay	**$0** copay
• Urgent care center	**$55** copay	**$55** copay
Nuclear medicine and services at a freestanding radiological facility	**$250** copay	**$250** copay
Sleep study		
• Member's home	**$0** copay	**$0** copay
• Specialist's office	**$40** copay	**$40** copay
Therapeutic Radiology (Radiation therapy)		
• Freestanding radiological facility	**20%** of the cost	**20%** of the cost
• Specialist's office	**$40** copay	**$40** copay
HEARING SERVICES		
Medicare-covered hearing	**$40** copay	**$40** copay

You do not need a referral to receive covered services from plan providers. Certain procedures, services and drugs may need advance approval from your plan. This is called a "prior authorization" or "preauthorization." Please contact your PCP or refer to the Evidence of Coverage (EOC) for services that require a prior authorization from the plan.

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Covered Medical and Hospital Benefits (cont.)

	IN-NETWORK	OUT-OF-NETWORK
Mandatory supplemental hearing benefit	**HER946** • **$0** copay for routine hearing exams up to 1 per year. • **$199** copay for each Advanced level hearing aid up to 1 per ear per year. • **$499** 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).**	
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	**$40** copay	**$40** copay
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	**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.	**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.

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
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	• **$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.	• **$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.

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	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	**$0** copay

You do not need a referral to receive covered services from plan providers. Certain procedures, services and drugs may need advance approval from your plan. This is called a "prior authorization" or "preauthorization." Please contact your PCP or refer to the Evidence of Coverage (EOC) for services that require a prior authorization from the plan.

Covered Medical and Hospital Benefits (cont.)

	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	**$40** copay	**$40** copay
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. • 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.	**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 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.

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
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	**$387** copay per day for days 1-5 **$0** copay per day for days 6-90
Therapy visits • Partial hospitalization • Specialist's office	 **$55** copay **$40** copay	 **$55** copay **$40** copay
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	**$0** copay per day for days 1-20 **$203** copay per day for days 21-100
PHYSICAL THERAPY		
Comprehensive outpatient rehab facility	**$20** copay	**$20** copay
Specialist's office	**$20** copay	**$20** copay
AMBULANCE		
	$300 copay per date of service	**$300** copay per date of service
TRANSPORTATION		
	Not 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.

Covered Medical and Hospital Benefits (cont.)

	IN-NETWORK	OUT-OF-NETWORK
MEDICARE PART B DRUGS		
Allergy shots and serum		
• Primary care physician's office	**$0** copay	**$0** copay
• Specialist's office	**$0** copay	**$0** copay
Chemotherapy drugs at a specialist's office	**20%** of the cost	**20%** of the cost
Other Part B drugs Some rebatable Part B drugs may be subject to a lower coinsurance. You pay no more than $35 for a one-month (up to 30-day) supply for all Part B insulin covered by our plan, and if your plan has a deductible it does not apply to Part B insulin.		
• Pharmacy	**20%** of the cost	**20%** of the cost
• Primary care physician's office	**20%** of the cost	**20%** of the cost
• Specialist's office	**20%** of the cost	**20%** of the cost

You do not need a referral to receive covered services from plan providers. Certain procedures, services and drugs may need advance approval from your plan. This is called a "prior authorization" or "preauthorization." Please contact your PCP or refer to the Evidence of Coverage (EOC) for services that require a prior authorization from the plan.

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Prescription Drug Benefits

PLAN HIGHLIGHTS	
$0 copays	**$0** copays at select pharmacy locations and tiers. Additional details below
Deductible	**$0** Deductible
Insulin costs	You won't pay more than **$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.

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						
	Retail Cost-Sharing Includes all in-network retail pharmacies		**Standard Mail-Order Cost-Sharing**		**Preferred Mail-Order Cost-Sharing** CenterWell Pharmacy™	
Day supply	**30-day**	**90-day***	**30-day**	**90-day***	**30-day**	**90-day***
Tier 3: Preferred Brand	$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	**$20** copay
Podiatry services (Medicare-covered)	**$40** copay	**$40** copay
Acupuncture services (Medicare-covered)	**$40** copay for acupuncture for chronic low back pain visits up to 20 visit(s) per year.	**$40** copay 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	**20%** of the cost	**20%** of the cost
• Network retail pharmacy	**10%** of the cost	**20%** of the cost
• Preferred diabetic supplier	**$0** copay	**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	**20%** of the cost
Prosthetics devices and related supplies at prosthetics provider	**20%** of the cost	**20%** of the cost
REHABILITATION SERVICES		
Cardiac rehabilitation services at a specialist's office	**$10** copay	**$10** copay
Occupational therapy		
• Comprehensive outpatient rehab facility	**$20** copay	**$20** copay
• Specialist's office	**$20** copay	**$20** copay
Physical therapy		
• Comprehensive outpatient rehab facility	**$20** copay	**$20** copay
• Specialist's office	**$20** copay	**$20** copay
Pulmonary rehabilitation services at a specialist's office	**$10** copay	**$10** copay

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Speech therapy • Comprehensive outpatient rehab facility	**$20** copay	**$20** copay
• Specialist's office	**$20** copay	**$20** copay
Supervised exercise therapy (SET) for Peripheral Artery Disease (PAD) at a specialist's office	**$10** copay	**$10** copay
TELEHEALTH SERVICES (in addition to Original Medicare)		
Primary care physician's office	**$0** copay	**Not Covered**
Specialist's office	**$40** copay	**Not Covered**
Substance abuse or behavioral health services	**$0** copay	**Not Covered**
Urgent care services	**$55** 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.

Chiropractic services
- In-network: **$15** copay for routine chiropractic visits up to 12 visit(s) per year.

- Out-of-network: **$15** copay for routine chiropractic 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.

Routine foot care
- In-network: **$40** copay for routine podiatry visits up to unlimited visit(s) per year.

- Out-of-network: **$65** copay for routine podiatry 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.

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.

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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.

$29.40
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.

$44.50
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.

$53.60
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.

2024

Optional Supplemental Benefits

HumanaChoice H5525-051 (PPO)

Greater Philadelphia

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My Options, My Choice
Adding Benefits to Your Plan

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

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 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
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
Basic Dental Services (Minor Restorative)			
Amalgam restoration (silver filings)	**$25 Per tooth**	**$25 Per tooth**	Unlimited per year
Composite resin restoration (white filings)	**$25 Per tooth**	**$25 Per tooth**	

OPTIONAL SUPPLEMENTAL BENEFITS (continued)

Covered Dental Services	In-Network* You Pay	Out-Of-Network** You Pay	Benefit Limitations
Basic Dental Services (Minor Restorative)			
Extraction, erupted tooth or exposed root	**$25 Per tooth**	**$25 Per tooth**	Unlimited per year
Surgical removal of erupted tooth	**$25 Per tooth**	**$25 Per tooth**	
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 Services (Endodontics, Periodontics, and 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%**	One per tooth per lifetime
Onlay	**50%**	**50%**	
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%**	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.

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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 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

OPTIONAL SUPPLEMENTAL BENEFITS (continued)

Covered Dental Services	In-Network* You Pay	Out-Of-Network** You Pay	Benefit Limitations
Preventive Dental 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
Basic Dental Services (Minor Restorative)			
Amalgam restoration (silver filings)	**0%**	**0%**	Unlimited per year
Composite resin restoration (white filings)	**0%**	**0%**	
Extraction, erupted tooth or exposed root	**0%**	**0%**	Unlimited per year
Surgical removal of erupted tooth	**0%**	**0%**	
Recement inlay, onlay or partial coverage restoration	**$25**	**$25**	One every five years
Recement indirectly fabricated or prefabricated post and core	**$25**	**$25**	
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 Services (Endodontics, Periodontics, and 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

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OPTIONAL SUPPLEMENTAL BENEFITS (continued)

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%**	One per tooth per lifetime
Onlay	**50%**	**50%**	
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%**	

OPTIONAL SUPPLEMENTAL BENEFITS (continued)

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**.

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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**.

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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.**

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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.

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Notes

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Notes

Important

At Humana, it is important you are treated fairly.

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

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

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

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

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Multi-Language Insert

Multi-language Interpreter Services

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

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

Chinese Mandarin: 我们提供免费的翻译服务，帮助您解答关于健康或药物保险的任何疑问。如果您需要此翻译服务，请致电 1-877-320-1235（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 (TTY: 711). Вам окажет помощь сотрудник, который говорит по-русски. Данная услуга бесплатная.

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

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

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

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

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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.

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To find out more about the coverage and costs of Original Medicare, look in the current "Medicare & You" handbook. View it online at http://www.medicare.gov or get a copy by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, seven days a week. TTY users should call 1-877-486-2048.

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

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

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

The 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."

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